STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00418152. Complaint IN00418152 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 5, 6, 10, 11 and 12, 2023 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF: 3 SNF/NF: 76 Total: 79 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 31 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 19, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/1/23.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Anthony Link | Executive Director | 10/31/2023

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure residents received non-disposable utensils to eat their meals with for 17 of 17 residents reviewed for	F 0550	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth	11/01/2023

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	dining on the locked dementia unit. Finding includes: During an observation, on 10/5/23 at 11:34 a.m., the residents were sitting in the dementia dining area. The residents' trays were served by taking food off the tray. Plastic utensils were provided for all residents. During an observation, on 10/5/23 at 12:01 p.m., the residents in the main dining room were being served with non-disposable utensils. During an observation, on 10/11/23 at 11:42 a.m., the residents in the dementia dining room were being served paper napkins and plastic silverware including a spoon, knife, and fork. The staff put the residents' drinks in non-disposable plastic cups. During an interview, on 10/11/23 at 11:52 a.m., CNA 8 indicated a resident owned a restaurant and would take the silverware. CNA 8 indicated the resident might have gone after someone with a fork and everyone got plastic. During an interview, on 10/12/23 at 4:00 p.m., the Dementia Unit Manger and the Director of Nursing Services (DNS) indicated they were only supposed to be using the plasticware for one resident. The resident was care planned for using plastic utensils. The kitchen had sent the non-disposable plastic utensils on the cart for lunch. A Resident Rights policy was not available at the exit conference. 3.1-3(t)		in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/1/23. F 550 Resident Rights **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** None of the 17 residents showed injury due to the alleged deficient practice. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Any instances of resident rights concerns will be addressed immediately. All staff were inserviced on resident rights, dining, and use of non-disposable utensils. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Staff were inserviced on resident rights, dining, and use of non-disposable	

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			utensils. Memory Care Support Specialist (MCSS) will conduct rounds daily to ensure non-disposable utensils are provided at meal times. **1.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?** Facility will used F550 CQI audit tool. Observations will be 5 times per week for 4 weeks, and then weekly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
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 observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment included the resident had a wanderguard for 1 of 1 resident reviewed for elopement. (Resident E) Finding includes:	F 0641	F 641 accuracy of assessments **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice**? Resident E was not affected due to the alleged deficient practice. Resident E	11/01/2023

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	During an observation, on 10/5/23 at 3:28 p.m., Resident E had a wanderguard on her right ankle. The record for Resident E was reviewed on 10/10/23 at 10:44 a.m. Diagnoses included, but were not limited to, depression, dementia with mood disturbance, cognitive communication deficit, difficulty in walking, and a history of a traumatic brain injury. An MDS assessment, dated 8/11/23, indicated the resident did not use a wanderguard. During an interview, on 10/10/23 at 2:33 p.m., the MDS Coordinator indicated the resident did not have a physician's order for the wanderguard which was placed on 8/7/23. The only way she found out if the resident had a wanderguard was by reviewing the physician's orders. Since there was no physician's order then she did not code the MDS assessment with the wanderguard. During exit, the facility indicated they used the RAI (Resident Assessment Instrument) manual for instructions to complete MDS assessments. 3.1-31(d)(3)		MDS was corrected to reflect use of wanderguard device. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident have the potential to be affected by this alleged deficient practice. All residents were assessed for the presence of a wanderguard, no additional devices found . All residents with a wanderguard had their MDS checked for accuracy with no further issues found. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Nursing and Social Services staff will be inserviced on ensuring MDS assessments are accurate for residents with wanderguards . MDSC and IDT will assess resident for any device use during bedside care plan review at least quarterly to ensure accurate MDS coding. 4. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**. Facility will use F641 CQI audit tool. MDS coordinator will use MDS accuracy QAPI tool,	

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			weekly X 4 weeks, and monthly X 5 months. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to give medications within the prescribed time for 6 of 6 residents reviewed for quality of care. (Residents B, C, D, E, F, G) Findings include: 1. The record for Resident B was reviewed on 10/12/23 at 4:28 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, hypertension, atrial fibrillation, dementia, unspecified severity with other behavioral disturbance, depressive disorder, and anxiety disorder. A physician's order, dated 11/3/21, indicated clonazepam (for anxiety) 0.5 mg tablet, to give 0.25 mg tablet twice a day related to anxiety.	F 0684	F684 Quality of Care 1. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Residents B,C,D,E,F,G medications were administered and MD was made aware of time variance. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Nurses and QMAs have been inserviced	11/01/2023

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	A physician's order, dated 12/2/22, indicated acetaminophen (a pain medication) 500 mg (milligram) tablet, to give 2 tablets three times a day related to chronic pain. A physician's order, dated 6/30/23, indicated simethicone (relieves painful symptoms of too much gas in the stomach) chewable 80 mg to give 2 tablets by mouth daily. The Medication Administration Record (MAR) indicated the following medications were administered late: a. clonazepam 0.5 mg tablet was administered late on 9/5/23. b. acetaminophen 500 mg tablet was administered late on 9/8/23, 9/11/23, 9/22/23, 9/25/23, 10/10/23, 10/11/23 and 10/12/23. c. simethicone chewable 80 mg tablet was administered late on 9/8/23, 9/11/23, 9/22/23, 9/25/23, 10/10/23, 10/11/23 and 10/12/23. During an interview, on 10/5/23 at 2:56 p.m., Resident B indicated medications could be given late depending on what nurses were working and what shift. 2. The record for Resident C was reviewed on 10/12/23 at 4:55 p.m. Diagnoses included, but were not limited to, chronic pulmonary edema, congestive heart failure, and hypertension. A physician's order, dated 10/25/22, indicated acetaminophen 325 mg tablet, to give 1 tablet three times a day related to pain. A physician's order, dated 12/5/22, indicated ferrous sulfate (for anemia) 325 mg tablet, to give 1 tablet by mouth twice a day related to anemia.		on proper medication administration process. 3. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Nursing administration will review medication administration compliance reports 5 X weekly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Med Pass skills validation will be completed 5 X weekly for 4 weeks, then weekly for 5 months. After six months the CQI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	A physician's order, dated 2/17/23, indicated torsemide (a diuretic) 20 mg tablet, to give 2 tablets twice a day. The MAR indicated the following medications were administered late: a. acetaminophen 325 mg tablet was administered late on 10/9/23, 10/10/23, 10/11/23 and 10/12/23. b. ferrous sulfate 325 mg tablet was administered late on 10/9/23, 10/10/23, 10/11/23 and 10/12/23. c. torsemide 20 mg tablet was administered late on 10/9/23, 10/10/23, 10/11/23, 10/12/23. 3. The record for Resident D was reviewed on 10/12/23 at 5:28 p.m. Diagnoses included, but were not limited to, quadriplegia (paralysis of all four limbs), asthma, and constipation. A physician's order, dated 8/11/23, indicated docusate sodium (a stool softener) 100 mg capsule, to give 1 capsule three times a day. A physician's order, dated 8/11/23, indicated torsemide (a diuretic) 20 mg tablet, to give 2 tablets by mouth daily. A physician's order, dated 8/24/23, indicated Tylenol Extra Strength (for pain) 500 mg tablet, to give 2 tablets three times a day. A physician's order, dated 8/11/23, indicated senna (a laxative) 8.6 mg tablet, to give 2 tablets daily. A physician's order, dated 8/11/23, indicated enoxaparin (an anticoagulant) 40 mg/0.4 milliliter(ml), give 40 mg subcutaneous (injection given just under the skin) daily. A physician's order, dated 9/15/23, indicated			

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	hydrocodone-acetaminophen (for pain) 5-325 mg tablet, to give 1 tablet twice a day. The MAR indicated the following medications were administered late: a. docusate sodium 100 mg capsule was administered late on 9/1/23, 9/6/23, 9/13/23, 9/21/23, 9/23/23. b. Tylenol extra strength 500 mg tablet was administered late on 9/1/23, 9/6/23, 9/13/23. c. senna 8.6 mg tablet was administered late on 9/20/23. d. enoxaparin 40 mg subcutaneous was administered late on 9/20/23. e. hydrocodone-acetaminophen 5-325 mg tablet was administered late on 9/15/23 and 9/20/23. 4. The record for Resident E was reviewed on 10/12/23 at 3:22 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and pain. A physician's order, dated 4/10/23, indicated acetaminophen 500 mg tablet, to give 2 tablets three times a day related to chronic pain. The MAR indicated the following medication was given late: a. acetaminophen 500 mg tablet was administered late on 9/23/23 and 10/9/23. 5. The record for Resident F was reviewed on 10/12/23 at 3:22 p.m. Diagnoses included, but were not limited to, dementia, pain, hypertension, and Alzheimer's disease. A physician's order, dated 8/19/23, indicated acetaminophen 500 mg tablet, give 1 tablet three times a day related to chronic pain.			

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	The MAR indicated the following medication was administered late: a. acetaminophen 500 mg tablet was administered late on 9/6/23 and 9/26/23. 6. The record for Resident G was reviewed on 10/12/23 at 4:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), asthma, and G-J tube (allows food to be given directly into the jejunum, bypassing the mouth, throat, and stomach). A physician's order, dated 6/29/23, indicated famotidine (for gastric reflux) 40 mg/5 ml suspension (liquid), give 20 mg daily. A physician's order, dated 9/8/23, indicated guaifenesin (for congestion) 100 mg/5 ml, give 600 mg twice a day related to congestion. A physician's order, dated 9/8/23, indicated magnesium oxide (for gastric reflux) 400 mg tablet give daily. A physician's order, dated 9/8/23, indicated multivitamin with folic acid (a supplement) 400 microgram (mcg) tablet, give 1 tablet daily. The MAR indicated the following medications were administered late: a. famotidine 40 mg/5 ml suspension 20 mg daily was administered late on 9/21/23, 9/22/23, and 9/26/23. b. guaifenesin 100 mg/5 ml, 600 mg twice a day was administered late on 9/30/23. c. magnesium oxide 400 mg tablet daily was administered late on 9/30/23. d. multivitamin with folic acid 400 microgram tablet was administered late on 9/30/23.			

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	During an interview, on 10/12/23 at 3:39 p.m., RN 3 indicated sometimes staff would get sidetracked when passing medication and would have to just chart late. During an interview, on 10/12/23 at 3:44 p.m., LPN 7 indicated things came up, you got too busy, or you just did not have time and medications were passed out late. A current policy, titled "Medication Pass Procedure," revised 12/2016 and received from the Director of Nursing Services on 10/12/23 at 3:53 p.m., indicated "...1. Medication administered within 60 minutes before and/or after time ordered...6. Perform the 5 rights of medication Right Resident, Right Medication, Right Dose, Right Route, Right Time...16. Medication administration will be recorded on the MAR/EMAR or TAR after given...." This Federal tag relates to Complaint IN00418152. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident with a wanderguard (an alarm bracelet) had a	F 0689	F689 Accident Hazards/ Supervision/ Devices 1. **What corrective action(s) will**	11/01/2023

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	physician's order, daily assessment for placement and a care plan for the alarm for 1 of 1 resident reviewed for elopement. (Resident E) Finding includes: During an observation, on 10/5/23 at 3:28 p.m., Resident E had a wanderguard on her right ankle. During an observation, on 10/10/23 at 2:21 p.m., the resident was in her room watching television and had the door to her room closed. During an observation, on 10/10/23 at 10:54 a.m., the resident was sitting up in a chair in the dining room and listening to music with other residents. The resident had not been observed wandering or trying to leave the locked unit. The record for Resident E was reviewed on 10/10/23 at 10:44 a.m. Diagnoses included, but were not limited to, depression, dementia with mood disturbance, cognitive communication deficit, difficulty in walking, and a history of a traumatic brain injury. A care plan, dated 5/1/23, indicated the resident was at risk for elopement as evidenced by walking up to the exit doors, intrusive wandering into other resident's room, asking for keys to her car and stating she needed to get out the doors to go upstairs. The interventions included, but were not limited to, offer assistance, all facility exits secured, resident resides on a secured unit, and to redirect to activities of interest. The care plan interventions did not include a wanderguard.		**be taken for those residents found to have been affected by the deficient practice?** Resident E now has a physician order, daily assessment, and care plan in place. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident were assessed for the presence of a wanderguard, no new devices found. All residents with a wanderguard have the potential to be affected by this alleged deficient practice. All residents with wanderguards have been reviewed and all have physician order and care plan in place. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Nurses and Social Services staff will be inserviced on ensuring residents with wanderguards have physician order which includes daily assessment for placement and care plan in place. IDT will review all new residents with wanderguards to ensure all have physician order, daily assessment, and care plan in place. IDT will review facility progress notes 5 x per week.	

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	155199	A. BUILDING 00 B. WING	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

(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
	A physician's order, dated 6/12/23, noted it was clinically indicated for the resident to reside on a secured unit. During an interview, on 10/11/23 at 11:00 a.m., the Minimum Data Set (MDS) Coordinator indicated there was no physician's order for the resident's wanderguard. The wanderguard was placed on 8/7/23. The resident knew the code to the dementia unit. Since there was no physician order, there was no documentation the wanderguard was checked daily for function and placement. A current policy, titled "Elopement Prevention and Response Program," revised on 10/20 and received from the Executive Director (ED) on 10/10/23 at 3:58 p.m., indicated "...Residents at risk for elopement may utilize a security bracelet [if the facility utilizes an electronic monitoring system and need for device is present on the care plan] per physician's order that will be checked for placement and function no less often than daily. Security bracelets will be placed on residents appropriately and per manufacturer's instructions...." 3.1-45(a)(1)		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** CQI tool for F689 will be completed 5 x week X 1 month, then weekly for 5 months to ensure wanderguards have physician order, daily assessment, and care plan in place. After six months the CQI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to identify and implement resident specific preventative nursing measures for a resident with multiple repeat urinary tract infections (UTI) for 1 of 3 residents reviewed for UTIs. (Resident F) Finding includes: The record for Resident F was reviewed on 10/10/23 at 3:55 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, chronic kidney disease stage 3, need for assistance with personal care, urinary tract infection, and difficulty in walking.	F 0690	F690 Bowel/ Bladder Incontinence, Catheter, UTI **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Preventative nursing measures, care planning and peri care interventions were put into place for Resident F. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what**	11/01/2023

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	The Surveillance Log indicated the resident had the following UTIs and treatments: 1. October 6-13, 2022, ceftriaxone for a urine culture positive for E coli. 2. October 26-November 11, 2023, amoxicillin for a culture report positive for P. mirabilis (a bacteria which causes UTIs). 3. January 1-7, 2023, Macrobid (an antibiotic for UTIs). There was no culture report. 4. February 15- 20, 2023, cephalexin (an antibiotic) for a urine culture positive for proteus mirabilis. 5. March 24-29, 2023, Augmentin for a urine culture positive for E. Coli (a bacteria found in stool). 6. April 4, 2023, Keflex (an antibiotic) for a UTI with no urine culture results on the log. 7. April 21, 2023, cephalexin for a UTI with no urine culture results on the log. 8. June 16, 2023, cephalexin as preventative for a UTI. 9. July 21-August 5, 2023, Bactrim DS for a UTI with no urine culture results on log. 10. September 26-October 3, 2023, cephalexin for a UTI with a culture report positive for E. Coli. A care plan, dated 7/5/22 and last reviewed/revised on 9/28/23, indicated the resident required assistance with toileting due to incontinence. The goal was the resident would not exhibit adverse effects from incontinence. The interventions included, but were not limited to, assist with clothing, incontinent care as needed, and toilet before rising, before or after meals and at bedtime. The care plan was not updated to include the repeat UTIs or the specific type of peri care to prevent stool from entering the urinary tract. During an interview, on 10/12/23 at 2:06 p.m., the		**corrective action will be taken?** All residents with multiple repeat urinary tract infections have the potential to be affected by this alleged deficient practice. All residents reviewed and care plans updated as needed. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Nursing staff will be educated on pericare, handwashing, signs and symptoms of UTIs and prevention of UTIs. In monthly QAPI meeting, infection trends will be reviewed to identify residents with recurrent UTIs. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** CQI tool for F690 will be completed weekly for 4 weeks, then monthly for 5 months to ensure residents with recurrent UTIs have a care plan with resident specific interventions. After six months the CQI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	Director of Nursing Services (DNS) indicated the resident's care plans were started and stopped each time the antibiotics for the UTIs were started and stopped. Even though the resident was being seen by a urologist and had repeat UTIs with E. Coli (a bacteria found in stool) there was no care plan for the repeat UTIs, and no care planned interventions for the repeat UTIs. A current policy, titled "Infection Prevention System of Surveillance," revised 05/2023 and received from the Executive Director (ED) on 10/5/23 at 2:20 p.m., indicated "...To conduct surveillance activities that will identify infections and prevent the spread of infections...SURVEILLANCE COMPONENTS...Investigation... Document/Records...Monitor...Data Analysis...Implementation...Report...MONITOR...P rovide ongoing tracking to rule out an infection, the development of new/recurrent infections and/or spread of infections...." 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			

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	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 identify significant weight changes, implement timely interventions, and notify the provider and family in a timely manner for 2 of 4 residents reviewed for nutrition. (Resident 31 and E) Findings include: 1. The record for Resident 31 was reviewed on 10/12/23 at 12:10 p.m. Diagnoses included, but were not limited to, iron deficiency anemia, chronic obstructive pulmonary disease, dementia, feeding difficulties, and fracture of the right femur. A weight log indicated the following: a. On 9/7/23, the resident's weight was 144 pounds. b. On 10/4/23, the resident's weight was 131 pounds. c. On 10/6/23, the resident's weight was 131 pounds. The resident had a 9.03%- or 13-pound weight loss in 27 days. A progress note, dated 10/06/2023 at 3:15 p.m., indicated an MDS (Minimum Data Set) significant change assessment was initiated for a significant weight loss.	F 0692	F 692 Nutrition/ Hydration status management **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 31's provider and family were notified of the significant weight loss. The facility did add ice cream to dinner tray card and peanut butter sandwich to lunch tray card. Resident E's family and provider were notified of the residents weight gain history. 1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who had experienced significant weight gain and loss have the potential to be affected by the alleged deficient practice. All residents who experience a significant weight loss or gain will have their provider and family notified. Timely interventions were put in place at the time of the significant weight loss.	11/01/2023

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	The facility did not contact the provider or family after recognizing the significant weight loss. A progress note, dated 10/12/23 at 12:28 p.m., indicated the facility notified the provider and called the family about the significant weight loss on 10/11/23. A progress note, dated 10/12/23 at 1:02 p.m., indicated the facility spoke with the son of the resident and he indicated the resident loved sliced ham, peanut butter sandwiches, ice cream, and cakes. The facility would add ice cream to the dinner tray with a peanut butter sandwich at lunch. During an interview, on 10/12/23 at 1:55 p.m., the DNS (Director of Nursing Services) indicated the provider was not notified until 10/11/23 because the facility reviewed weights on Mondays. The NP (Nurse Practitioner) was notified on 10/11/23. There was a 7-day gap between when the resident had a significant weight loss, and the provider and family were notified. The resident had the weight loss on 10/4/23 and the facility recognized the weight loss on 10/6/23 when an MDS significant change assessment was initiated but did not notify the provider or family until 10/11/23.2. The record for Resident E was reviewed on 10/10/23 at 10:44 a.m. Diagnoses included, but were not limited to, nutritional anemia, dementia with mood disturbance, cognitive communication deficit, need for assistance with personal care, and a history of a traumatic brain injury. A care plan, dated 5/1/23 and last reviewed/revised on 8/18/23, indicated the resident was at a nutritional risk due to the		1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? IDT will meet weekly to review and develop new interventions for residents with significant weight changes. DNS/ Designee will ensure timely notification of significant weight changes. Dietary, nursing staff, and nursing administration have been inserviced on policy regarding significant weight loss or gains, provider and family notification, and provision of timely interventions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. Facility will use F692 CQI audit tool weekly X 4 weeks, and then monthly for 5 months to ensure timely notification and implementation of interventions. If 95% compliance is not achieved, an action plan will be completed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	diagnoses of metabolic encephalopathy and protein-calorie malnutrition. The goal indicated the resident would not have a significant weight change. The interventions included, but were not limited to, honor known food preferences, monitor weight, and notify physician/family of significant weight changes. A Registered Dietician (RD) note, dated 5/5/23 at 11:44 a.m., indicated the resident's diagnoses may increase her nutritional risks. The current weight was 142 pounds and the resident's usual body weight was 130-140 pounds. The resident had the following weights: a. On 4/29/23, the weight was 135.8 pounds. b. On 5/16/23, the weight was 145 pounds which was a 6.77% increase in 17 days. c. On 7/6/23, the weight was 152 pounds which was a 11.93% increase in 68 days. d. On 8/4/23, the weight was 157 pounds which was a 15.61% increase in 97 days. e. On 8/14/23, the weight was 160 pounds which was a 17.88% increase in 107 days. f. On 10/4/23, the weight was 168 pounds which was a 23.71% weight increase since the admission weight on 4/29/23. The resident's body mass index (BMI) on 10/4/23 was 27.11. During an interview, on 10/11/23 at 3:26 p.m., the Director of Nursing Services (DNS) indicated the family was notified of the weight gain in August and there were no notifications to the physician or the family prior to August 2023. The computer variance report only triggered for significant weight changes at 30 days, 90 days, and 180 days. If the significant changes happened at other times, the computer would not show the changes.			

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	The facility did not recognize the continued weight gain after August. There was no documentation to show if the significant weight gain was desired, the cause of the significant weight gain, or if interventions were needed for the significant weight gain. A current policy, titled "Resident Weight Monitoring," reviewed in July 2023 and received from the DNS on 10/11/23 at 11:10 a.m., indicated "...Residents who have experienced a significant wight loss or gain of 5% in 30 days...The physician/health care practitioner will be notified of unplanned significant weight loss/gains...." A current policy, titled "Resident Change of Condition Policy," reviewed in November 2018 and received from the DNS on 10/12/23 at 3:37 p.m., indicated "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...The nurse in charge is responsible for notification of physician and family/responsible party prior to the end of assigned shift when a significant change in the resident's condition is noted...." 3.1-46(a)(1)			
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			

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	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 residents oxygen tubing was dated and replaced for 2 of 3 residents reviewed for respiratory care. (Residents 38 and 76) Findings include: 1. During an observation, on 10/5/23 at 11:52 a.m., Resident 38's oxygen tubing did not have a date on it. The record for Resident 38 was reviewed on 10/10/23 at 10:45 a.m. Diagnoses included, but were not limited to, restrictive lung disease, dyspnea (difficulty breathing), chronic respiratory failure, and obstructive sleep apnea. A physician's order, dated 9/22/23, indicated the resident was on 3 liters of oxygen continuously. A physician's order, dated 9/22/23, indicated to change the oxygen tubing once a day on Sundays. During an interview, on 10/5/23 at 2:48 p.m., RN 9 indicated the oxygen tubing should have been dated. During an interview, on 10/10/23 at 3:53 p.m., the ED (Executive Director) indicated the oxygen tubing for residents should be dated. 2. During an observation, on 10/5/23 at 2:45 p.m.,	F 0695	F 695 Respiratory/ Tracheostomy Care and Suctioning **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Residents 38 and 76 oxygen tubing was replaced and dated. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who have oxygen tubing have the potential to be affected by the alleged deficient practice. All nursing staff will be inserviced on the policy of replacing and dating oxygen tubing weekly. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff will be inserviced on the policy of replacing oxygen tubing weekly. DNS/ nurse manager will observe 5 times per week oxygen tubing to ensure it is replaced and dated weekly or more often as needed.	11/01/2023

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	Resident 76's oxygen tubing was dated 8/6/23. The record for Resident 76 was reviewed on 10/10/23 at 9:24 a.m. Diagnoses included, but were not limited to, chronic respiratory failure and cognitive communication deficit. A physician's order, dated 6/9/23, indicated the resident was to wear 3 liters of oxygen continuously. A physician's order, dated 6/8/23, indicated to change the oxygen tubing once a day on Sundays. During an interview, on 10 /5/23 at 2:48 p.m., RN 9 indicated the oxygen tubing should have been changed. A current policy, titled "Oxygen Therapy and Devices," received from the ED on 10/10/23 at 11:00 a.m., indicated "...Change out weekly and PRN...." 3.1-47(a)(6)		**1.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?** All nursing staff will be inserviced on the policy of replacing and dating oxygen tubing weekly. Facility will use F695 CQI audit tool. Observations will be weekly x 4 weeks and then monthly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic			

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	Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure symptom monitoring was in place for the use of an antipsychotic medication prescribed and a gradual dose reduction (GDR)	F 0758	F 758 Free from Unnecessary Psychotropic meds/ PRN use **1.What corrective action(s) will**	11/01/2023

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	was considered for 1 of 5 residents reviewed for unnecessary medications. (Resident F) Finding includes: The record for Resident F was reviewed on 10/10/23 at 3:55 p.m. Diagnoses included, but were not limited to, dementia with other behavioral disturbance, delusional disorder, major depressive disorder, generalized anxiety disorder, and a cognitive communication deficit. A care plan, dated 2/23/23, indicated the resident was at a risk for adverse side effects related to the use of an antipsychotic. The interventions included, but were not limited to, administer the medication as ordered and observe for effectiveness, the interdisciplinary team (IDT) to review routinely, and to attempt a gradual dose reduction unless contraindicated by the physician. A physician's order, dated 4/10/23, indicated risperidone (an antipsychotic) 0.5 milligram (mg) twice a day for a delusional disorder. The resident had the following documented behaviors: 1. On 5/21/23 at 2:33 p.m., the resident was observed by staff to kneel on the floor and then laid down. 2. On 5/24/23 at 9:58 a.m., the resident was witnessed sitting herself on the floor in her room. 3. On 6/9/23 at 10:57 a.m., the interdisciplinary team met to discuss the resident behavioral expression of the resident laying on the floor. She had intermittent periods of laying on the floor. 4. On 6/27/23 at 2:20 p.m., the resident was walking around in the common area getting up and down out of the chairs and the recliner. The resident		**be taken for those residents found to have been affected by the deficient practice?** A care plan had been developed 2/23/23 for resident F that addresses her delusions, usual behavioral expressions, and interventions for staff to use when behavior is exhibited. This care plan has been updated and facility will continue to document behavior expressions. The physician had considered on 8/2/23 that a GDR was contra indicated and noted it was contraindicated. The residents medication was reduced on 10/18/23 with physicians order and family approval. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who antipsychotic medication prescribed have the potential to be affected by the alleged deficient practice. All nursing staff, social services staff, and MDS Coordinator will be inserviced on ensuring behavioral expressions are documented when they occur, a care plan is in place for appropriate residents and that GDRs will be reviewed by the physician for consideration. **3.What measures will be put into place or what systemic**	

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	155199	A. BUILDING 00 B. WING	10/12/2023

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	was seated in the recliner and scooted forward and slid on the floor. The resident was sitting upright and continued scooting. A Pharmacy Consultation report, dated 7/26/23, indicated the resident had a diagnosis of dementia and received risperidone 0.5 mg twice daily for dementia and related behaviors. Antipsychotics had a boxed warning for the increased risk of mortality in older adults with psychosis related to dementia. Additionally, the antipsychotics were associated with other potentially serious adverse effects including movement disorders, metabolic abnormalities, and orthostatic hypotension. Please consider attempting a gradual dose reduction of risperidone to 0.25 mg twice daily with the end goal of discontinuation. An evaluation of gradual dose reduction of psychotropic medication, dated 8/2/23, indicated the risperidone 0.5 mg supporting diagnosis was delusional disorders. The physician's response included to not reduce the medication since it was clinically contraindicated related to the family was resistant to the dose reduction. The documentation did not include any delusions, for the months of May, June, and July 2023, prior to the GDR being declined on 8/2/23. During an interview, on 10/11/23 at 11:08 a.m., the Dementia Unit Manager (UM) indicated the staff would document delusions in the progress notes or events section of the electronic record if the resident had them. The UM did not remember Resident F having any delusions and she did not mark her as having delusions. During an interview, on 10/11/23 at 12:01 p.m., the Dementia UM indicated the care plan for		**changes will you make to ensure that deficient practice does not recur?** All nursing staff, social services staff, and MDS Coordinator will be inserviced on ensuring behavioral expressions are documented when they occur, a care plan is in place for appropriate residents and that GDRs will be reviewed by the physician for consideration . Social Services and MDSC/ designee will ensure care plans are in place for residents with prescribed antipsychotic medications. Progress notes will be reviewed 5 times per week for documentation of behavioral expressions. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Facility will use F758 CQI audit tool. Care plan review, GRD notification, and IDT behavior review for new and worsending behaviors, and progress note review will be 5 X weekly for 1 month, and the monthly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to	

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	delusions was stopped in July 2023 and she did not know why it was discontinued. If the resident was not having delusional behaviors, then the care plan would not be kept. During an interview, on 10/12/23 at 10:42 a.m., the Director of Nursing Services (DNS) indicated there was no documentation to show the resident's delusions were monitored after the care plan was discontinued in July 2023. The resident had behaviors when the medication was restarted and not delusions. A current policy, titled "Psychotropic Management," revised on 7/22 and received from the Dementia Unit Manager on 10/11/23 at 4:08 p.m., indicated "...It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with professional services and facility staff to include non-pharmacological interventions, assessment and reduction as applicable...Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnoses, and this is documented in the medical record. Each resident receiving psychotropic medication will have an adequate indicate for use and supporting diagnosis for use which is documented in the clinical record...Symptoms and therapeutic goals must be clearly documented prior to initiating or increasing a psychotropic medication...Gradual dose reductions [GDR] and use of non-pharmacological interventions will occur for residents receiving psychotropic medication unless contraindicated by the prescriber with a specific rationale...For		and including termination of the responsible employee.	

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	antipsychotic medications, diagnoses alone do not necessarily warrant the use [of]these medications. Antipsychotic medications may be indicated if...behavioral symptoms present a danger to the resident or others...expressions or indications of distress that are significant distress to the residents...Non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress...GDR was attempted but symptoms returned...Prescribers will evaluate the efficacy and risks for psychotropic medications and document their assessment in the medical record...Psychotropic medications may be considered regularly for potential GDR including during monthly pharmacy reviews, during behavioral health services visits, and when the IDT is evaluating behavioral expressions...When considering a GDR, the prescriber will assess the risks/benefits of the reduction. The prescriber may reduce the medication or clinically contradict the GDR based on relevant clinical standards of practice...." 3.1-48(a)(3) 3.1-48(b)(2)			
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			

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	Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to label medications with an open date on medications with a shortened expiration date once opened in 1 of 2 medication storage refrigerators and 2 of 3 medication carts (300 Unit, 100 Unit and 300 North Unit). Findings include: 1. During an observation, of 300-unit medication storage room and refrigerator, on 10/5/23 at 12:55 p.m., with LPN 2 in attendance, a bottle of Tuberculin (the testing solution for a Tuberculosis skin test) was found open in the medication storage refrigerator. It did not have an open date. During an interview, on 10/5/23 at 12:55 p.m., LPN 2 indicated it should have been labeled with the open date when it was opened. 2. During an observation, of the 100 Unit Medication Cart, on 10/10/23 at 9:21 a.m., with RN 3 in attendance, an Advair inhaler was found	F 0761	**F761 Label/ Store Drugs Biologicals** **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The opened and not dated vial of TB solution was disposed of. The Advair inhaler and the Novolin Insulin were disposed of, with replacements being ordered and paid for by the facility. No residents were affected due to the alleged deficient practice. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who receive medications that require and open date have the potential to be	11/01/2023

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	outside the original foil packaging. The inhaler had 56 of 60 doses left. The label on the packaging indicated the medication expired 30 days after opening. There was no open date on the packaging or inhaler. During an interview, on 10/10/23 at 9:21 a.m., RN 3 indicated the inhaler should have been labeled with an open date. 3. During an observation, on 10/10/23 at 9:30 a.m., with LPN 2 in attendance, a Novolin insulin pen was found open in the drawer of the 300 North Hall cart. The pen had approximately 200 units left. There was no open date on the packaging or pen. During an interview, on 10/10/23 at 9:30 a.m., LPN 2 indicated it should have been dated when opened and the insulin pen was good for 28 days after opening. A current facility policy, titled "Storage and Expiration Dating of Medications, Biologicals," dated as last revised on 8/7/2023 and received from the Director of Nursing Services on 10/10/23 at 11:32 a.m., indicated "...Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened...." 3.1-25(j)		affected by the alleged deficient practice. All vials of TB solution, Advair inhalers, and Novolin pens were checked and none were found undated. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nurses were inserviced on policy for labelling and dating medications. DNS/ Designee will audit medication carts weekly that open dates are present. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? Facility will use F761 CQI audit tool. Observations will be 5 times per week for 4 weeks, and then monthly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
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			

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	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; (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			

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	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, interview and record review, the facility failed to ensure a catheter bag was not touching the ground for 1 of 1 resident reviewed for infection control related to catheters. (Resident 14) Finding includes: During an observation, on 10/11/23 at 10:21 a.m., Resident 14 was being seen for wound care. The resident's catheter bag was observed to be touching the ground.	F 0880	**F880 Infection Prevention & Control** **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No residents were affected due to the alleged deficient practice. A wash basin was placed under the residents catheter bag to prevent it from touching the floor.	11/01/2023

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	During an observation, on 10/11/23 at 10:33 a.m., the bed was lowered back down after wound care was completed and the catheter bag touched the ground again. The basin to protect the catheter bag from touching the floor was underneath the bed towards the head of the bed and not underneath the catheter bag. The record for Resident 14 was reviewed on 10/11/23 at 3:09 p.m. Diagnoses included, but were not limited to, obstructive and reflux uropathy, history of urinary tract infections, and dementia. During an interview, on 10/11/23 at 10:37 a.m., the ADON (Assistant Director of Nursing) indicated the catheter bag should have a basin which the catheter bag sat in to prevent it from touching the ground. During an interview, on 10/12/23 at 11:37, the DNS (Director of Nursing Services) indicated the basin was in place when staff set up the wound care but must have been kicked under the bed before it was observed. The basin was not in place during wound care. A CDC (Centers for Disease Control) guideline, titled "GUIDELINES FOR PREVENTING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS 2009," dated 2009 and updated 6/6/2019 indicated "...Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor...." 3.1-18(b)		**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who have a catheter have the potential to be affected by the alleged deficient practice. All residents with catheters in the facility were inspected with no concerns noted. **3.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff were inserviced on policy for infection control related to catheter. Charge nurses will observe for proper placement of catheters and tubing daily during rounds. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? Facility will use F880 CQI audit tool. Observations will be 5 times per week for 4 weeks, and then monthly for 5 months. If 90% compliance is not achieved, an action plan will be developed. After six months the QAPI committee will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to	

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			and including termination of the responsible employee.	