STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 00 B. WING	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(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. This visit included the Investigation of Complaints IN00432312 and IN00433238. Complaint IN00432312 - No deficiencies related to the allegations are cited. Complaint IN00433238 - No deficiencies related to the allegations are cited. Survey dates: June 3, 4, 5, 6, and 7, 2024 Facility number: 000249 Provider number: 155358 AIM number: 100267640 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 6 Medicaid: 36 Other: 17 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 13, 2024.	F 0000	The plan of correction is to serve as Majestic Care of Deming Park's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Majestic Care of Deming Park or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review and will provide any additional information as requested.	
F 0561 SS=E Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela J. Clevenger	Executive Director/HFA	06/28/2024

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	must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility lacked documentation of showers being provided related to resident preferences for 3 of 24 residents reviewed for choices (Residents 57, 14, and 11). Findings include: 1. During an interview, with Resident 57's wife, on 6/3/24 at 2:05 p.m., she indicated the resident was not getting the number of showers that he and	F 0561	I corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 57, 14, and 11 offered showers and received. Shower preferences confirmed with each resident with facility shower schedule and CNA sheets updated. II. The facility will identify other residents that may potentially be affected by the	06/28/2024

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	she preferred. He should be getting 2 showers a week but most often he had only been getting 1 per week. Resident 57's record was reviewed on 6/6/24 at 11:09 a.m. The profile indicated the resident had been admitted on 4/10/24, for diagnoses which included, but were not limited to, fracture of the right pubis (a type of crack or break in a person's pelvis), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). An admission Minimum Data Set (MDS) assessment, dated 4/17/24, indicated the resident had severe cognitive deficit and required extensive assistance with his activities of daily living (ADLs-activities related to personal care). The MDS lacked documentation of any behaviors for rejection of care. A care plan, with a revision date of 6/4/24, indicated the resident had personal preferences. A goal with a target date of 8/13/24, indicated staff would honor the resident's preferences. Interventions included, but were not limited to, the resident would like a shower on Monday and Friday evenings, as he prefers. The resident's April and May 2024 shower sheets lacked documentation of any showers being provided or of any refusals of care. The shower sheets indicated the following: a. A bed bath without washing the resident's hair was provided on 4/12/24.		practice. All that reside in the facility have the potential to be affected by the deficient practice. All facility residents interviewed for shower preferences with facility shower schedule and CNA sheets updated. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. Educate all nursing staff to follow CNA sheets and facility shower schedule. Resident preferences for bathing to be confirmed on admission, annually, and with any significant change. Documentation of showers to be done at time of care with procedure review for refusals, if occur. IV. The facility will monitor the corrective action by implementing the following measures. DON or designee will interview 5 residents to determine of shower given to preference and audit to ensure documentation accurate 5 days a week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	b. A bed bath without washing the resident's hair was provided on 4/19/24. c. A bed bath without washing the resident's hair was provided on 4/22/24. d. A bed bath without washing the resident's hair was provided on 4/29/24. e. A bed bath without washing the resident's hair was provided on 5/6/24. On 6/6/24 at 10:45 a.m., review of the March through May 2024, Resident Council meeting minutes indicated concerns had been raised by the Council members about residents not receiving their showers. During an interview, on 6/6/24 at 11:56 a.m., Unit manager 14 indicated the resident did not wish to get out of bed for a shower, so he was given a bed bath. She was not aware why the shower sheets did not indicate he had refused to get out of bed. She believed the staff needed to be educated on how to accurately document shower sheets. During an interview, on 6/7/24 at 2:19 p.m., the Executive Director (ED) indicated that the issue of the resident's showers had been taken on as a performance improvement project (PIP) for the Quality Assurance Performance Improvement (QAPI) committee as an area of concern.2. During the initial interview with Resident 14, on 6/3/24 at 1:48 p.m., she indicated staff had not been providing her showers "very often," and her last shower was on 5/27/24. Her shower days were supposed to be in the evenings on Tuesdays and Saturdays. At one point she had gone about a month without a shower because staff would tell her they would return to give her one, and never			

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	came back. Resident 14's record was reviewed on 6/6/24 at 9:48 a.m. Her diagnoses included, but were not limited to, dementia (loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) with late onset, unspecified lack of coordination (poor muscle control that causes clumsy movements that can affect walking and balance), and unsteadiness on feet (a pattern of walking that is unstable). A care plan, dated 11/28/23, indicated staff would honor the personal preferences the resident had indicated to be important to her. The interventions included, but were not limited to, Resident 14 preferred to have a shower on Tuesdays and Saturdays in the evenings. A Minimum Data Set (MDS) assessment completed for payment assessment, dated 5/20/24, indicated Resident 14's brief interview for mental status (BIMS) score was 11, which indicated moderate cognitive impairment. The MDS assessment indicated that she had not exhibited behaviors for rejecting care. 3. During the initial interview with Resident 11, on 6/4/24 at 9:53 a.m., he indicated that he only received showers when staff thought he should, not when he wanted to. Staff would tell him they were going to give him a shower, and then never did. He indicated his shower days were Mondays and Thursdays. Resident 11's record was reviewed on 6/6/24 at			

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	9:17 a.m. His diagnoses included, but were not limited to, difficulty walking, repeated falls, need for assistance with personal care, dizziness and giddiness (a feeling of being unbalanced or lightheaded), Alzheimer's disease with late onset (brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and fusion of the spine, lumbar region (a surgery technique that connects two or more pieces of the lower back bones). A care plan, dated 8/17/23, indicated staff would honor the personal preferences the resident had indicated to be important to her. The interventions included, but were not limited to, Resident 11 preferred to have a shower on Mondays and Thursdays in the evenings. A quarterly Minimum Data Set (MDS) assessment, dated 4/10/24, indicated Resident 11's brief interview for mental status (BIMS) score was 13, which indicated he was cognitively intact. The MDS assessment indicated that he had not exhibited behaviors for rejecting care. On 6/5/24 at 3:45 p.m., the Assistant Director of Nursing (ADON) provided shower records reports from 3/7/24 to 6/5/24 and indicated all shower/bath documentation was completed electronically. The record lacked documentation of shower/bath completion, or refusal, for 4/4/24 and 5/9/24. During an interview with Unit Manager 14, she indicated that if there were blanks in the shower records, it could have been missed charting, not necessarily that they missed the shower entirely. If a resident had refused their shower, they were to document three attempt refusals. Resident council meeting minutes, dated 3/25/24,			

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	indicated that showers were still an issue in old business. In the new business, multiple residents had concerns about not getting showers and bed baths. The response from the department manager, signed by the Administrator (ADM) on 3/30/24 and the Director of Nursing Services (DNS) on 4/1/24, indicated they would look into individual complaints of no showers and that residents should fill out individual grievances. Resident council meeting minutes, dated 4/29/24, indicated that multiple residents had concerns about not getting showers. The response from the department manager, signed by the ADM and DNS on 5/15/24, indicated shower audits were being conducted. Resident council meeting minutes, dated 5/28/24, indicated that multiple residents had concerns about not getting showers. The response from the department manager, signed by the DNS on 5/29/24, indicated individual shower complaints needed to be made and grievance forms were to be handled individually. On 6/6/24 at 1:57 p.m., the DNS provided an undated document, titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy Explanation and Compliance Guidelines ... 2. Planning and implementing care ... b. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to ... iv. The right to receive the services and/or items included in the plan of care ...." 3.1-3(u)(1)			

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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 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 observation, record review, and interview, the facility failed to ensure an	F 0690	I corrective actions to be accomplished for those residents found to have been affected by the	06/28/2024

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	indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bag and tubing were prevented from contact with the floor for 1 of 2 residents reviewed for catheter/UTI (urinary tract infection-an infection in any part of the urinary system)(Resident 56), and to ensure that indwelling urinary catheter care (clean the area where the catheter exits your body and the catheter itself with soap and water every day) was for 2 of 2 residents reviewed for catheter/UTI documented (Residents 56 and 41). Findings include: 1. During a random observation, on 6/3/24 at 1:16 p.m., the resident was sitting in the hallway next to the smoking area. Her catheter bag was in contact with the floor. During a random observation, on 6/5/24 at 10:38 a.m., the resident was propelling herself in the 100 hall outside of the dining room. Her catheter tubing was dragging the floor. During a random observation, on 6/5/24 at 4:07 p.m., the resident was sitting outside in the smoking area. Her catheter tubing was in contact with the ground. During a random observation, on 6/6/24 at 8:36 a.m., the resident was sitting in the hallway waiting to go out to smoke. Her catheter bag was in contact with the floor. During a random observation, on 6/6/24 at 10:22 a.m., the resident was sitting at a table in the dining room eating a snack. Her catheter bag and tubing were in contact with the floor. During a random observation, on 6/6/24 at 9:12		practice. Resident 56's catheter bag and tubing secured and ensured tubing not touching the floor. Catheter care provided to Resident 56 and Resident 41 and documented with no adverse reactions noted. II. The facility will identify other residents that may potentially be affected by the practice. All residents with catheters have potential to be affected by the deficient practice. All residents with catheters audited to ensure catheter bag and tubing secured and not touching the ground. All catheter care documentation audited for completion and provided as ordered. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. All nursing staff that catheter and tubing should be secured and not touching the ground due to infection risk. All nursing staff on proper catheter care and documentation with return demonstration. IV. The facility will monitor the corrective action by implementing the following measures. DON or will audit all catheter bags and tubing to ensure they are secured and not touching the ground 5x/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for total of 12 months of monitoring. DON or designee will audit documentation for all	

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	a.m., the resident was outside sitting in the smoking area with the smoking group. Her catheter bag and tubing were in contact with the ground. During a random observation, on 6/7/24 at 8:43 a.m., the resident was in her bed asleep, lying on her right side. The bed was observed in a lower position and the catheter bag was in contact with the floor. Resident 56's record was reviewed on 6/5/24 at 12:09 p.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). A 5-day Minimum Data Set (MDS) assessment, dated 2/5/24, indicated the resident had moderate cognitive deficits, required extensive assistance with 2 plus (+) persons with her activities of daily living (ADLs-activities related to personal care), and had a urinary catheter. A care plan, dated 1/31/24, and revised on 5/13/24, indicated the resident was at risk for infections/complications related to an indwelling urinary catheter. A physician's order, dated 1/31/24 with an end date of 2/21/24, indicated to perform catheter care every shift. The resident's February 2024, Treatment Administration Record (TAR) lacked documentation of catheter care being completed on the day shifts of 2/6/24 and 2/14/24, and on the evening shifts of 2/2/24, 2/9/24. 2/13/24, and 2/16/24.		residents with catheters to ensure catheter care is performed and documented as ordered 5x/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	The resident's TARs lacked documentation of orders for catheter care from 2/21/24 to 3/1/24. A physician's order, dated 3/1/24, indicated to perform catheter care every shift and document milliliters (mls) output. The resident's March 2024, TAR lacked documentation of catheter care being completed on the day shift of 3/2/24. The resident's April 2024, TAR lacked documentation of catheter care being completed on the evening shifts of 4/12/24, 4/19/24, 4/20/24, and 4/24/24. The resident's May 2024, TAR lacked documentation of catheter care being completed on the day shift of 5/12/24, and on the evening shifts of 5/3/24 and 5/4/24. 2. Resident 41's record was reviewed on 6/5/24 at 9:34 a.m. The profile indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (hemiplegia is defined as paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis) and neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). An admission Minimum Data Set (MDS) assessment, dated 4/12/24, indicated the resident had moderate cognitive deficit, required extensive assistance of 2 + with her activities of daily living (ADLs-activities related to personal care) and had an indwelling urinary catheter.			

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	A care plan, dated 4/2/24 and revised on 5/14/24, indicated the resident was at risk for infection/complications related to an indwelling urinary catheter. Interventions included, but were not limited to, catheter care at least every shift and as needed. A physician's order, dated 4/2/24, with an end date of 5/14/24, indicated to perform catheter care every shift every shift for neurogenic bladder and document milliliters (mls) output. A physician's order, dated 5/14/24, with an end date of 5/30/24, indicated to perform catheter care every shift every shift for neurogenic bladder and document mls output. A physician's order, dated 5/30/24, indicated to perform catheter care every shift every shift for neurogenic bladder and document mls output. The resident's May 2024, TAR lacked documentation of catheter care being completed on the day shifts of 5/1/24, 5/7/24, and 5/19/24, and on the evening shift of 5/23/24. During an interview, on 6/5/24 at 11:06 a.m., the Infection Preventionist (IP) indicated she had noted an increase in the number of UTIs in February and March of 2024. She had not determined a specific root cause for the increase. Education to the nursing staff on catheter care had been provided on 12/20/23. During an interview, on 6/5/24 at 2:07 p.m., Certified Nursing Assistant (CNA) 6 indicated when catheter care was completed, the procedure should be documented in the medical record.			

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	During an interview, on 6/5/24 at 2:16 p.m., CNA 7 indicated any procedure, including catheter care, should always be documented when it was completed. During an interview, on 6/5/24 at 2:18 p.m., CNA 8 indicated catheter care should be documented in the medical record when completed. On 6/5/24 at 12:20 p.m., the IP provided a document, with a revision date of September 2014, titled, "Catheter Care, Urinary," and indicated it was the policy currently being used by the facility. The policy indicated, "...Infection Control...2...b. Be sure that catheter tubing and drainage bag are kept off the floor...Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given...." 3.1-41(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. A. Based on observations, record reviews, and interviews, the facility failed to complete a respiratory assessment on a resident prior to receiving a nebulizer treatment for 1 of 1 resident	F 0695	I corrective actions to be accomplished for those residents found to have been affected by the practice.	06/28/2024

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	155358	A. BUILDING 00 B. WING	06/07/2024

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	observed (Resident 8) B. Based on observations, record reviews, and interviews, the facility failed to ensure proper storage of respiratory equipment for 3 of 3 residents reviewed for respiratory care. (Residents 8, 14, and 54). C. Based on observations, record reviews, and interviews, the facility failed to obtain a physician order for oxygen supplementation for 1 of 3 residents reviewed for respiratory care (Resident 14). Findings include: A. During a medication administration observation, on 6/5/24 at 9:15 a.m., Registered Nurse (RN) 13 administered an albuterol nebulization solution (medication used to treat wheezing and shortness of breath caused by breathing problems such as asthma) breathing treatment to Resident 8. The RN did not complete a respiratory assessment prior to administering the nebulizer treatment. Resident 8's record was reviewed on 6/5/24 at 9:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A quarterly Minimum Data Set (MDS) assessment, dated 4/27/24, did not indicate the resident was receiving respiratory treatments. A care plan, dated 11/2/23, indicated the resident was at risk for respiratory distress related to COPD. Interventions included, but were not		Respiratory assessment completed on Resident 8 with no abnormal findings. Respiratory equipment for Residents 8, 14, and 54 labeled and properly stored. Physicians supplemental oxygen obtained for Resident 14. II. The facility will identify other residents that may potentially be affected by the practice. All residents with nebulizer orders audited for pre and post treatment assessment orders. All residents with respiratory equipment audited to ensure equipment labeled and stored properly. All residents on oxygen therapy audited to ensure physicians order in place. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nursing staff educated on nebulizer treatment procedure utilizing skills validation with return demonstration. All nursing staff will be proper labeling and storage of respiratory care equipment. All nursing staff to be in-serviced on the need for physician order for supplemental oxygen if in use. IV. The facility will monitor the corrective action by implementing the following measures. DON or designee will audit 5 residents to ensure pre and post nebulizer assessments completed, respiratory care equipment properly labeled and stored, and all residents receiving	

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	limited to, administer medications as ordered and observe for effectiveness and adverse side effects, administer nebulizer treatments as ordered, and notify medical doctor of changes in respiratory status. A physician order, dated 12/2/23, indicated to administer albuterol sulfate nebulization solution, 2.5 milligrams (mg)/ 3 milliliters (ml) 0.83%., 1 vial orally via nebulizer three times a day. A physician order, dated 11/2/23, indicated to document pulse, respiratory rate, breath sounds, oxygen saturation, and minutes before and after the nebulizer treatment every 6 hours as needed. Resident 8's Medication Administration Record (MAR) lacked documentation of pre and post assessments being completed for the month of May and June 2024. During an interview, on 6/5/24 at 10:00 a.m., Licensed Practical Nurse (LPN) 12 indicated the nursing staff should assess a resident's lungs prior to and after administering a breathing treatment. During an interview, on 6/5/24 at 11:00 a.m., Resident 8 indicated the nursing staff did not assess her lungs before or after administering a breathing treatment. On 6/5/24 at 10:35 a.m., the Assistant Director of Nursing Services (ADNS), provided an undated document as a current facility policy, titled, "Nebulizer Therapy." The policy indicated, " ...6. Obtain resident's vital signs and perform respiratory assessment to establish a baseline ...Documentation ...4. Resident vital signs and respiratory assessment. 5. Resident's response to		supplemental oxygen therapy have physician order for treatment 5x/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Update	

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	treatment ...." B1. On 6/5/24 at 11:00 a.m., Resident 8's unbagged nebulizer mouthpiece and tubing were observed on her bed next to the nebulizer machine. The resident was sitting in her wheelchair next to her bed. On 6/5/24 at 1:26 p.m., Resident 8's unbagged nebulizer mouthpiece and tubing were observed on her bed next to the nebulizer machine. The resident was not currently in her room. On 6/5/24 at 2:59 p.m., Resident 8's unbagged nebulizer mouthpiece and tubing were observed on her bed next to the nebulizer machine. The resident was sitting in her wheelchair next to her bed. On 6/7/24 at 8:44 a.m., Resident 8's unbagged nebulizer mouthpiece and tubing were observed on her bed next to the nebulizer machine. The resident was sitting in her wheelchair next to her bed. On 6/7/24 at 11:57 a.m., Resident 8's unbagged nebulizer mouthpiece and tubing were observed on her bed next to the nebulizer machine. The resident was not currently in her room. Resident 8's record was reviewed on 6/5/24 at 9:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A care plan, dated 11/2/23, indicated the resident was at risk for respiratory distress related to COPD. Interventions included, but were not			

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	limited to, administer medications as ordered and observe for effectiveness and adverse side effects, administer nebulizer treatments as ordered, and notify medical doctor of changes in respiratory status. A physician order, dated 12/2/23, indicated to administer albuterol sulfate nebulization solution, 2.5 milligrams (mg)/ 3 milliliters (ml) 0.83%, 1 vial orally via nebulizer three times a day. During an interview, on 6/5/24 at 10:00 a.m., Licensed Practical Nurse (LPN) 12 indicated respiratory equipment should be stored in a clear plastic bag after use. B2. During an initial interview with Resident 54 on 6/4/24 at 11:00 a.m., observed her nebulizer (device that can change liquid medication into a mist) machine on the nightstand table, the assembled mouthpiece and tubing were observed to be sitting on top of the table, unbagged and undated. The resident indicated she had recently received a nebulizer treatment and staff retrieved the mouthpiece and tubing from her when she was finished and placed it on the table. The resident indicated she was unable to reach the nightstand or get out of bed without assistance. On 6/5/24 at 12:01 p.m., observed Resident 54's assembled nebulizer mouthpiece and tubing on the nightstand table, unbagged and undated. On 6/6/24 at 11:56 a.m., observed Resident 54's assembled nebulizer mouthpiece and tubing on the nightstand table, unbagged and undated. On 6/7/24 at 10:07 a.m., observed Resident 54's assembled nebulizer mouthpiece and tubing on the nightstand table, unbagged and undated.			

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	On 6/7/24 at 10:59 a.m., observed Resident 54's assembled nebulizer tubing and mouthpiece on the nightstand table with the IP, she indicated that she could not find a dated label or bag for the mouthpiece and tubing, and it should have had both. Resident 54's record was reviewed on 6/6/24 at 2:37 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), and shortness of breath). A physician's order, dated 1/23/24, indicated to administer albuterol sulfate (a medication used to treat COPD and shortness of breath) nebulization solution, 2.5 milligrams (mg)/ 3 milliliters (ml) 0.083%. Administer 3 ml, inhale orally via nebulizer every six hours as needed for shortness of breath. A physician's order, dated 1/24/24, indicated to replace and date nebulizer tubing and mouthpiece/mask every night shift every Sunday. A care plan, dated 12/31/23, indicated Resident 54 was at risk for respiratory distress related to COPD and inability to lie flat due to causing shortness of breath. Interventions included, but were not limited to, nebulizer treatments as ordered. A quarterly Minimum Data Set (MDS) assessment, dated 4/25/24, indicated Resident 54's brief interview for mental status (BIMS) score was 15, which indicated she was cognitively intact. The MDS indicated the resident required extensive assistance, requiring physical assistance of two or more persons, for transfers.			

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	During an interview with Unit Manager 14 on 6/6/24 at 10:30 a.m., she indicated that when nebulizer and oxygen tubing get replaced, staff should put the date on the bag for when it was changed, and the tubing will have tape on it with the date it was changed. During an interview with the Infection Preventionist on 6/7/24 at 10:46 a.m., she indicated that staff should know how to maintain nebulizer and oxygen equipment. Education was provided by method of forms and demonstration for where to put the equipment, how to hook everything up, and how to date everything. The dates were to be written on tape and placed on the tubing. The tubing, masks, and mouth pieces were to be put in the plastic respiratory bag, that were to also be dated. All oxygen and nebulizer supplies were replaced every Sunday evening for all residents. On 6/5/24 at 10:35 a.m., the Director of Nursing Services (DNS) provided an undated document, titled, "Nebulizer Therapy," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ... Care of Equipment ... 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 8. Change nebulizer tubing every seventy-two hours or per facility policy. ...." C. During an initial interview with Resident 14 on 6/3/24 at 1:48 p.m., she was observed sitting up in bed receiving oxygen via nasal cannula. The			

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	oxygen concentrator was observed to be set at 3 Liters (L). Her assembled nebulizer mask, and separate mouthpiece were observed sitting on the lamp table at the foot of the bed, unbagged and undated. The resident indicated she could not get out of bed without assistance and that staff were responsible for giving her breathing treatments. On 6/5/24 at 1:34 p.m., observed Resident 14's assembled nebulizer mask, machine, and tubing sitting on the foot of the bed, unbagged and undated. The mouthpiece was observed to be sitting on the lamp table at the foot of the bed. The oxygen concentrator was observed to be on and delivering 3 L of oxygen to the resident via nasal cannula. She indicated she had only received oxygen since her last trip to the hospital the week before. On 6/6/24 at 10:19 a.m., observed Resident 14's assembled nebulizer mask, mouthpiece, and tubing sitting on the lamp table at the foot of the bed, unbagged and undated. On 6/7/24 at 11:04 a.m., observed Resident 14's assembled nebulizer mask, mouthpiece, and tubing sitting on the lamp table at the foot of the bed with the IP, she indicated that she could not find a dated label or bag or tubing, and it should have had both. The resident was no longer wearing oxygen. Resident 14's record was reviewed on 6/6/24 at 9:48 a.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), and shortness of breath) and chronic diastolic heart failure (your heart's main pumping chamber becomes stiff and unable to fill properly).			

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	A physician's order, dated 4/28/24, indicated to administer ipratropium-albuterol solution 0.5-2.5, 3 milligrams (mg)/ 3 milliliters (ml). Administer 3 ml, inhale orally every four hours as needed for shortness of breath or wheezing, via nebulizer. Resident 14's record lacked documentation of a physician's order for oxygen administration. Resident 14's care plan, dated 11/15/23, indicated she was at risk for respiratory distress related to COPD. Interventions included, but were not limited to, nebulizer treatments as ordered with a goal that she would be free from respiratory distress through the next review date. A Minimum Data Set (MDS) assessment completed for payment assessment, dated 5/20/24, indicated Resident 14's brief interview for mental status (BIMS) score was 11, which indicated moderate cognitive impairment. The MDS assessment indicated that she had not exhibited behaviors for rejecting care. During an interview with Unit Manager 14 on 6/6/24 at 10:30 a.m., she indicated that when nebulizer and oxygen tubing get replaced, staff should put the date on the bag for when it was changed, and the tubing will have tape on it with the date it was changed. During an interview with the Nurse Practitioner (NP) on 6/6/24 at 2:58 p.m., she indicated the resident went to the emergency room on 5/29/24, she would consider orders to be obtained as soon as practicable to be within one week. On 6/5/24 at 10:35 a.m., the Director of Nursing Services (DNS) provided an undated document,			

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	titled, "Nebulizer Therapy," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ... Care of Equipment ... 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 8. Change nebulizer tubing every seventy-two hours or per facility policy. ...." On 6/6/24 at 1:57 p.m., the DNS provided an undated document, titled, "Oxygen Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences ... Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control ...." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered			

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	care plan, and the residents' goals and preferences. A. Based on interview and record review, the facility failed to ensure a dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) resident received a tray for meals missed while at dialysis for 1 of 1 residents reviewed for dialysis (Resident 27). B. Based on record review and interview, the failed to ensure documentation of an assessment of a residents arteriovenous (AV) dialysis fistula (a connection that's made between an artery and a vein for dialysis access) for 1 of 1 residents observed for dialysis (Resident 27). Findings include: Resident 27's record was reviewed on 6/6/24 at 1:27 p.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and arteriovenous dialysis fistula. An admission Minimum Data Set (MDS) assessment, dated 3/1/24, indicated the resident had no cognitive deficit, was supervision with set-up for eating, had no nutritional issues, and received dialysis. A care plan, dated 3/1/24, indicated the resident required adequate nutrition to promote overall good health related to risk of weight changes and fluid changes due to dialysis services three days a week on Monday, Wednesday, and Friday.	F 0698	I corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 27 provided sack lunch in his refrigerator for when he returns from dialysis and dialysis fistula assessment completed and documented with no abnormal findings. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary manager nursing will in-service all dietary staff providing education to ensure all residents who are out on appointments are offered a meal upon return to facility. II. The facility will identify other residents that may potentially be affected by the practice. Any resident receiving dialysis treatment outside of the has the potential be affected by the deficient practices. All dialysis residents audited to ensure meals received after HD appointment and assessments completed and documented for dialysis fistula as ordered. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. Nursing and dietary staff educated on the to provide meals upon return from dialysis appointments. Sack lunch will be provided in refrigerator with for to request items as desired	06/28/2024

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	A care plan, dated 3/19/24, indicated the resident received dialysis due to end stage renal disease. Interventions included, but were not limited to assess AV dialysis fistula located in right arm, every shift for bruit (the abnormal sound generated by turbulent flow of blood in an artery due to either an area of partial obstruction or a localized high rate of blood flow through an unobstructed artery) and thrill (a thrill or buzz is like a vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above your incision line), swelling, pain, change in temperature, or bleeding. A. During an interview, on 6/4/24 at 11:23 a.m., Resident 27 indicated he did not get his lunch trays when he returned from dialysis. A physician's order, dated 3/14/24, indicated the resident was to receive a regular diet with mechanical soft texture and thin consistency. A Dietician assessment, dated 3/1/24, indicated the resident was able to feed self after tray set-up. He tolerated his diet with a good intake and had no chewing or swallowing issues. The resident required adequate nutrition to promote overall good health, strength and stamina. During an interview, on 6/7/24 at 8:44 a.m., the Dietary Manager indicated the resident was able to make his needs known and had chosen to eat 2 soft fried eggs for every meal. He often would come to the kitchen doorway and ask for 2 cartons of milk to take back to his room with him. She understood that he went to dialysis 3 days a week. She had spoken with her staff and determined that the resident was not getting his lunch meal when he returned from dialysis. She		from kitchen staff. Licensed nurses educated on assessment and documentation requirements for dialysis fistula as ordered. IV. The facility will monitor the corrective action by implementing the following measures. DON or designee will audit all dialysis residents to ensure meals provided upon return from dialysis appointment and dialysis fistula assessment completed and documented 5x/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	and her staff were not made aware when the resident returned from dialysis. During an interview, on 6/7/24 at 8:54 a.m., the Executive Director (ED) indicated residents should be provided meals any time they were out of the building and missed a meal service. On 6/7/24 at 8:54 a.m., the ED provided a document, with a revision date of February 2023, titled, "Frequency of Meals," and indicated it was the policy currently used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines: ...2. Alternative mealtimes will be specified...in accordance with the resident's need, preferences, and requests...." B. A physician's order, dated 2/26/24, indicated to assess the dialysis AV fistula, located in the right arm, every shift for thrill and bruit, swelling, pain, change in temp and/or bleeding. Review of the resident's Treatment Administration Records (TARs) from March, April, and May 2024, indicated the following: a. The March 2024 TAR lacked documentation of the assessment of the resident's dialysis AV fistula on the day shifts of 3/14/24 and 3/24/24. b. The April 2024 TAR lacked documentation of the assessment of the resident's dialysis AV fistula on the evening shift of 4/25/24. c. The May 2024 TAR lacked documentation of the assessment of the resident's dialysis AV fistula on the day shift of 5/19/24 and the evening shift of 5/23/24. During an interview, on 6/7/24 at 10:40 a.m., the			

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	155358	A. BUILDING 00 B. WING	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

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	Director of Nursing Services (DNS) indicated she had observed there were holes in the TARs and they were looking into the situation through their QAPI program. On 6/7/24 at 10:40 a.m., the DNS provided a document, with a revision date of February 2023, titled, "Hemodialysis," and indicated it was the policy currently being used by the facility. The policy indicated, "...Compliance Guidelines: ...14. The nurse will ensure that the dialysis access site...is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill...." 3.1-37(a)			
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 observations, record reviews, and interviews, the facility failed to ensure proper administration of inhaled medication during the medication administration pass for 2 of 4 residents observed, resulting in a medication error rate of 11.54 percent and 3 errors out of 26 opportunities for errors (Resident 8 and 13). Findings include: 1. During a medication administration observation, on 6/5/24 at 9:07 a.m., Registered Nurse (RN) 13 was administering a Symbicort (contains an inhaled corticosteroid know as budesonide to reduce inflammation in the lungs) inhaler (small	F 0759	I corrective actions to be accomplished for those residents found to have been affected by the practice. Residents 8 and 13 were assessed and no negative outcomes found due to deficit practice. II. The facility will identify other residents that may potentially be affected by the practice. All inhaler medication orders (as applicable) audited for administration instructions to rinse mouth and spit after use. III. The facility will put into place the	06/28/2024

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	handheld devices that allows you to breath medicine through your mouth, directly to your lungs) to Resident 8. The resident handed the inhaler back to the nurse and the nurse immediately gave the resident an Incruse Ellipta (inhaled medication that works by relaxing the muscles around the airways in the lungs to help you breathe easier) inhaler to use. The resident did not rinse and spit with water after the use of the first inhaler nor did the nurse wait in between administering the two inhaled medications. Resident 8's record was reviewed on 6/5/24 at 9:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A physician order, dated 12/2/23, indicated to administer Symbicort Aerosol 160-4.5 mcg (micrograms) two puffs inhale orally two times a day for cough/congestion. Rinse mouth after each use. A physician order, dated 11/3/23, indicated to administer Incruse Ellipta 62.5 mcg one puff inhale orally one time a day for COPD. A care plan, dated 11/2/23, indicated the resident was at risk for respiratory distress related to COPD. Interventions included, but were not limited to, administer medications as ordered and observe for effectiveness and adverse side effects. 2. During a medication administration observation, on 6/5/24 at 9:30 a.m., Registered Nurse (RN) 13 was administering Trelegy Ellipta (a combination of 3 medications which includes a corticosteroid		following systematic changes to ensure that the practice does not recur. Licensed nursing staff educated on proper administration of medications by inhaler via skills check with return demonstration (including rinsing mouth and spiting after use of applicable medications and timing between dose and medication administrations). IV. The facility will monitor the corrective action by implementing the following measures. DON or designee will monitor 5 medication administrations by inhaler for skills validation compliance 5x/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	in one inhaler that helps control symptoms of chronic obstructive pulmonary disease [COPD]) to Resident 13. The resident did not rinse and spit with water after use of the inhaler. Resident 13's record was reviewed on 6/5/24 at 10:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A physician order, dated 12/6/23, indicated to administer Trelegy Ellipta 100-62.5-25mcg (micrograms) one puff inhale orally one time a day for COPD. A care plan, dated 5/21/24, indicated the resident was at risk for respiratory distress related to COPD. Interventions included, but were not limited to, administer medications as ordered. During an interview, on 6/5/24 at 9:45 a.m., Licensed Practical Nurse (LPN) 12 indicated the resident should rinse and spit with water after use of inhaled medications and the nurse should wait several minutes in between administering inhaled medications to the same resident. During an interview, on 6/5/24 at 9:49 a.m., LPN 11 indicated the nurse should wait 5 minutes in between administering inhaled medications to the same resident and the resident should rinse and spit with water after use of the inhaled medications. On 6/5/24 at 10:35 a.m., the Assistant Director of Nursing Services (ADNS), provided an undated document as a current facility policy, titled, "Administration of Metered-Dose Inhaler." The			

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	policy indicated, " ...16. If a resident is using a corticosteroid, allow resident to rinse and gargle with water ...to remove medication from mouth and back of throat ...17. If resident is using a corticosteroid and a bronchodilator, administer the bronchodilator first then wait 5 minutes before administering the corticosteroid ...." 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 observations, interviews, and record	F 0761	I corrective actions to be	06/28/2024

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	reviews, the facility failed to ensure medications were labeled properly and the facility failed to ensure expired medications were disposed of for 2 of 2 medication storage rooms reviewed for medication storage (Resident 43). Findings include: 1. On 6/5/24 at 9:52 a.m., the 200-hall medication storage room refrigerator contained an undated and opened multi- use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution. The label on the medication box indicated it was for facility stock and was delivered to the facility on 2/14/24 from the pharmacy. During an interview, on 6/5/24 at 9:55 a.m., Licensed Practical Nurse (LPN) 11 indicated she was not aware of how long the Aplisol solution was good for once the vial was opened but indicated it should contain and open date once opened for use. During an interview, on 6/5/24 at 10:02 a.m., Registered Nurse (RN) 13 indicated she was not aware of how long the Aplisol solution was good for once opened. During an interview, on 6/5/24 at 10:03 a.m., Unit Manager 14 indicated she was not aware of how long the Aplisol solution was good for once opened. During an interview, on 6/5/24 at 10:05 a.m., LPN 11 indicated she had spoken with management and the Aplisol was good for 30 days once opened. 2. On 6/5/24 at 10:03 a.m., the 100-hall medication		accomplished for those residents found to have been affected by the practice. House and Covid vaccine for Resident 43 disposed of per facility policy. Resident 43 reviewed to ensure medication was given as ordered. No adverse reactions noted. II. The facility will identify other residents that may potentially be affected by the practice. All facility refrigerated medications audited for proper labeling and expiration dates. All expired or outdated medications discarded per facility policy. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nursing staff educated on proper labeling and destruction of expired medications. IV. The facility will monitor the corrective action by implementing the following measures. Don or designee will audit facility refrigerators for improperly labeled or expired medications 5X/week for 4 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%.	

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	storage room refrigerator contained a COVID vaccine (helps our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness). The pharmacy bottle contained a label that indicated it was for Resident 43. The bottle also contained a pharmacy label that indicated the vaccine expired on 3/27/24. During an interview, on 6/5/24 at 10:04 a.m., Unit Manager 14 indicated the vaccine was expired and the Infection Preventionist (IP) nurse was the one that handled the vaccines and Aplisol solutions for the facility. The vaccine should have been disposed of. On 6/5/24 at 11:12 a.m., the Assistant Director of Nursing Services (ADNS), provided an undated document as a current facility policy, titled, "Aplisol." The policy indicated, " ...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency ...." On 6/5/24 at 11:13 a.m., the ADNS, provided a document as a current facility policy, titled, "Medication Administration," revised date of 10/30/18. The policy indicated, " ...Policy: To ensure all prescription drugs/medications are labeled appropriate expiration dates according to manufacturer recommendations and in compliance with State and Federal regulations and that all expired drugs/medications are removed from medication storage areas for proper disposal ... i. Expired medication(s) will be removed from use and destroyed per facility policy and procedure ...." 3.1-25(j) 3.1-25(o)		Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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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 facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure refrigerator temperatures were up to date, and outdated food was discarded during 2 of 3 kitchen observations. Findings include: During the initial kitchen tour with Cook 2, on 6/3/24 at 7:20 a.m., observed the June temperature logs posted on the outside of each unit for the potato freezer, vegetable and meat freezer, and the ice cream freezer. The records lacked both a.m. and p.m. temperature log documentation for 6/1/24 and 6/2/24.	F 0812	I corrective actions to be accomplished for those residents found to have been affected by the practice. Kitchen refrigerator log completion confirmed and outdated food items discarded. Dietary Manager educated on temperature logs to only be filled out for current date and time. Dietary Manager to audit temperature logs and ensure all food items stored in the refrigerator are not outdated, and any outdated food items discarded. Audits will be	06/28/2024

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	During a follow up kitchen tour with the Dietary Manager, on 6/3/24 at 8:34 a.m., observed the reach-in refrigerator with an opened gallon of milk that had an expiration date of 6/2/24, and hard-boiled eggs dated 5/29/24. When asked, the Dietary Manager indicated that the milk had passed the expiration date, and the hard-boiled eggs were passed the use by date, then indicated that was enough and shut the door preventing further observations inside the refrigerator. Observed, for the second time, the June temperature logs for the potato freezer, vegetable and meat freezer, and ice cream freezer, the missing documentation had been filled in. The Dietary Manager indicated that the temperatures were to be logged twice daily, and the temperatures did not get written down anywhere else besides the logs on the outside of each refrigerator or freezer unit. During an interview on 6/5/24 at 10:52 a.m., the Dietary Manager indicated that she had instructed Cook 2 to fill in the missing June temperature logs with Cook 20's initials for 6/1/24 and 6/2/24. When asked how she knew what the temperatures were for those dates, the Dietary Manager indicated it was an educated guess, and since the refrigerators and freezers had been working, she did not think it would hurt. On 6/6/24 at 1:56 p.m., the Director of Nursing Services (DNS) provided an undated document, titled, "Monitoring of Cooler/Freezer Temperature," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy Explanation and Compliance Guidelines ...1 ...a. Temperatures will be checked and logged at least twice per day by designated personnel ...11. Refrigerated food shall be labeled, dated, and monitored so that it is used by the use		completed weekly x 4 weeks, bi-monthly and monthly x 4 months. Tool will be reviewed by Executive Director or DNS. 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 II. The facility will identify other residents that may potentially be affected by the practice. All kitchen temperature logs audited for completion and all food items audited for expiration dates with any expired items discarded. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. All dietary staff educated that temperature logs are to be completed twice daily for current time and date only and any outdated food items should be discarded immediately. IV. The facility will monitor the corrective action by implementing the following measures. Dietary manager or will audit completion of fridge temperature log and proper disposal of expired food items 5x/week for 4 weeks, then weekly for 8weeks, then monthly for 9 months for total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at	

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	by date, frozen, or discarded, whichever is applicable...." On 6/6/24 at 1:56 p.m., the DNS provided an undated document, titled, "Date Marking for Food Safety," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food ...Policy Explanation and Compliance Guidelines for Staffing ...2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded ... 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly ...." 3.1-21(i)(3)		100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	