STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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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 IN00401518, IN00400894 and IN00412250. Complaint IN00401518 - No deficiencies related to the allegations are cited. Complaint IN00400894 - No deficiencies related to the allegation are cited. Complaint IN00412250 - No deficiencies related to the allegation are cited. Survey dates: July 10, 11, 12, 13 & 14, 2023 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 0 Medicaid: 58 Other: 18 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 7/24/23.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We respectfully request Paper Compliance.	
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher A Gill	Administrator	08/05/2023

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review, observation and interview, the facility failed to revise/update a resident care plan when a wander guard was discontinued for 1 of 21 residents whose care plans were reviewed. (Resident 46) Finding includes: The record for Resident 46 was reviewed on 7/13/2023 at 9:41 A.M. The diagnoses included, but were not limited to: Alzheimer's Disease,	F 0657	**F 657 Care Planning and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 46 care plan has been reviewed and revised.	08/19/2023

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	vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and major depression. A Care Plan, dated 11/4/2021, indicated the Resident has a history of attempting to exit the facility. She utilizes a wander guard. During an observation, on 7/13/2023 at 2:26 P.M., there was no wander guard on the resident wrists or ankles. A Quarterly Minimum Data Set (MDS) Assessment, dated 6/26/2023, indicated wander/elopement alarm is not used. During an interview, on 7/14/2023 at 10:49 A.M., the Director of Nursing indicated that it was a joint effect of all Interdisciplinary Team (IDT) to update the care plans. They run off a report prior to morning meeting and review/update then on Wednesdays when the IDT meet and go over care plans due that week. She indicated does not exit seek as much as she used to and that her wander guard was not discontinued as she was still on the board in the Director of Nurses office. After the Director of Nursing reviewed the orders, she indicated it was discontinued on 9/16/2022 and the care plan should have been updated. On 7/14/2023 at 11:42 P.M., the Regional Nurse provided a policy titled, "Care Plan Revisions Upon Status Change", dated 2022, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. f. Care Plans will be modified as needed by the MDS Coordinator of other designated staff member...."		**How will you identify other residents having the potential to be affected by the same deficient practice and what correction action will be taken?** · All residents have the potential to be affected by this alleged deficiency. · IDT will review all resident care plans, four (4) per week, to ensure each resident has individualized care plans in place, until all current residents have been reviewed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Regional consultant nurse will re-educate the IDT on the care plan process including individualization. · DON/Designee has educated nursing staff on the care plan process **How the correction actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** · IDT will review four (4) care plans weekly to confirm that a review and revisions/updates have been completed. · The Director of	

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	3.1-35(e)		Nursing/Designee will report on care plan revision progress at monthly QAPI meetings, times six months, then quarterly thereafter. The QAPI committee will identify any trends or patterns and make recommendations to revise this plan of correction if needed. **Date of Compliance: 8/19/2023**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interviews, the facility failed to ensure showers and/or nail care was provided for 2 of 5 residents reviewed for Activities of Daily Living (ADL) needs. (Residents 44 and 48) Findings include: 1. The clinical record for Resident 44, reviewed on 7/13/2023 at 10:57 A.M., indicated the resident had diagnoses including, but not limited to: seizures, diabetes mellitus, end stage renal disease, dependence on dialysis, mild cognitive impairment, urine retention, hemiplegia, lack of coordination and weakness. The most recent Minimum Data Set (MDS) Assessment, completed for an annual review on 4/10/2023, indicated the resident required	F 0677	**677- ADL Care for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 44 and 48 at time of identified concern were provided with ADL care related to nail care. **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 in the facility have the potential to be affected by alleged deficient practice	08/19/2023

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	extensive staff assistance of one staff for personal hygiene needs and was dependent on staff assistance for bathing needs. The current care plan for Resident 44, included a plan to address the resident's ADL (Activities of Daily Living) self-care performance deficit. The plan included interventions to provide total care for bathing /showering needs twice a week on Wednesday and Saturday afternoons. The plan included the following intervention: " BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse." Resident 44 was observed, on 7/10/2023 at 7:00 P.M., lying in his bed, dressed in a hospital gown. His fingernails were observed to be very long and had a dark substance underneath them. Resident 44 was observed, on 7/12/2023 at 7:08 A.M., lying in his bed. His fingernails were long and had a dark colored substance. Resident 44 was observed, on 7/13/2023 at 9:47 A.M., lying in his bed in a hospital gown. His fingernails were long and had an orange-colored substance underneath them. The resident had just finished eating his breakfast from a tray on his over bed table. Resident 44 was observed, on 7/14/2023 at 10:17 A.M., up in his wheelchair in the main dining room. His nails were clean but were still very long. The shower sheet documentation for Resident 44 indicated he had received a shower on 7/8/2023 and had refused a shower on 7/12/2023.		· DON/designee completed a vidual audit of all residents in the facility and ADL nail care was offered and provided. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff in servicing conducted related to ADL care for dependent resident, utilizing the ADL policy with emphasis on nail care. · Nursing managers and “guardian angels” will monitor as part of daily walking rounds and report any observed concerns to the nurse for follow-up. **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?** · * DON/ designee will complete ADL care Audits to monitor residents ADL status including facial hair. · * Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · * The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved	

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	During an observation and interview of Resident 44's nails, on 7/14/2023 at 11:17 A.M., with the resident and RN 14, the resident's fingernails were long and had a slightly orange-colored substance underneath the nails. The resident shook his head "no" when asked if he preferred to have long fingernails. He agreed to have them trimmed when RN 14 offered the assistance after he returned from the dialysis center. RN 14 disclosed Resident 44' snails should have been trimmed during the showering/bathing care. During an interview, on 7/14/2023 at 10:45 A.M., the Director of Nursing indicated she would expect her staff to do the following care with showers: wash hair, provide pericare , put on deodorant, complete nail care, clean their body and get them dressed.2. The record for Resident 48 was reviewed on 7/13/2023 at 10:52 A.M. The diagnoses included, but were not limited to: dementia without behavioral disturbances, mood and psychotic disturbances, anxiety, and severe protein-calorie malnutrition. During an observation, on 7/11/2023 at 10:20 A.M., Resident 48 had a brown substance under her fingernails. During an observation, on 7/13/2023 at 1:21 P.M., a brown substance was under her fingernails. During observation, on 7/14/2023 at 10:25 A.M., a brown substance was under the residents fingernails. A Care Plan, dated 6/10/2021, indicated that she has an activity of daily living, self- care performance deficit due to her dementia, advanced age and lack of coordination. She requires extensive assistance from one staff member for		an action plan will be developed to ensure compliance. **By what date will the systemic changes be completed?** Compliance of 8/19/23	

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	bathing/showering, personal hygiene and dressing. During an interview, on 7/13/2023 at 3:22 P.M., Certified Nurse Aide (CNA) 15 indicated when she gives a shower, she gets all the supplies together, checks the temp of the water and washes the resident from top to bottom, including the hair, inspect the skin and cuts toe and finger nails. During an interview, on 7/13/2023 at 3:29 P.M., Certified Nurse Aide (CNA) 16 indicated that when she gives a shower, she gets the supplies together takes the resident to shower room and washes their hair, brushes their teeth, dries them off, applies lotion and puts on clothing. During an interview, on 7/14/2023 at 9:26 A.M., Certified Nurse Aide (CNA) 18 indicated when she gives a shower, she gathers all supplies needed, warms the water then assists with shaving and washing of the hair unless they go to beauty shop, washes them from top to bottom and gets them involved, then assists with drying and dressing. During an interview, on 7/14/2023 at 10:45 A.M., the Director of Nursing indicated she would expect her staff to totally give them a shower: wash hair, peri care, put on deodorant, do nail care, clean, and get dressed. On 7/14/2023 at 11:42 A.M., the Regional Nurse provided a policy titled, "Nail Care", dated 2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care to include trimming and filing, will be provided on a regular schedule (such as			

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	weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. c. The person responsible for providing nail care...." 3.1-38(3)(E)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review and interview, the facility failed to ensure 2 of 2 residents reviewed for hearing needs received timely treatment and received recommended hearing devices. (Residents 60 and 29) Findings include: 1. During the initial tour of the facility, conducted on 7/10/2023 between 6:15 P.M. and 7:15 P.M., Resident 60 was observed in her bed. She had a distorted speech pattern. She indicated she could not hear very well and needed to read the lips of the person speaking with her. During the	F 0685	**685 – Treatment/Devices to maintain hearing/vision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #60 remains in the facility. Social Services spoke with POA. POA reports that she has called resident's Private Insurance Provider and paid the copay due for hearing aids. Audiology Service confirmed that	08/19/2023

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	conversation, at times, the resident would apologize and state "I just do not know what you are trying to ask me". There was no paper or dry erase board noted within reach of the resident. During an interview with Resident 60, conducted on 7/12/23 at 9:43 A.M., she indicated she was waiting on hearing aids, could read lips but could not really hear very much at all. During an interview with Certified Nurse Aide (CNA) 3 at 7/13/2023 at 11:45 A.M., she indicated the resident sometimes does not understand as she reads lips and lately, with the seizures, the resident was more confused. The record for Resident 60, reviewed on 7/13/2023 at 9:13 A.M., indicated the resident was admitted with diagnosis, including but not limited tom bilateral hearing loss. The most recent Quarterly Minimum Data Set (MDS) Assessment for Resident 60, completed on 2/8/2023, indicated the resident hearing was highly impaired and sometimes understood spoken word. A current care plan regarding hearing and communication needs, initiated on 11/25/2022 included the following: "(Resident's name) had difficulty hearing." The interventions included "Anticipate needs, (resident' name is able to communicate by: lip reading, writing, gestures, and talking loudly directly beside her ear" During an interview with the Social Services Director (SSD), on 7/13/2023 at 2:30 P.M., she indicated she was not aware of any resident waiting on hearing aids, but after she "researched" she discovered the hearing aids for		hearing aids have been ordered and should arrive within 30 days. Staff continue to communicate with resident by speaking slowly, and looking at her directly, or utilizing written communication when needed. · Resident #29 remains in the facility and all paperwork has been resubmitted to Audiology for hearing aids. **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 in the facility have the potential to be affected by alleged deficient practice. · Audit of all resident records was completed to confirm that any resident with a need for hearing/vision services have been seen or had appointments scheduled as ordered or other recommended services or adaptive equipment obtained. · SSD/Designee has also reviewed hearing/vision notes to ensure that all follow up appointments and needs have been arranged and communicated to residents, staff, and families. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	Resident 60 were not made or delivered yet because the audiology clinic was waiting on payment for the hearing aides from the resident's Power of Attorney (POA). During an interview with SSD, on 7/14/23 at 8:30 A.M., she indicated she had gotten ahold of the resident's POA/sister, and she had not received a bill for the hearing aides, just the hearing evaluation. The SSD indicated Resident 60's sister was going to call the audiology office and pay the bill for the hearing aids. The SSD indicated the resident had a hearing evaluation, on 3/16/2023 and she did not know where the breakdown in communication had occurred. She indicated the facility was without an in-house audiology provider off and on for the past year. She did not know why it took so long to get the resident scheduled for an audiology exam, after she was initially admitted. The consent for audiology services had first been signed, for Resident 60, on 4/12/2022. Review of the care plan meeting notes, from 2/28/2022 through 3/7/2023 indicated Resident 60's diagnosis were listed on some of the notes, including bilateral hearing loss, but there was no mention of the resident's highly impaired hearing loss and communication needs. 2. During an interview, on 7/10/2023 at 8:28 P.M.,Resident 29 indicated he was having hearing issues and that he had hearing test one year ago, was supposed to have gotten hearing aids at that time but had not heard anything about hearing aids since testing. A record review, on 7/12/2023 at 3:18 P.M., indicated that Resident 29 had a hearing test on 5/11/2022 with (Name) audiology group. A hearing aid recommendation was made at that time with		· SSD/ IDT team will be educated on consult/referral process and follow up to ensure that hearing/vision needs are met for each resident. **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?** · SSD will complete Audit related to vision/ hearing services to ensure that all notes have been reviewed to ensure all referrals and appointments are made. · Audits will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date will the systemic change be completed?** Compliance of 8/19/23	

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	mold taken for hearing aid left shell. A medical clearance was requested at that time for approval of hearing aid. Resident 29 had diagnoses that included, but not limited to: hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side,epilepsy and anemia. A MDS dated 7/7/2022, indicated resident had adequate hearing with ability to understand others and no hearing aid. A MDS dated 1/3/2023, indicated resident had adequate hearing with ability to understand others and no hearing aid. A MDS dated 4/5/2023, resident had adequate hearing with ability to understand others and no hearing aid. During an interview, on 7/12/2023 at 3:26 P.M., Employee 10 indicated that if resident sees the facility associated audiology group(Name) and a recommendation is made for hearing aids, social services receives the recommendation and they obtain the MD order and clearance. During an interview, on 7/12/2023 at 4:07 P.M., Employee 10 indicated that there was a change in the charting system and Resident 29 fell through the cracks and the order and recommendation for hearing aid were not received. She spoke with the office manager of audiology group and the resident will have to have new test and fitting for hearing aids in the future to obtain one. A current policy titled "Hearing and Vision Services" with no implementation or revision date, was provided by the DON, on 7/14/2023 at 1:48 P.M. The policy indicated that " ...It is the policy			

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	of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker/social service designee is responsible for assisting resident, and their families, in locating and utilizing any available resources (e.g. Medicare or Medicaid programs payment, local health organizations offering items and services which are available free to the community), for the provision of the vision and hearing services the resident needs. Once vision or hearing services have been identified, the social worker/social services designee will assist the resident by making appointments and arranging for transportation. Assistive devices to maintain hearing include, but are not limited to, hearing aids and amplifiers ...." 3.1-39(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral			

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	eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to elevate the head of bed when an enteral feeding pump was infusing, and label feeding bags where appropriately for 1 out of 1 resident reviewed for tube feeding. (Resident 48) Finding includes: The record for Resident 48 was reviewed on 7/13/2023 at 10:52 A.M. The diagnoses included, but were not limited to: dementia without behavioral disturbances, mood and psychotic disturbances, anxiety, and severe protein-calorie malnutrition. A Physician Order, dated 6/21/2023, indicated to elevate HOB (head of bed) 30 - 45 degrees at all times. A Physician Order, dated 6/21/2023, indicated glucerna 1.5 to be ran at 45 ml/hr (milliliter per hour) continuously throughout 24 hours via G-tube. A Care Plan, dated 11/25/2022, indicated she needed the head of her bed elevated 45 degrees during and 30 minutes after tube feed. During an observation, on 7/11/2023 at 10:14 A.M., Resident 48 had a tube feeding infusing, there were 2 bags hanging both dated 7/11 with a time of 10 A.M. one with tan liquid and the other a clear liquid.	F 0693	**693 Tube Feeding Mgmt** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 48 did not have a negative outcome related to the alleged deficient practice. · Resident 48 enteral feeding bags were replaced, dated, and labeled. **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 in the facility with enteral tubes have the potential to be affected by alleged deficient practice. · An Audit of residents with enteral tubes completed to ensure that all residents have all · appropriate enteral orders and that bags are labeled and dated **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	08/19/2023

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	During an observation, on 7/12/2023 at 2:46 P.M., the resident was in bed lying on her right side in a fetal position with the bed not elevated, and 2 bags infusing one with tan liquid and the other with clear liquid dated 7/12/23 infusing at 45 ml/hr. During an interview, on 712/2023 at 2:51 P.M., Licensed Practical Nurse (LPN) 19 indicated that her head of bed should be elevated when her feeding is running. During an interview, on 7/14/2023 at 9:12 A.M., the Director of Nursing indicated that she would expect her staff to check for placement and make sure bags are dated and appropriate, pumps on correct settings and pump cleared, head of bed up and check periodically that it is flowing correctly and verify the orders. On 7/14/2023 at 3:54 P.M., the Regional Nurse provided a policy titled, "Enteral Tube Feeding via Continuous Pump", dated November 2018, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings. 4. Position the head of the bed at 30-45 degrees for feeding. 5. On the formula label document pintails, date and time the formula was hung/administered, and initial that the label was checked against the order...." 3.1-44(a)(2)		· Licensed Nursing Staff were educated on appropriate enteral feeding maintenance with emphasis on labeling and dating bags/ feeding and head of bed elevated. · Angel Care Representatives educated on checking residents with enteral feedings to ensure that bags/ feeding is labeled and dated during rounds · DON to conduct weekly rounds to ensure that bags/feeding is labeled and dated appropriately **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?** · DON/ designee will complete the Enteral Feeding audit tool to ensure that all residents have necessary enteral orders, and that bags/ feeding is labeled appropriately · Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved	

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			an action plan will be developed to ensure compliance. **By what date will the systemic change be completed?** Compliance of 8/19/23	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled and stored appropriately in 1 of 2 medication rooms and 1 of 3 medication carts	F 0761	**F 761- Med Storage** **What corrective action(s) will be accomplished for those residents found to have been**	08/19/2023

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	observed. (300/400 hall medication room, and Dementia unit medication cart) Finding includes: During observation of medication rooms, conducted on 7/12/2023 at 10:15 A.M., the following was observed in the 300/400 hall medication room: -2 bottles and one carton of dietary shake supplements were stored in the medication refrigerator along with two unopened vials of insulin. During an interview with Licensed Practical Nurse (LPN) 4, on 7/12/2023 at 10:20 A.M., she indicated there was no pantry refrigerator to store nutritional supplements in, so they just used the medication refrigerator. During an observation of a medication cart on the secured, Dementia unit, conducted on 7/12/2023 at 10:30 A.M., the following was observed: - A box containing a bottle of over- the- counter aspirin tablets. There was no label on the box or the bottle, the resident's name was written on the bottle but, the dose and physician's name were not written on the bottle and/or box. During an interview with LPN 22, an agency nurse, she indicated the pharmacy was actually sending the aspirin tablets in the plastic sleeve type bags, so the facility was not actually utilizing the bottle of aspirin. The facility policy and procedure, titled, Medication Storage and Medication Labeling, provided by the Director of Nursing, on 7/13/2023 at 4:08 P.M. included the following: "...6. Medication are stored separately from food and		**affected by the deficient practice?** · No Residents have had a negative outcome related to the alleged deficient practice. · An additional refrigerator was purchased and placed in 300/400 Medication Room to keep dietary supplements separate from medications. · OTC bottle of aspirin was removed from medication cart. **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 in the facility have the potential to be affected by alleged deficient practice. · DON/designees audited all Medication carts to ensure that all medications and treatments were labeled, dated, and stored correctly. Identified concerns were corrected per policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nursing Staff were educated on Medication Storage policy. **How the corrective action (s) will be monitored to ensure the deficient practice will not**	

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	are labeled accordingly...Medication Labeling: 1. Labeling of mediations and biological dispensed by the pharmacy is consistent with applicable federal and state requirement and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name; b. prescribed dose; c. strength; d. expiration date, when applicable; f. route of administration; and g. appropriate instructions and precautions...5. Multidose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial...." 3.1-25(j)		**recur, i.e., what quality assurance program will be put into place?** · DON/designee will complete medication storage audits as specified to ensure compliance. · Audit will be completed 2 times/weekly x 4 weeks, weekly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date will the systemic changes be completed?** Compliance of 8/19/2023	
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			

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	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 and interview, the facility failed to maintain clean exhaust ductwork and hoods in the kitchen and above food preparation area. This deficient pracice had the potential to affect 74 of 76 residents that had food prepared in the kitchen. Finding includes: During an observation, on 7/10/23 at 6:19 P.M., it was noted that the ductwork and hoods above the food preparation area were dusty and greasy. During an observation, on 7/11/23 11:50 A.M., ductwork and hoods above food preparation area was still dusty and greasy. During an interview, on 7/10/23 6:19 P.M., Employee 11 indicated she did not know who was responsible for cleaning the duct work and hoods above the food preparation area. During an interview, on 7/11/23 10:41 A.M., Employee 12 indicated he was unsure how often ductwork and hoods are cleaned, and that maintenance was responsible for cleaning them. During an interview, on 7/14/23 10:25 A.M., Employee 13 indicated that ductwork and hoods	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**· No resident was directly affected by the alleged deficient practice. **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 that have food prepared by the kitchen have the potential to be affected by the alleged deficient practice. Environmental staff promptly cleaned the exhaust ductwork areas in the kitchen. The kitchen stove hood was also cleaned; the hood unit was also already scheduled for its semi-annual deep cleaning which occurred on July 26th. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not**	08/19/2023

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	are cleaned once a month and that the ducts in the kitchen were cleaned on 7/12/2023. He indicated he was new to this position and unsure of what the procedure and cleaning schedule was for cleaning the ductwork and hoods prior and was unsure when they were last cleaned. On 7/14/2023 at 9:00 A.M., a current policy issued 9/01/2021 with no revision date was provided by the ED. The policy indicated " ...All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The dining services director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation ...." 3.1-21(i)(2)		**recur?**· RD/Dietary Manager/Designee will retrain all dietary staff on facility's established cleaning schedules. The ductwork & hood unit will be cleaned off-hours by designated maintenance staff or contractor since cleaning requires ladder use. RD/DM/Designee will regularly review schedules to ensure completion. · Facility Administrator has added the ductwork cleaning into the TELS System, designating it as a monthly task, or "prn" as requested by Dietary Manager. **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?**· Dietary Manager or designee will utilize the Kitchen Sanitation QAPI tool weekly for 4 weeks, monthly for 3 months or longer, until compliance has been obtained for 3 consecutive months. The Administrator will also conduct a weekly kitchen sanitation inspection during this time period and review results with Dietary Manager. The results of these audits will all be reviewed by the QAPI committee. If the monthly threshold of 95% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of	

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			responsible employee. **By What date will the systematic changes be completed?**· Compliance date of 08/19/2023	