STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. BUILDING 00 B. WING	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30, 31, April 3, 4, and 5, 2023 Facility number: 000026 Provider number: 155066 AIM number: 100274820 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 8 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 12, 2023.	F 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

Victoria Kinley 04/26/2023

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

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to provide dressing assistance to physically dependent residents with developmental disabilities, to protect each resident's dignity while sleeping, for 4 of 4 residents reviewed for dignity (Residents 5, 6, 9 and 43). Findings include:	F 0550	**F550 Resident Rights/Exercise of Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · **Residents 5, 6, 9, and 43 have updated care plans to ensure an appropriate level of**	04/25/2023

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	1. During observations on the following dates and times, Resident 5 was in bed without any clothing (such as a shirt, t-shirt, pajama top or hospital gown), exposing his chest and torso, as follows: 3/31/23 at 10:15 a.m., 3/31/23 at 1:16 p.m., 4/3/23 at 9:33 a.m., 4/0/23 at 10:07 a.m., 4/3/23 at 11:23 a.m., 4/3/23 at 1:01 p.m., 4/3/23 at 1:48 p.m., 4/3/23 at 2:51 p.m., 4/4/23 at 9:10 a.m., 4/4/23 at 9:58 a.m., 4/4/23 at 10:44 a.m., 4/4/23 at 11:39 a.m., 4/4/23 at 2:39 p.m., and 4/5/23 at 8:45 a.m. No clothing was observed as removed and in the resident's bed or in the surrounding area, during any of the above observations. Resident 5's clinical record was reviewed 4/05/23 at 10:28 a.m. Current diagnoses included legally blind, intellectual disabilities, epilepsy, deaf-nonspeaking, depression, and cerebral palsy. The resident had a current, 7/29/22, physician's order for a continuous feeding by g-tube. The resident had a current, 3/30/23, physician's order to receive no food orally. The resident had a current, 11/22/2010, care plan/problem/need regarding the resident's inability to complete ADLs due to intellectual disabilities. Approaches to this problem included "anticipate wants and needs." The resident had a current, 11/22/2010, care plan/problem/need regarding being mute and unable to communicate wants and needs. Approaches to this problem included " staff to anticipate needs." A current, 3/20/23, annual, Minimum Date Set (MDS) indicated the resident was severely		**care. Resident profiles have been updated to reflect resident dignity while sleeping.** **· Staff education has been completed by DNS/designee by 4/25/23 to ensure that each staff member is aware of the residents' level of care and where to find appropriate plans of care ie care sheets.** **· All residents' level of care has been reviewed with each care plan meeting to ensure appropriate.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **· All residents have the potential to be affected by the alleged deficiency.** **· An audit of all dependent residents will be completed by IDT to address dignity while sleeping and to ensure preferences were followed.** **· In-service to all care providers will be completed by 4/25/23 by Director of Nursing/Designee on activity level and level of care.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· In-service will be provided to all care providers**	

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	cognitively impaired, was non-speaking, required staff assistance for all activities of daily living including dressing, displayed no maladaptive behaviors during the assessment period, and was rarely or never understood. The clinical record lacked a plan of care or documentation regarding the resident desiring/needing to sleep without clothing to the upper body. 2. During observations on the following dates and times, Resident 6 was in bed without any clothing (such as a shirt, t-shirt, pajama top or hospital gown), exposing his chest and torso, as follows: 3/30/23 at 11:17 a.m., 3/31/23 at 10:10 a.m., 3/31/23 at 1:15 p.m., 4/3/23 at 9:32 a.m., 4/3/23 at 10:06 a.m., 4/3/23 at 11:22 a.m., 4/3/23 at 12:58 p.m., 4/3/23 at 1:47 p.m., 4/3/23 at 2:50 p.m., 4/4/23 at 9:08 a.m., 4/4/23 at 10:00 a.m., 4/4/23 at 10:43 a.m., 4/4/23 at 11:38 a.m., 4/4/23 at 2:35 p.m., 4/4/23 at 2:38 p.m., and 4/5/23 at 8:44 a.m. No clothing was observed as removed and in the resident's bed or in the surrounding area, during any of the above observations. Resident 6's clinical record was reviewed 3/31/23 at 1:33 p.m. Current diagnoses included spastic quadriplegic cerebral palsy, depression, and anxiety. The resident had a current, 7/21/22, physician's order for feeding by g-tube two times per day. The resident had a current, 7/1/19, physician's order for no food orally. The resident had a current, 6/29/29, care plan/problem/need regarding requiring assistance with all activities of daily living. Approaches to this problem included "Assist with dressing/grooming/hygiene as needed..."		**by 4/25/23 by Director of Nursing/Designee** **· Unit Managers/Life Path Director will complete audit via observations and discuss with staff during GEMBA rounds if indicated.** **· DNS/Life Path Director/designee will round each evening to ensure residents are appropriately clothed per preference.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· Ongoing compliance with this corrective action will be monitored via facility QAPI tool Residents Rights and Activity Level and given to the DNS for review at the end of each week x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be developed to ensure compliance.** **· QAPI tool will be reviewed monthly during QAPI meeting which is overseen by the executive director.**	

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A 2/15/23, quarterly, MDS assessment indicated the resident was severely cognitively impaired, did not speak, displayed no maladaptive behaviors during the survey process, was dependent on staff for all activities of daily living including dressing and was rarely or never understood.

The clinical record lacked a plan of care or documentation regarding the resident desiring/needing to sleep without clothing to the upper body.

3. During observations on the following dates and times, Resident 9 was in bed without any clothing (such as a shirt, t-shirt, pajama top or hospital gown), exposing his chest and torso, as follows: 3/31/23 at 1:16 p.m., 4/3/23 at 9:33 a.m., 4/3/23 at 10:07 a.m., 4/3/23 at 11: 30 a.m., 4/3/23 at 1:00 p.m., 4/3/23 at 2:51 p.m., 4/4/23 at 9:10 a.m., and 4/4/23 at 9:58 a.m.

No clothing was observed as removed and in the resident's bed or in the surrounding area during any of the above observations.

Resident 9's clinical record was reviewed 3/31/23 at 1:41 p.m. Current diagnoses included dementia, Down syndrome, anorexia, epilepsy, and dysphasia.

The resident had a current, 1/22/21, care plan/problem/need regarding requiring assistance with activities of daily living.

A 2/19/23, significant change, Minimum Date Set (MDS) assessment indicated the resident was severely cognitively impaired and required staff assistance with all activities of daily living

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	including dressing. The clinical record lacked any documentation of the resident refusing clothing, did not desire clothing in bed, or removing clothing. 4. During observations on the following dates and times, Resident 43 was in bed without any clothing (such as a shirt, t-shirt, pajama top or hospital gown), exposing his chest and torso, as follows: at 11:17 a.m., 3/31/23 at 10:10 a.m., 3/31/23 at 1:14 p.m., 4/3/23 at 9:32 a.m., 4/3/23 at 10:06 a.m., 4/3/23 at 11:21 a.m., 4/3/23 at 12:58 p.m., 4/3/23 at 1:47 p.m., 4/3/23 at 2:50 p.m., 4/4/23 at 9:08 a.m., 4/4/23 at 9:59 a.m., 4/4/23 at 10:42 a.m., 4/4/23 at 11:37 a.m., 4/4/23 at 2:37 p.m., and 4/5/23 at 8:43 a.m. No clothing was observed removed and in the residents bed or in the surrounding area during any of the above observations. Resident 43's clinical record was reviewed 3/31/23 at 1:28 p.m. Current diagnoses included dementia, Down syndrome, anxiety and epilepsy. The resident had a current, 6/14/18, care plan/problem/need requiring assistance with activities of daily living. Approaches to this problem included, "Assist with dressing/grooming/hygiene as needed..." A current, 3/21/23, quarterly, MDS assessment indicated the resident was severely cognitively impaired, had unclear speech, had no maladaptive behaviors during the assessment period, and required assistance of staff for all activities of daily living including dressing. The clinical record lacked any documentation of			

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	the resident refusing clothing, did not desire clothing in bed, or removing clothing. During an interview on 4/05/23 at 8:49 a.m., LPN 5 indicated there were no residents on the unit who had a bed rest order or any medical reason to not be out of bed. During an interview on 4/5/23 at 8:53 a.m., the Life Path Unit Manager (the unit for residents which provides services for residents with development/intellectual disabilities) indicated there were no residents on the unit with bed rest orders or who could not get out of bed. The staff may not get residents out of bed or dressed because they felt overwhelmed and unable to get everything done. The Administrator had been aware that dependent residents were frequently not out of bed. However, the problem had not yet been corrected. No residents on the unit had orders or care plans to only wear briefs when in bed. During an interview on 4/05/23 at 9:00 a.m., CNA 6 indicated most of the CNAs had a habit of not putting clothes on Resident's 5, 6,9, and 43 when in bed. She had been told these four residents did not like clothing. However, there was no guidance on the CNA assignment sheet to say not to put sleeping clothes on them. Residents 5, 6, 9, and 43 all appeared to need more things to do, like activities, when they were out of bed, in order to stay up and happy. During a confidential interview, a staff member indicated heavy - care residents might not be assisted to get out of bed when there was a call in and staffing was tight. A current, 2/2010, facility policy, titled, "AM			

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	[morning care]" which was provided by the DON on 4/5/23 at 9:53 a.m., indicated: "...Assist resident with dressing, including applying make-up and/or jewelry as requested...." 3.1-3(a)			
F 0568 SS=E Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on observation, interview, and record review, the facility failed to manage resident funds using acceptable accounting principals (Residents 6 and 27). This deficient practice had the potential to impact 16 of 16 residents with diagnoses of intellectual/developmental disabilities, for whom the facility managed funds. Findings include: A current, 4/3/23, facility document titled, "Trial Balance," provided by the Business Office manager on 4/3/23 at 2:50 p.m., indicated the facility managed resident funds for 54 of the facility's residents. Sixteen of the 54 residents for whom the facility managed funds resided on the unit designated to address the needs of	F 0568	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · **Resident 6 and 27 have their trust fund balanced by BOM** · **The OBRA provider, Hillcroft, no longer provides services to our facility.** · **Immediately and ongoing, withdrawals will be balanced using accountability for each dollar withdrawn by an outside service provider by the next business day.**	04/25/2023

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	individuals with development and/or intellectual disabilities. A review of four individual resident funds were reviewed with the Business Office Manager on 4/4/23 at 10:10 a.m. The last two quarterly statements (7/1/22 to 9/30/22 and 10/1/22 to 12/30/22) and March 20 2023 were reviewed for individual withdrawals for "Social Events". The "Social Events" charges billed were reviewed and lacked corresponding receipts and reconciliation as follows: 1. Resident 6: 7/6/22- Social Event-$25.00 8/3/22-Social Events- $10.00 10/5/22-Social Events--$10.00 10/25/22-Social Events-$20.00 11/15/22-Social Events-$50.00 12/21/22-Social Events-$10.00 3/9/23-Social Event -$4.00 3/17/23-Social Events-$10.00 2. Resident 27: 9/2/22-Social Events-$25.00 9/14/22-Social Events-$50.00 11/10/22-Social Events-$30.00 During an interview on 4/4/23 at 10:15 a.m., the Business Office Manager indicated she did not believe she had a receipt for each "Social Event" withdrawal to each resident account. Residents would go on outings with their OBRA (socialization and mental stimulation services offered for residents with intellectual/developmental disabilities) services provider. The facility would have the OBRA service provider sign for the money. The facility		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **· This deficient practice had the potential to impact 16 or 16 residents with diagnosis of intellectual/developmental disabilities for whom the facility managed funds.** **· Business Office Manager and/or designee educated on 4/25/2023 regarding managing resident funds using acceptable accounting principles. Withdrawals will be balanced using accountability for each dollar withdrawn by an outside service provider. Outside service providers will be required to provide receipts for each social outing enabling the facility to reconcile the receipts with the money taken to ensure all resident funds were recorded and accurately accounted.** **· Executive Director/designee will complete audit "Resident Trust Fund" for each resident** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· Business Office Manager and/or designee educated on**	

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	did not have the OBRA provider provide a receipt, observe any items purchased, or have the change from the outing returned to the resident account for each outing. The OBRA provider would sometimes keep receipts and change for a month. The facility did not reconcile the receipts with the money taken to ensure all resident funds were recorded and accurately accounted. She did received various receipts from the OBRA provider throughout the month. During the interview, the Business Office Manager provided various receipts for the time periods above, but she could not reconcile the receipts to the dates of withdrawal and the amount taken. The facility did not have any system to ensure each withdrawal was balanced out to provided accountability for each dollar withdrawn by an outside service provider. Residents 6 and 27 had special needs/developmental disabilities and did not make decisions for themselves. Other residents received OBRA services for their developmental disability and the same system was used for them. She had been handling resident funds for two years and this was the method she was taught when she began managing the funds. Her consultant had identified a problem with OBRA services withdrawals on 3/7/23 and indicated changes should be made moving forward. She had made changes after 3/7/23 but her changes were not to develop a system to ensure reconciliation of every " Social Event" OBRA withdrawal with a corresponding receipt, visual proof of items purchased, and/or the receipt of returned funds to ensure accountability for all money received. During an interview on 4/4/23 at 11:27 a.m., the Business Office Manager indicated after review all receipts for the above "Social Events" for Residents 6 and 27, she was still unable to		**4/25/2023 regarding managing resident funds using acceptable accounting principles.** **· Executive Director/designee will complete audit "Resident Trust Fund"** **· Withdrawals will be balanced using accountability for each dollar withdrawn by an outside service provider by the next business day. Balance sheets will be reviewed by ED/Designee to ensure receipts and accounting principles are followed.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· Ongoing compliance with this corrective action will be monitored via facility QAPI tool Resident Trust Funds and given to the DNS for review at the end of each week x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be developed to ensure compliance.** **· QAPI tool will be reviewed monthly during QAPI meeting which is overseen by the executive director.**	

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	reconcile the total accountability for all funds received. A current, 2/2019, facility policy titled "Resident Trust Funds Policy," provided by the Business Office Manager on 4/4/23 at 4:00 p.m., indicated the following: "...6. The Business Office Manager during the next business day will reconcile each resident's account based on the withdrawals...." A "Resident Census and Conditions of Residents" (CMS -672 form), completed by the facility on 3/30/23, indicated 16 of the facility's 70 residents had intellectual and/or developmental disabilities. 3.1-3(v)(1)			
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, interview, and record review, the facility failed to ensure a dependent resident received assistance to mail care for 1 of 2 residents review for activities of daily living (Resident 27). Findings include: During an interview on 3/31/23 at 10:19 a.m., Resident 27's family member indicated the resident was often in need of nail care. His nails were often uneven, jagged, and had dark debris under most nails. This issue was concerning to the family because the resident required assistance for hand washing and nail care. The family would	F 0677	**F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **· Resident 27 had nail care completed and will have nail care completed with each shower and as needed.** **How other residents having the potential to be affected by the same deficient practice will be**	04/25/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	often do nail care during their visits because they were concerned with long unclean hands and nails. He ate items like bread or sandwiches, using his unclean hands. The resident was observed in his wheelchair, in the hallway, with long, uneven nails during the following dates and times: 3/31/23 at 1:18 p.m., 4/3/23 at 9:30 a.m., 4/3/23 at 10:07 a.m., and 4/3/23 at 11:24 a.m. During an interview on 4/4/23 at 11:40 a.m., the resident's family member was in the resident's room with the resident, providing nail care. The family member used a nail care orange stick, running it under the resident's nails, and removing thick brown residue from under each nail. The family member displayed a paper towel with nail clippings and additional dark debris. She indicated this was the condition of the resident's nails of concern to her. The resident had seizures on a frequent bases and when he fell or hit a limb, he would often hit his hands and break nails, and required nail care when this occurred. During an observation on 4/4/23 at 12:22 p.m., following nail care by family, Resident 27 was eating a grilled cheese sandwich with his hands. Resident 27's clinical record was reviewed 3/31/23 at 1:30 p.m. Current diagnoses included severe intellectual disabilities, epilepsy, cerebral palsy, and dementia. The resident had a current, 2/2/23, care plan problem/need regarding the risk for decline in activities of daily living. The goal for this problem was for the resident to be neat, clean, and dressed appropriately.		**identified and what corrective action(s) will be taken;** **· All dependent residents have the potential to be affected by the alleged practice.** **· All dependent residents' nails were checked to ensure completion of care by DNS/designee.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· In-service will be completed to address when nail care is to be provided to all residents by 4/25/23 by Director of Nursing/Designee.** **· In-service will include all aspects of shower sheets and care to be provided with showers.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· Ongoing compliance with this corrective action will be monitored via the QAPI tool Nail Care of Dependent Residents which will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be**	

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	155066	A. BUILDING 00 B. WING	04/05/2023

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	A current, 1/17/23, significant change, Minimum Date Set (MDS) assessment indicated the resident was severely cognitively impaired, displayed no maladaptive behaviors during the assessment period, and required staff assistance for all activities of daily living, including bathing and grooming. During an interview on 4/5/23 at 8:49 a.m., LPN 5, who was working on Resident 27's unit, indicated CNAs should do nail care during showers, unless the resident was diabetic, then the nurse would provide nail care. Resident 27 was not diabetic. During an interview on 4/5/23 at 9:00 a.m., CNA 6, who indicated she routinely worked on Resident 27's unit, indicated CNAs didn't usually do nail care, most nail care was done by activities staff, unless the resident was diabetic. A current, 3/2012, facility policy, titled "Fingernail Care," provided by the DON on 4/5/23 at 9:53 a.m., indicated the following: "...7. Soak resident's hands and pat dry...9. Clean under nails with orange stick. 10. Clip fingernails straight across, then file in a curve...." 3.1-38(a)(3)		**developed to ensure compliance.** **· QAPI tool will be reviewed monthly during QAPI meetings which is overseen by the Executive Director.** **By what date will the systemic change be completed;** **· Completion Date 4/25/23**	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental,			

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	and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and clinical record review, the facility failed to provide an out of room activities program to encourage mental stimulation and socialization for developmentally/intellectually disabled residents for 3 of 3 dependent residents reviewed for activities programing (Residents 5, 6, and 43). Findings include: 1. Resident 5's clinical record was reviewed 4/05/23 at 10:28 a.m. Current diagnoses included legally blind, intellectual disabilities, epilepsy, deaf-nonspeaking, depression, and cerebral palsy. The resident had a current physicians orders for (7/29/22) continuous feeding by g-tube, (2/12/15) activity level up ad lib (as much and as often as desired), (12/7/15) transfer with a mechanical lift and the assistance of 2 staff members, and (5/24/19) resident to be up in custom wheelchair. The resident had a current, 11/22/10, care plan/problem/need regarding the resident being hearing impaired, deaf, and mute. The resident had a current, 6/27/11, care plan/problem/need regarding "Resident appears to enjoy the warmth of sunlight for tactile stimulation". Approaches to this problem included "sit near window for sunlight." The resident had a current, 5/20/23, care plan problem/need regarding depression. Approaches to this problem included, "Encourage activities of interest."	F 0679	**F679 Activities Meet Interest/Needs of Each Resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **· Residents 5, 6, and 43 have updated activity care plans completed and are receiving activities per plan of care/preference.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **· All residents have the potential to be affected by the alleged practice.** **· Activity staff educated on the importance of following residents plan of care for activities and number of one-on-one activities of interest by the Director of Nursing/Designee by 4/25/23.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· Education was provided to activity staff on following the activity calendar and one on**	04/25/2023

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	A current, 3/20/23, annual, Minimum Date Set (MDS) indicated the resident was severely cognitively impaired, was non-speaking, required staff assistance for all activities of daily living including dressing, displayed no maladaptive behaviors during the assessment period, and was rarely or never understood. The clinical record lacked any documentation of the resident refusing any activities during the previous three- month period. Review of the activity attendance record for Resident 5 for March 5, 2023 to April 5, 2023 indicated the following: a. He attended zero out of room activities during this one month period. b. He attended zero group activities during this period. c. He was provided two in-room one to one activities each week. This totaled nine activities offered in one month. d. Five of nine documented activities were related to physical care or environmental care required by the resident: 3/10/23- turned music on for him and changed bed, 3/13/23-cleaned up his room for him, 3/17/23- clip his nails & groomed, 3/24/23- changed his bed & groomed him, and 3/30/23-talked with him and groomed him. During observations on the following dates and times Resident 5 was in bed, in his room and not engaged in any activities: 3/31/23 at 10:15 a.m., 3/31/23 at 1:16 p.m., 4/3/23 at 9:33 a.m., 4/3/23 at 10:07 a.m., 4/3/23 at 11:23 a.m., 4/3/23 at 1:01 p.m., 4/3/23 at 1:48 p.m., 4/3/23 at 2:51 p.m., 4/4/23 at 9:10 a.m., 4/4/23 at 9:58 a.m.,		**one activity by the Director of Nursing/Designee by 4/25/23.** **· A leadership support schedule was developed and implemented which will ensure activity oversight by members of the facility's management team to ensure residents are attending activities per preference and per care plan.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· The life path director/unit manager will complete the QAPI tool Activity Engagement and Activity Leadership Support weekly x 4 weeks, monthly x 6 months, and then quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be developed to ensure compliance.** **· QAPI tool will be reviewed monthly during QAPI meeting which is overseen by the Executive Director.** **By what date will the systemic change be completed;** **· Completion Date 4/25/23**	

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	4/4/23 at 10:44 a.m., 4/4/23 at 11:39 a.m., 4/4/23 at 2:39 p.m., and 4/5/23 at 8:45 a.m. The resident was not observed out of his room, or engaged in activity programing at any time during the survey process. 2. Resident 6's clinical record was reviewed 3/31/23 at 1:33 p.m. Current diagnoses included spastic quadriplegic cerebral palsy, depression, and anxiety. The resident had a current physician's orders for (7/21/22) feeding by g-tube two times per day, (7/1/19) no food orally, (11/10/22) up ad lib with mechanical lift and assist of two staff, and (7/3/19) title in space wheelchair. The resident had a current, 7/1/19, care plan/problem/need regarding altered mood state/depression. The resident had a current, 7/22/19, care plan problem/need regarding both a long and short term memory deficit. Approaches to this problem included, "Engage resident in activities of interest and stimulation." The resident had a current, 7/22/19, care plan problem/need needing assistance to start and completed activities and enjoying being around animals, peers, watching sports and being outside in nice weather. A current, 2/15/23, quarterly, MDS assessment indicated the resident was severely cognitively impaired, did not speak, displayed no maladaptive behaviors during the survey process, was dependent on staff for all activities of daily living including dressing, and was rarely or never			

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	understood. The clinical record lacked documentation regarding the resident refusing any activities during the previous three month period. Review of the activity attendance record for Resident 5 for March 5, 2023 to April 5, 2023 indicated the following: a. He attended zero out of room activities during this one month period. b. He attended zero group activities during this period. c. He was provided two in room one to one activities each week. This totaled nine activities offered in one month. d. Four of nine documented activities were related to physical care or environmental care required by the resident: 3/3/23- cleaned his room and talked to him, 3/10/23- clipped nails, 3/17/23- clean his closet and 3/20/23- gave a bed bath and changed bedding. During observations on the following dates and times, Resident 5 was in bed in his room and not engaged in any activities: 3/30/23 at 11:17 a.m., 3/31/23 at 10:10 a.m., 3/31/23 at 1:15 p.m., 4/3/23 at 9:32 a.m., 4/3/23 at 10:06 a.m., 4/3/23 at 11:22 a.m., 4/3/23 at 12:58 p.m., 4/3/23 at 1:47 p.m., 4/3/23 at 2:50 p.m., 4/4/23 at 9:08 a.m., 4/4/23 at 10:00 a.m., 4/4/23 at 10:43 a.m., 4/4/23 at 11:38 a.m., 4/4/23 at 2:35 p.m., 4/4/23 at 2:38 p.m., and 4/5/23 at 8:44 a.m. The resident was not observed out of his room or engaged in activity programing at any time during the survey process. 3. Resident 43's clinical record was reviewed 3/31/23 at 1:28 p.m. Current diagnoses included			

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	dementia, Down's syndrome, anxiety and epilepsy. The resident had a current physician's orders for (3/30/23) bolus feeding by g-tube five times a day, (7/10/18) transfer with mechanical lift and assistance of two staff, and (1/21/19) up ad lib in custom wheelchair. The resident had a current, 8/1/19, care plan/problem/need a risk for depression and altered mood. Approaches to this problem included to encourage participation in activities if interest. The resident had a current, 7/3/18, care plan problem/need regarding the risk of psychosocial distress due to placement in a facility at a young age. Approaches to this problem included, assist and encourage participation in activities of interest. A current, 3/21/23, quarterly, MDS assessment indicated the resident was severely cognitively impaired, had unclear speech, had no maladaptive behaviors during the assessment period, and required assistance of staff for all activities of daily living including dressing. The clinical record lacked any documentation of the resident refusing to participate in activities at any time during the previous three month period. Review of the activity attendance record for Resident 5 for March 5, 2023 to April 5, 2023 indicated the following: a. He attended zero out of room activities during this one month period. b. He attended zero group activities during this period.			

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	c. He was provided two in room one to one activities each week. This totaled nine activities offered in one month. d. Three of eight documented activities were related to physical care or environmental care required by the resident: 3/13/23- gave him a message and changed his bedding, 3/17/23- clipped nails, and 3/20/23- cleaned room. During observations on the following dates and times, Resident 43 was in bed in his room as follows: 3/30/23 at 11:17 a.m., 3/31/23 at 10:10 a.m., 3/31/23 at 1:14 p.m., 4/3/23 at 9:32 a.m., 4/3/23 at 10:06 a.m., 4/3/23 at 11:21 a.m., 4/3/23 at 12:58 p.m., 4/3/23 at 1:47 p.m., 4/3/23 at 2:50 p.m., 4/4/23 at 9:08 a.m., 4/4/23 at 9:59 a.m., 4/4/23 at 10:42 a.m., 4/4/23 at 11:37 a.m., 4/4/23 at 2:37 p.m., and 4/5/23 at 8:43 a.m. The resident was not observed out of his room or engaged in activity programing at any time during the survey process. During an interview on 4/5/23 at 8:49 a.m., LPN 5 indicated there were no residents on the unit who had a bed rest order or any medical reason to not be out of bed. During an interview on 4/5/23 at 8:53 a.m., the Life Path Unit Manager (the unit for residents which provided services for residents with development/intellectual disabilities) indicated there were no residents on the unit with bed rest orders or who could not get out of bed. The staff may not get residents out of bed or dressed because they felt overwhelmed and unable to get everything done. The Administrator had been aware that dependent residents are frequently not out of bed. However the problem had not yet been corrected.			

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	During an interview on 4/5/23 at 9:00 a.m., CNA 6 indicated Residents 5, 6, and 43 all appeared to need more things to do, like activities, when they were out of bed in order to stay up and happy. During a confidential interview, a staff member indicated heavy care residents might not be gotten out of bed when there was a call-in and staffing was tight. A current, 1/06, facility policy titled "Activities," provided by the DON on 4/5/23 at 9:53 a.m., indicated the following: "...It is the policy of the facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and and psychosocial well-being of each resident...." 3.1-33(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to follow physicians orders related to oxygen administration for a dependant resident for 1 of 2 residents reviewed for respiratory care (Resident 55).	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/25/2023

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	Findings include: During an observation on 3/31/23 at 9:12 a.m., the resident was noted to be sleeping soundly with the head of the bed at a 30 degree angle. The oxygen concentrator supply to her tracheostomy site was set at 4.5 liters per minute. On 4/3/23 at 9:10 a.m. she was observed lying on her back with the head of bed under 30 degrees. The oxygen concentrator supply to her tracheostomy site was set at 4.5 liters per minute. During an observation of tracheostomy care on 4/3/23 at 1:18 p.m., Nurse 4 removed the resident's oxygen mask and provided suction. After the nurse completed this task, he reapplied the oxygen mask but did not verify the oxygen settings. On 4/4/23 at 9:50 a.m. she was observed in her Broda (high-backed reclining wheelchair) chair at the side of her bed. The oxygen liter flow was at 4.5 liters per minute. Resident 55's clinical record was reviewed on 3/31/23 at 10:33 a.m. Her diagnoses included anoxic brain damage, cognitive communication deficit, muscle weakness, acute respiratory failure, shortness of breath, and tracheostomy status. The MDS (Minimum Date Set), dated 1/1/23, indicated that she required total assistance for bed mobility, bathing, and personal hygiene. Current physician orders, dated 12/14/22, indicated oxygen at 2-3 liters per minute via tracheostomy, continuous. A respiratory care plan, dated 6/14/21, indicated		**practice;** **· Resident 55 has updated oxygen order to include titration to keep > 92%** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **· All residents who are oxygen dependent have potential to be affected by the alleged practice.** **· All oxygen dependent residents now have orders to include LPM that nurses must enter after verifying to ensure appropriate liter flow.** **· All nurses have been in serviced by the DNS/designee on verification of oxygen settings by 4/25/23.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· Education was provided to all nurses on verification of oxygen settings by DNS/designee by 4/25/23.** **· Nurses are aware of changes to oxygen orders so that they must document the amount of LPM on each oxygen order.** **· Unit Manager/designee will review oxygen dependent**	

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	she was at risk for impaired gas exchange related to acute respiratory failure and tracheostomy status. The approaches included administer oxygen as ordered, monitor oxygen saturation rates as needed/ordered, and assess vital signs and lung sounds as needed. During an interview, on 4/4/23 at 10:36 a.m., the DON indicated the resident's oxygen could have been titrated up by staff. Review of a current, undated facility policy, titled "Oxygen Concentrator," provided by the DON on 4/5/23 at 10:15 a.m., indicated "... Procedure 1. Verify and understand the physician's order. 2. Know the flow rate and duration of use...9. Adjust the flow meter control knob to the flow setting prescribed by the physician. The graduated line of the meter should be aligned with the center of the floating ball...." 3.1-47(a)(6)		**residents to ensure appropriate settings.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· The unit managers/designee will complete the QAPI tool Oxygen Dependent Residents weekly x 4 weeks, monthly x 6 months, and then quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be developed to ensure compliance.** **· QAPI tool will be reviewed monthly during QAPI meetings which is overseen by the Executive Director.** **By what date will the systemic change be completed;** **· Completion Date 4/25/23**	
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			

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	§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, interview, and record review, the facility failed to ensure insulin pens were labeled with open dates and the expiration date for 1 of 2 carts reviewed for medication storage and labeling (Moving Forward cart 1). Findings include: During an observation, accompanied by LPN 7 on 4/5/23 at 1:38 p.m., the Moving Forward medication cart 1 included the following: A Levemir Flex pen had been opened, and the insulin pen did not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen contained 50 units. An Aspart insulin pen had been opened, and the pen did not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen was full. A Victoza pen had been opened, and the pen did	F 0761	**F761 Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **· All medication carts have been checked and insulins removed and re-ordered if not dated or no longer utilizing.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** **· All diabetic residents utilizing insulin have the potential to be affected by the alleged practice.** **· All nurses have been in serviced by the DNS/designee**	04/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. BUILDING 00 B. WING	04/05/2023

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	not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen contained 13 units. A Glargine insulin pen had been opened, and the pen did not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen contained 30 units. A Humalog KwikPen had been opened, and the pen did not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen contained 200 units and the resident was no longer receiving this medication. A Humalog KwikPen had been opened, and the pen did not indicate the date it had been opened, nor the date it would expire. LPN 7 indicated the pen contained 10 units and the resident was no longer receiving this medication. Review of the current facility policy, titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles," with the latest revision date of 10/31/16 and provided by the DON on 4/15/23 at 2:13 p.m., indicated the following: "...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...16. Facility should destroy or return all discontinued, outdated/expired or deteriorated medications or biologicals in accordance with the Pharmacy return/destruction guidelines or other Applicable Law...." 3.1-25(j)		**on appropriate storage, dating, and removal of insulin in medication carts by 4/25/23.** **· All carts have been checked to ensure insulin pens were labeled with open dates and were not expired.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** **· Education was provided to nurses on correct dating of insulin pens.** **· Nurses were educated on removal of medications no longer in use.** **· Unit Managers will check medication carts weekly for expired, discontinued, or not dated medications.** **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** **· The unit managers/designee will complete the QAPI tool Label/Storage of Medications weekly x 4 weeks, monthly x 6 months, and then quarterly there after until compliance is achieved.** **· If a threshold of 100% is not met, an action plan will be developed to ensure**	

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			compliance. **· QAPI tool will be reviewed monthly during QAPI meetings which is overseen by the Executive Director.** **By what date will the systemic change be completed;** **· Completion Date 4/25/23**	