DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155269 | A. BUILDING 00<br>B. WING | 11/03/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| EAST LAKE NURSING & REHABILITATION CENTER | 1900 JEANWOOD DR<br>ELKHART, IN 46514 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00387842, IN00380160 and IN00372996.<br><br>Complaint IN00387842 - Substantiated. Federal deficiency related to the allegations is cited at F921.<br><br>Complaint IN00380160 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00372996 - Unsubstantiated due to lack of evidence.<br><br>Survey dates: October 26, 27, 28, 31 and November 1, 2 and 3, 2022<br><br>Facility number: 000169<br>Provider number: 155269<br>AIM number: 100267100<br><br>Census Bed Type:<br>SNF/NF: 67<br>SNF: 9<br>Total: 76<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 53<br>Other: 17<br>Total: 76<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 11/12/22. | F 0000 | The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| McKenzie Hojara | Executive Director | 11/28/2022 |

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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| F 0582<br>SS=D<br>Bldg. 00 | 483.10(g)(17)(18)(i)-(v)<br>Medicaid/Medicare Coverage/Liability Notice<br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, | | | |

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| | the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. | | | |
| | Based on record review and interview, the facility failed to ensure the appropriate financial liability notification forms were provided to 2 of 3 residents who were reviewed for the ABN (Advanced Beneficiary Notice) and the NMNC (Notice of Medicare Non-Coverage). (Residents 72 & 100)<br><br>Findings include:<br><br>1. A clinical record review was completed on 10/28/22 at 10:43 A.M. An Admission MDS (Minimum Data Set) Assessment, dated 6/30/2022, indicated Resident 72's BIMS (Brief Interview for Mental Status) score was 7, indicating severe cognitive impairment.<br><br>Resident 72's ABN and NNMNC had not been signed by the resident, or the residents' representative. The clinical record indicated a phone call had been made to the spouse, however, there was no indication that the documents had been mailed. | F 0582 | It is the practice of the facility to ensure the appropriate financial liability notification forms are provided. Business Office, Therapy, and social service staff in-service will be completed on or before 11/28/22 on issuing notice of all advanced beneficiary notices and notice of Medicare non-coverage letters.<br>All residents have the potential to be impacted by this deficient practice. An audit of all Advanced Beneficiary Notices and Notice of Medicare Non-Coverage letters were reviewed and corrected by 11/28/22.<br>Business Office, Therapy, and social service staff in-service will be completed on or before 11/28/22 on issuing notice of all advanced beneficiary notices and notice of Medicare non-coverage letters. Business office log will be | 11/28/2022 |

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| | 2. A clinical record for Resident 100 was completed on 11/03/2022 at 11:19 A.M. An Admission MDS Assessment, dated 7/4/2022, indicated Resident had a BIMS score of 4, severe cognitive impairment. The clinical record lacked the documentation of any communication with the residents' representative, or that the ABN/ NMNA documents had been mailed.<br><br>On 11/2/2022 at 3:40 P.M., the DON provided the policy titled, "Checklist/Instructions for issuing a Notice of Medicare Non-Coverage (NOMNC) /Determination On Continued Stay". The policy indicated " ...Responsible party must come into sign the NOMNC or it needs to be sent out by mail with a return envelope ...."<br><br>During an interview, on 11/03/2022 at 11:30 A.M., Social Service staff indicated the NMNC and ABN had not been mailed to the residents' representatives and should have been mailed, along with a return envelope.<br><br>3.1-4(f)(2) | | reviewed by home office business office monthly to ensure the NOMNOC was issued timely. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Notice of Medicare Non-Coverage Letters” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - | | | |

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| | (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. | | | |
| | Based on record review and interview, the facility failed to develop person centered care plans for hives and for a resident with depression in 2 of 22 residents whose care plans were reviewed. (Resident 30 and 7)<br><br>Findings include:<br><br>1. During an observation, on 10/27/2022 at 9:57 | F 0656 | It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan residents with hives and for residents with depression. The care plans for residents 30 and 7 have been reviewed and updated to include a care plan for hives and depression. | 11/28/2022 |

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| | A.M., Resident 30 was observed with round red raised areas to the right upper arm, left and right lower leg and the left inner arm.<br><br>A clinical record review was completed on 10/31/2022 at 1:56 P.M. Resident 30's diagnoses included, but were not limited to: Alzheimer's disease, dementia, arthritis, and hyperthyroidism.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, dated 8/30/2022, indicated Resident 30 was severely impaired cognitively. Required extensive assist of 2 staff for bed mobility, total assist for toilet use and transfers, and extensive assist of 1 for eating and dressing and had no skin issues.<br><br>A current care plan, dated 2/21/2022, indicated the resident had a history of hives around her mouth.<br><br>During an interview, on 10/31/2022 at 1:23 P.M., the IP (Infection Preventionist) indicated Resident 30's hives just come and goes and had been treated with hydrocortisone cream. She indicated the staff had been talking about the hives last week. The IP indicated she was unsure if there was a care plan for the hives currently on her body.<br><br>A Progress Note, dated 11/1/2022, indicated the IDT (Interdisciplinary Team) met to review the hives to the resident.<br><br>The clinical record lacked a person centered care plan for the hives to the residents arms, legs and torso.2. During a random observation on 10/27/2022 at 11:40 A.M., Resident 72 had a flat affect.<br><br>During an interview, 10/27/2022 at 11:40 A.M., | | All residents have the potential to be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans related to hives and depression will be completed and updated appropriately. Comprehensive Care Plan will be reviewed to ensure care plans are resident centered.<br>Comprehensive Care Plans will be established for all residents upon Admissions and quarterly thereafter or when changes occur.<br>All staff in-servicing will be conducted by the ED/designee on or before 11/28/22 and will review the facility policy related to Comprehensive Care Plans. This will ensure that all residents are provided with comprehensive care plans are resident centered. IDT will review care plans during morning meeting to ensure care plans are resident centered and address depression and hives if indicated.<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).<br>The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be | |

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| | Resident 72 cried when asked how she was feeling, and indicated she was not feeling good.<br><br>A clinical record review was completed on 10/28/2022 at 2:47 P.M. Resident 72's diagnoses included, but were not limited to: Non-Alzheimer's dementia, depression, and diabetes mellitus.<br><br>Physician orders dated, 10/6/2021, included, Zoloft (an antidepressant) 50 mg (milligrams) oral once a day, and on 2/21/2022, Mirtazepine 7.5 mg oral at bedtime.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, dated 10/4/2022, indicated Resident 72 had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact.<br><br>A care plan problem, dated 10/6/2022, indicated the resident was at risk for signs and symptoms of depression, upset with current situation, and not seeing family often. Interventions included but were not limited to: medications per order; encourage family support and involvement; emphasize and promote independence and feelings of control and choice; allow resident to express feelings; offer validation and support; and encourage activities of interest.<br><br>A Progress Note, dated 7/13/2022, indicated the resident had been seen by the psychologist. The note indicated, "Resident is anxious about upcoming medical procedure in 5 days and Ativan was started until the day of procedure."<br><br>A Progress Note, dated 9/19/2022, indicated the resident had been seen by the psychologist. The note indicated, "Resident having an anxiety about starting hemodialysis and continued difficulty with nursing home placement. Visits will be | | developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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increased to every 2-4 weeks as needed."

A Progress Note, dated 10/10/2022, indicated Resident 72 had been seen by the psychologist and the "Resident still has difficulty adjusting to potential need for hemodialysis and appeared depressed. She was in better mood at end of session."

The GDR (Gradual Dose Reduction) note for Zoloft, dated 9/26/2022, indicated, "Patient with symptoms of depression. She is not getting out from her room. Decreasing Zoloft can worsen her mood". GDR note dated 9/26/2022 for Remeron indicated, "Discontinuation of Remeron can worsen her sleep."

During an interview on 11/01/2022 at 11:29 A.M., the Social Service staff indicated the interventions instructing staff on what made her feel better were not present and should have been. The care plan was not person centered.

On 11/2/2022 at 3:41 P.M., the Director of Nursing provided the policy titled, "IDT Comprehensive Care Plan Policy." The policy indicated, " ...Care plan problems, goals, and interventions will be updated based on changes in the resident assessment/condition, resident preferences, or family input ...."

3.1-35(a)

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;

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| | Based on observation, record review and interview, the facility failed to provide showers timely for 2 of 3 residents reviewed for ADL's (activities of daily living). (Resident 30 & 60)<br><br>Findings include:<br><br>1. During an observation, on 10/27/2022 at 9:57 A.M., Resident 30 had long, jagged and dirty fingernails.<br><br>A clinical record review was completed on, 10/31/2022 at 1:56 P.M. Resident 30's diagnoses included, but were not limited to: Alzheimer's disease, dementia, hypertension and arthritis.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, dated 8/30/2022, indicated Resident 30 BIMS (Brief Interview for Mental Status) was unable to be completed, severe cognitive impairment. Required extensive assist of 2 staff for bed mobility, and total assist for toilet use, transfers and bathing.<br><br>A care plan, dated 3/23/2022, indicated the resident required assistance with ADLs including bed mobility, transfers, eating and toileting related to: weakness, history of falls, and impaired cognition. Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Assist with dressing/grooming/hygiene as needed.<br><br>The shower schedule indicated she was to receive showers on Wednesdays and Saturdays on the evening shift.<br><br>Resident 33's shower documentation, dated 9/28/2022 to 10/29/2022, indicated the resident had | F 0677 | It is the practice of this facility to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>Resident 30 and 60 have been provided with a shower and nail care per preference.<br>All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and frequency will be completed on or before 11/28/22.<br>The DNS/designee will ensure Shower schedules are maintained per resident preference. The DNS/Designee will review Shower Sheets with resident preferences daily to ensure showers are provided per resident preference.<br>Furthermore, all staff will be educated on or before 11/28/22 on shower schedule and resident preferences to ensure all residents maintain good grooming and personal hygiene.<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).<br>The DNS/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be | 11/28/2022 |

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| | a shower documented on 9/28/2022; a bed bath on 10/12/2022; shower on 10/21/2022; shower on 10/22/2022; bed bath on 10/29/2022. There was no documentation to show Resident 30 had received any type of bathing on: 10/1, 10/5, 10/8, 10/15, and 10/26/2022.<br><br>During an observation, on 11/1/2022 at 10:07 A.M., Resident 30's nails were observed dirty with a black substance under the nails.<br><br>During an interview, on 11/01/2022 at 2:13 P.M., LPN 5 indicated there should have been more shower sheets to indicate the resident had received showers.<br><br>2. During an observation, on 10/27/2022 at 9:59 A.M., Resident 60's hair was greasy and had dirty fingernails.<br><br>A clinical record review was completed on 10/31/2022 at 2:19 P.M. Resident 60's diagnoses included, but were not limited to: seizure disorder, Alzheimer's disease and dementia.<br><br>An Annual MDS ( Minimum Data Set) Assessment, dated 8/2/2022, indicated the resident required extensive assist of 2 staff for bed mobility, transfers, toilet use, and was totally dependant for bathing.<br><br>A care plan, dated 3/24/2022, indicated the resident required extensive assistance with ADLs (Activities of daily living). Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, and partial bath in between.<br><br>The shower schedule indicated she was to receive showers on Tuesday and Fridays on the evening | | developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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| | shift<br><br>Resident 60's shower documentation, dated 9/28/2022 to 10/29/2022, indicated the resident had a bed bath on 9/13, shower on 9/27, shower on 10/24 and a bed bath on 10/27/2022. There was no documentation to show Resident 30 had received any type of bathing on: 9/30, 10/4, 10/7, 10/14, 10/18, 10/21, 10/25 and 10/28/2022.<br><br>During an observation on, 11/01/2022 at 10:06 A.M., Resident 60 was observed with dirty nails.<br><br>During an interview, on 11/01/2022 at 2:13 P.M., LPN 5 indicated there should have been more shower sheets to indicate the resident had received showers.<br><br>On 11/2/2022 at 3:40 P.M., the Director of Nursing provided the policy titled," Resident Rights - Know Your Rights under Federal Nursing Home Regulations", dated March 15, 2017, and indicated the policy was the one currently used by the facility. The policy indicated..." You have the right to be informed, and participate in, your treatment. This includes the right to: Received services and/or items included in the plan of care...."<br><br>3.1-38(a)(3) | | | |
| F 0758<br>SS=D<br>Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: | | | |

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| | (i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident | | | |

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| | for the appropriateness of that medication.<br>Based on record review and interview, the facility failed to have an appropriate diagnosis for the use an Antipsychotic medication for 2 of 5 residents reviewed for unnecessary medication. (Resident 16 & 21)<br><br>Findings include:<br><br>1. A clinical record review was completed on 11/01/2022 at 1:42 P.M. Resident 16's diagnoses included but were not limited to: Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, altered mental status and anxiety.<br><br>Current physician orders, dated 11/1/2022, indicated Resident 16 had received Seroquel (antipsychotic) 12.5 mg (milligrams) daily for the diagnosis of unspecified dementia with behavioral disturbance since 10/12/2022.<br><br>During an interview, on 11/01/2022 at 2:40 P.M., the Social Service Director indicated the current diagnosis was not appropriate for the use of Seroquel.<br><br>2. A clinical record review was completed on 10/28/2022 at 2:38 P.M. Resident 21's diagnoses included but were not limited to: Unspecified dementia with behavioral disturbance, major depressive disorder, altered mental status and anxiety.<br><br>Current physician orders, dated 11/1/2022, indicated Resident 21 had received Seroquel (antipsychotic) 25 mg daily since 10/12/2022 for the diagnosis of encounter for other specified aftercare. | F 0758 | It is the practice of this facility to provide the resident an environment free of unnecessary psychotropic medication.<br>Residents 16 and 21 had current medication regimen reviewed by psych provider.<br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents receiving psychotropic medications to ensure supportive documentation and diagnosis.<br>The DNS/designee will in-service all staff on unnecessary medications on or before 11/28/22. Social Services and Psych provider to collaborate prior to change in psychotropic medication to ensure compliance.<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).<br>The DNS/designee will be responsible for completing the QAPI Audit tool “Unnecessary Medications” weekly for 4 weeks and monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | 11/28/2022 |

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| | During an interview, on 11/01/2022 at 2:40 P.M., the Social Service Director indicated the current diagnosis was not appropriate for the use of Seroquel.<br><br>On 11/2/2022 at 3:41 P.M., the Director of Nursing provided the policy titled, "Psychotropic Management" undated, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed, and this is documented in the medical record...."<br><br>3.1-48(b)(1) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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 | | | |

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| | 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 keep medication storage carts secured/locked when visually seen in 4 of 4 medications carts observed. ( Halls 400, 500, 600 and the Cottage Unit)<br><br>Findings include:<br><br>1. On 10/28/2022 at 4:40 A.M., the medication carts for the 400 and the 600 halls were observed unlocked with no licensed staff using the medication carts.<br><br>2. During a medication pass observation, on 10/28/2022 at 4:45 A.M., RN 10 retrieved medication for the resident. RN 10 indicated "it might be hard to wake the resident up because she's up all night walking around." RN 10 entered room 510 B and administered the medication to her without any issues. The medication cart was left unlocked when the nurse was in the residents room.<br><br>During an interview, on 10/28/2022 at 4:46 A.M., RN 10 indicated the medication cart should have been locked.<br><br>3. During a random observation, on the Cottage unit on 10/28/2022 at 5:20 P.M., the medication cart was observed unlocked.<br><br>During an interview, on 10/28/2022 at 8:16 A.M., the Administrator indicated the medication carts should have been locked. | F 0761 | It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. 4 of 4 medication carts were found to be unlocked, all medication carts were locked immediately.<br>All residents have the potential to be affected by this finding. The DNS/designee will complete an inspection of all medication rooms, medication room refrigerators, medication carts and treatment carts to ensure that all are locked appropriately when not in the presence of licensed nurse or pharmacy personnel. In addition, the DNS/designee will be responsible for a facility wide weekly medication cart/room inspection. This will ensure that all medication storage areas are locked appropriately per facility policy and procedure.<br>The DNS/designee will in-service nurses on Medication Storage on or before 11/28/22. The in-service will be conducted by the DNS/designee and will review the facility policy related to Storage and Expiration dates of medications and biologicals.<br>Nursing staff will be re-educated | 11/28/2022 |

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| | On 11/2/2022 at 3:40 P.M., the Director of Nursing provided the policy titled,"5.3 Storage and Expiration of Medications, Biological's, Syringes and Needles", dated 12/01/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...3.3 Facility should ensure that all medications and biological's, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors...."<br><br>3.1-25(m) | | regarding proper locking of medication carts, treatment carts, medication rooms and medication refrigerators. In addition, the DNS/designee will be responsible for a facility wide weekly medication cart/room inspection. This will ensure that all medication storage areas are locked appropriately per facility policy and procedure. The DNS/designee will round daily to ensure medication carts are locked timely and appropriately.<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” daily for 4 weeks, weekly for 1 month, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |
| F 0921<br>SS=E<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation, record review and interview, the facility failed to ensure resident rooms and common areas were maintained in a clean and homelike manner on 4 of 4 nursing | F 0921 | It is the practice of the facility to ensure a safe, functional, sanitary, and comfortable environment. Facility repairs have been initiated | 11/28/2022 |

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| | units, and in the main dining room and activity room. This deficient practice potentially affected all 76 residents residing in the facility.<br><br>Findings include:<br><br>During an environmental tour of the facility, conducted on 11/01/2022 between 9:30 A.M. - 10:38 A.M., accompanied by the Administrator and the Maintenance Supervisor the following was noted:<br><br>In Room 407 a chair rail molding had been removed and there were a few finishing nails, which were utilized to secure the plastic wall protective skin on the lower half of the wall, that were sticking out and were rough.<br><br>During an interview with the Maintenance Supervisor, he indicated he had removed the old chair rail and had sanded the repainted the wall in the past week. He indicated he would go back and ensure the nails were smooth. In addition, there was an area on the wall, beside the soap dispenser with drywall mud visible.<br><br>In Room 416 there were visible cobwebs in the corner between the window wall and Resident B's room. In addition, the wall beside and behind Bed B had dried spilled liquid stains. The bathroom door and door frame were also noted to be heavily gouged with missing paint. There was also visible drywall mud noted above the toilet paper holder in the bathroom. In Room 401, the window blind was noted be sagging in the middle with the bottom blind cracked in the middle.  In addition, there were deep gouges in the wall beside Resident B's bed.  There was also a missing chair rail above Resident B's bed. There were multiple holes noted in the drywall above Resident A's bed. In Room | | per plan. Room 407 chair rail was replaced, and nails are smooth, and area by soap dispenser has been painted. Room 416 wall has been cleaned, the bathroom door, door frame and area by paper holder has been painted. Room 401 window blind had been replaced. Wall has been repaired and chair rail has been replaced. Room 409 windowsill has been cleaned and wall has been repaired. Room 508 chair rail has been replaced; wall has been repaired. Room 511 chair rail has been replaced, the air conditioning unit has been cleaned, and floor has been cleaned. Room 514 windowsill has been repaired. Room 602 wall behind toilet and wall in room has been painted. Room 609 wall has been repaired and toilet has been repaired. Main dining room and activity room the corners have been cleaned. Resident 60 wheelchair has been cleaned. Room 110 chair rail has been replaced and paper holder has been repaired.<br>All residents have the potential to be impacted by this deficient practice. A facility audit will be completed by Maintenance Director/designee to ensure all resident rooms and common area rooms are in good repair and are clean, and wheelchairs are clean.\ Maintenance Director/designee will complete a facility wide audit to ensure safe, functional, | |

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| | 409 there were 4 dead flies noted on the windowsill. In addition, there were deep gouges in the wall noted beside Bed B.<br><br>In Room 508 there was a missing chair rail along the wall behind Bed A and B. There were gouges and old adhesive noted where the chair rail was missing. In addition, there were deep gouges noted in the wall beside Bed B. There was also marred paint and missing drywall noted on the corner of the wall beside the bathroom door. In Room 511 the chair rail was missing and there were holes and old adhesive noted where the rail was missing. In addition, the air conditioning and heating unit was noted to have visible dust and debris in the vent. The Maintenance Supervisor removed the plastic covering and dust and debris were noted on the screen. In addition, the floor in the corner by the air-conditioning unit was dirty with multiple cobwebs and debris. In Room 514 the windowsill was cracked from the front to the back and the whole window sill was loose and easily pulled away from the wall when lifted.<br><br>In Room 602, there was a large area of dry wall mud noted behind the toilet and behind Bed B. The chair well had been removed and there was old adhesive and multiple holes noted on the drywall. In addition, the corner of the wall beside the closet was noted to be heavily gouged and was missing paint and wallboard. In Room 609, the corner of the wall beside the bathroom door was heavily gouged and missing drywall. The toilet tank was noted to be leaning against the wall behind it. The maintenance Supervisor indicated he had a special piece of plastic he utilized to secure the toilet tank to the base.<br><br>In the main dining room, there were cobwebs noted in the corner by an exit door into the | | sanitary, and comfortable environment. All staff to be in serviced on completion of Work Orders when repairs needed on or before 11/28/22. ED/Designee will monitor to ensure work orders are completed. ED/Designee will round each day to ensure rooms are clean and in good repair. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Housekeeping (Environmental Cleanliness)” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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| | courtyard area.<br>In the Activity room, there were cobwebs hanging from the corner of the wall beside the television. In addition, Resident 60 was observed seated in her wheelchair in the activity room. Her wheelchair was noted to be heavily soiled with a build up of dried food particles, dried splashed liquids, and grime. The soilage was noted on her wheelchair wheels, metal wheelchair sides, wheelchair brakes and brake hands and pedals. The Administrator noted the condition and indicated it was "horrible."<br><br>In room 110 the chair rail was missing with holes in the wall and in the bathroom by the toilet paper holder.<br><br>During the Environmental tour of the facility, the Administrator disclosed the facility had been without a maintenance supervisor for approximately 6 months. The current Maintenance Supervisor had been hired about 2 months ago. The Administrator indicated the facility was aware of some of the needed repairs, had an action plan and had compiled a "list." She indicated the Maintenance Director had started on the repairs.<br><br>Review of the Action Plan, dated Oct 2022 and provided by the Administrator on 11/01/2022 at 11:42 A.M. indicated the environmental concerns included "patch work, trim and paining on walls, chipped tile/flooring in rooms, broken privacy curtain hooks, broken TP Toilet paper) hooks, light fixtures." There were 52 rooms with rooms with needed repairs and/or painting indicated on the list. The goal on the action plan, after compiling the comprehensive list of repairs, was to have two resident rooms repaired per week.<br><br>The facility policy and procedure, titled "Daily | | | |

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| | Maintenance" included the following: "The listed tasks should be performed on a daily basis ..." The list included air conditioning and heating units, Painted/Stained surfaces, and Wheelchairs.<br><br>On 11/2/2022 at 3:40 P.M., the Director of Nursing provided the policy titled, "Resident Rights", dated March 15, 2017. The policy indicated"... Safe Environment. you have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely..."<br><br>This Federal tag relates to Complaint IN00387842.<br><br>3.1-19(e) | | | |