

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

PRINTED: 05/15/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/22/2024	
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 5600 E 16TH ST INDIANAPOLIS, IN 46218			
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00432069 and IN00431934.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00432753.</p> <p>Complaint IN00432069 - No deficiencies related to the allegations are cited. Complaint IN00431934 - No deficiencies related to the allegations are cited. Complaint IN00432753 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 16, 17, 18, 19, and 22, 2024</p> <p>Facility number: 000012 Provider number: 155029 AIM number: 100274900</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 1 Medicaid: 47 Other: 7 Total: 55</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on April 29, 2024</p>			F 0000	<p>This provider respectfully requests a desk review in lieu of a post survey review on or after May 10th, 2024. Please feel free to contact Paige Metzler, if you need any additional information to support the desk review at 317-406-4368. Thank you for your consideration.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Paige Metzler

Executive Director

05/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 30 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 0677 SS=D Bldg. 00	<p>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;</p> <p>Based on observation, interview, and record review, the facility failed to timely provide assistance with dressing for 1 of 1 resident reviewed for ADL (Acts of Daily Living) care (Resident 6).</p> <p>Findings include:</p> <p>The clinical record for Resident 6 was reviewed on 4/16/24 at 3:21 p.m. The Resident's diagnosis included, but were not limited to, dementia and heart failure.</p> <p>A care plan, initiated 6/16/2020, indicated Resident 6 required assistance with ADL care related to his dementia, heart failure and muscle weakness. The goal was for him to improve current functional status. The interventions included, but were not limited to, assist with toileting and/or incontinent care, start date 6/16/2020, and assist with dressing, grooming, and hygiene as needed. Encourage him to do as much for self as possible, start date 6/16/2020.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, completed 3/4/24, indicated he had moderately impaired cognition and needed cues and supervision with dressing.</p> <p>On 4/16/24 at 3:21 p.m., Resident 6 was observed sitting in his wheelchair in his room. He was wearing a brown t-shirt and purplish sweatpants</p>			F 0677	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 6's clothes were changed and careplan updated to reflect preferences.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Residents were interviewed by care companion/designee to ensure resident clothes are being changed per preference. DNS/designee will conduct an in-service with all nursing staff on ADL best practices by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all nursing staff by 5/10/2024. If a resident's preferences are</p>		05/10/2024

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F 0684 SS=D Bldg. 00	<p>with a binder clip attached to the waist band. The sweatpants were not pulled up to his waist and the back of the waist band was around his thighs. He indicated the sweatpants were too big for him.</p> <p>On 4/17/24 at 9:13 a.m., Resident 6 was observed wearing the same sweatpants and t-shirt.</p> <p>On 4/18/24 at 9:20 a.m., Resident 6 was observed wearing the same purplish pants and brown shirt. A blue sweatshirt and a pair of grey sweatpants were laying on the chair in his room.</p> <p>On 4/19/24 at 9:24 a.m., Resident 6 was observed sitting in his room. He continued to wear the same purplish sweatpants with the waist band at his mid-thigh.</p> <p>During an interview on 4/19/24 at 9:36 a.m., CNA (Certified Nursing Assistant) 2 indicated Resident 6 would change his clothing if approached correctly. He was wearing the same clothing as the day before. She would assist him is changing his clothing.</p> <p>3.1-38(b)(4)</p> <p>483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p>				<p>not in the best practice of ADL care, the interdisciplinary team (IDT) will review and update the careplan.</p> <p>IDT members and nursing staff will monitor residents daily to ensure appropriate ADL care, regarding changing of clothes, is completed per resident plan of care.</p> <p>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?</p> <p>·Accommodation of Needs QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director</p> <p>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>Based on interview and record review, the facility failed to assess a resident's skin condition; timely clarify the dosage and administration time of a resident's antipsychotic medication; administer insulin as ordered; and monitor frequency of bowel movements for a resident with constipation for 1 of 1 resident review for constipation, 1 of 5 residents reviewed for unnecessary medications, and 1 of 1 resident reviewed for skin conditions. (Residents B and 27)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident B was reviewed on 4/17/24 at 9:00 a.m. The diagnoses for Resident B included, but were not limited to, type 2 diabetes mellitus, borderline personality disorder, somatization disorder, post-traumatic stress disorder and bipolar disorder.</p> <p>A care plan dated 4/17/24 indicated "...Resident is at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus...Approach...medications as ordered...Monitor blood sugars as ordered..."</p> <p>A physician order dated 4/1/24 indicated Resident B was to receive 10 units of lispro insulin prior to meals three times a day.</p> <p>The April 2024 Medication Administration Record (MAR) for Resident B indicated the following days and times the lispro insulin was not administered: 4/4/24 at 8:00 a.m., 4/5/24 at 12:00 p.m., and 5:00 p.m., 4/11/24 at 8:00 a.m., 5:00 p.m., and 4/12/24 at 8:00 a.m.,</p>			F 0684	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B's skin condition was assessed, and a treatment order written per the MD. Clarification was received for resident B's medication dosage and administration time with new order written to reflect clarification.</p> <p>Resident 27 was provided an MD order following facility Bowel Management Program.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>All residents were assessed by DNS/designee for skin conditions and appropriate action was taken as needed per MD. All residents receiving antipsychotic medications were reviewed by DNS/designee to ensure MD orders are clear and being followed. All residents on insulin MAR were reviewed to ensure residents who had an order for insulin received the order as prescribed. DNS/designee reviewed documentation of resident bowel movement to ensure no additional interventions were needed.</p>		05/10/2024

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	<p>During an interview with Resident B on 4/17/24 at 9:25 a.m., she indicated she does not receive her insulin as often as she should. There are times she misses dosages and does not receive at all.</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 4/19/24 at 3:34 p.m. She indicated she was unsure why the resident had not received her lispro insulin on 4/4/24, 4/5/24, 4/11/24, and 4/12/24.</p> <p>1b. A physician order dated 3/23/24 indicated Resident B was to receive 400 milligrams of seroquel at bedtime.</p> <p>A physician order dated 4/1/24 indicated Resident B was to receive 50 milligrams of seroquel twice a day.</p> <p>A psych visit note dated 4/3/24 for Resident B indicated "...Staff has reported that she has made multiple false accusations against the facility staff. This clinician discussed her case with collaborating physician, who believes that her behaviors are due to her borderline personality disorder and somatization disorder...Antipsychotic use...Seroquel dosage/route/: 450 mg [milligrams] po [by mouth] qhs [every night] and 50 mg daily.</p> <p>A medical provider visit note dated 4/4/24 indicated Resident B was to receive 400 milligrams of seroquel at night and 50 milligrams of seroquel in the morning and afternoon.</p> <p>The April 2024 Medication Administration Record (MAR) indicated the resident was to receive 50 milligrams of seroquel at 9:00 a.m., and 1:00 p.m. The resident was to receive 400 milligrams of seroquel at bedtime.</p>				<p>DNS/Designee will conduct an in-service with all nursing staff as it relates to skin checks, medication administration, and Bowel Management Program by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>DNS/Designee will conduct an in-service with all nursing staff as it relates to skin checks, medication administration, and Bowel Management Program by 5/10/2024.</p> <p>Skills check off completed for all nursing staff for skin assessments and medication administration.</p> <p>Interdisciplinary team (IDT) will review weekly skin assessments and shower sheets to ensure accuracy. Nursing Managers validate missed administrations for all medications daily – if any medication administrations are missed, MD will be notified per policy. Clinical team to run the Bowel Management report to identify residents who have not had a bowel movement in three days. Residents, if cognitive, are interviewed to determine accuracy of charting then MD is notified for additional treatment per policy.</p> <p>How the corrective action (s) will be monitored to ensure the</p>		

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	<p>An interview was conducted with the DNS on 4/19/23 at 11:46 a.m. She indicated she will contact the pysch provider to clarify the dosage and administration time of Resident B's seroquel medication.</p> <p>1c. An interview was conducted with Resident B on 4/17/24 at 9:25 a.m. She indicated she has an area on her stomach that was opened, and she needs a dressing applied. The staff are not addressing it.</p> <p>A physician order 4/3/24 indicated staff was to "Cleanse area to umbilicus twice a day. Keep area as clean and dry as possible.</p> <p>The April 2024 Treatment Record indicated the staff were cleansing the area twice a day.</p> <p>The resident's clinical record did not include assessments of an area on her umbilicus.</p> <p>The weekly skin assessments dated 4/3/24 and 4/10/24 did not indicate the resident had any skin altercations.</p> <p>A wound management note dated 4/17/24 indicated the resident had an old biopsy site reopen. The location of the skin area was the umbilicus. The measurements 1 centimeter in length and 1 centimeter in width with a depth of 0.5 centimeters. The area had bloody drainage.</p> <p>An interview was conducted with the DNS on 4/19/23 at 11:46 a.m. She indicated she did not know the reason why there was an order placed on 4/3/24, to cleanse Resident B's umbilicus twice a day. She was unable to locate any skin assessments that included the staff assessing the</p>				<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Skin Management Program QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·Medication Administration QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·Bowel Management QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 		

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	<p>area on her umbilicus prior to 4/17/24.</p> <p>A skin management policy was provided by the Infection Preventionist Float on 4/22/24 at 11:47 a.m. It indicated "...Procedure for wound prevention:...6. any skin altercations noted by the direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The license nurse is responsible for assessing all skin altercations by the direct caregivers on the shift reported..."2. The clinical record for Resident 27 was reviewed on 4/16/24 at 2:02 p.m. The Resident's diagnosis included, but were not limited to, constipation, heart failure and chronic kidney disease.</p> <p>A care plan, initiated 12/8/22, indicated Resident 27 was at risk for constipation due to her medications and mobility deficit. The goal was for her to have a soft formed bowel movement at least every 3 days. The approaches included, but were not limited to, notify physician if no bowel movement after 3rd day, initiated 12/8/22, administer medications as ordered, initiated 12/8/22, monitor bowel function, initiated 12/8/22, and abdominal assessment if no BM x 4 days. Document and notify physician of abnormal findings, initiated 12/8/22.</p> <p>A physician's order, dated 3/13/24, indicated she was to receive Dulcolax 5 mg tablet once every 24 hours as needed for constipation.</p> <p>A physician's order, dated 3/14/24, indicated she was to receive Milk of Magnesia suspension 30 milters once a day as needed for constipation.</p> <p>A Significant Change of Status MDS (Minimum</p>						

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	<p>Data Set) Assessment, completed 3/20/24, indicated she was cognitively intact and was dependent on staff for toileting.</p> <p>During an interview on 4/16/24 at 2:02 p.m., Resident 27 indicated she did not feel well. She was constipated and it had been at least 3 days since she had a bowel movement. She did not feel like eating.</p> <p>The April 2024 bowel record for Resident 27 was as follows: 4/1/24 at 1:55 a.m.- no bm (bowel movement), 4/1/24 at 6:43 a.m.- small bm, 4/1/24 at 7:58 p.m.- large bm, 4/2/24 at 9:03 p.m.- no bm, 4/3/24 at 9:09 p.m.- no bm, 4/4/24 at 9:37 p.m.- no bm, 4/5/24 at 10:12 p.m.- no bm, 4/8/24 at 6:17 a.m.- no bm, 4/8/24 at 9:24 p.m.- no bm, 4/9/24 at 8:10 p.m.- no bm, 4/10/24 at 7:43 p.m.- no bm, 4/11/24 at 9:04 p.m.- no bm, 4/13/24 at 6:28 a.m.- no bm, 4/14/24 at 10:21 p.m.- small bm, 4/15/24 at 1:52 a.m.- no bm, 4/15/24 at 6:17 a.m.- no bm, 4/16/24 at 4:45 p.m.- large bm, 4/18/24 at 7:33 p.m.- no bm, 4/19/24 at 8:24 p.m.- no bm, 4/20/24 at 6:18 a.m.- no bm, and 4/20/24 at 10:27 p.m.- no bm.</p> <p>The April 2024 MAR (Medication Administration Record) did not indicate that Resident 27 had received any doses of her as needed Dulcolax or Milk of Magnesia during April.</p> <p>During an interview on 4/22/24 at 11:36 a.m., the</p>						

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F 0693 SS=D Bldg. 00	<p>IPF (Infection Preventionist Float) indicated that normally bowel movement status should be documented each shift.</p> <p>On 4/22/24 at 11:36 a.m., the IPF provided the Bowel Elimination policy, dated 1/2015, which read "...It is the policy of ... to ensure that each resident maintains a safe and healthy bowel elimination pattern...4. Bowel movements will be recorded on the facility EMR [Electronic Medical Record] and/or record daily by the direct care staff. 5. A resident bowel report will be completed by the assigned charge nurse of resident [s] who have not had a bowel movement for 3 consecutive days. 6. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day...8. If by the 4th afternoon, the resident [s] has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order..."</p> <p>3.1-37(a)</p> <p>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-</p> <p>§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</p>						

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	<p>consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral 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.</p> <p>Based on observation, interview, and record review, the facility failed to provide oral care, as ordered by the physician, and to timely obtain a physician's order to provide gastrostomy tube site care for 1 of 1 resident reviewed for tube feeding (Resident 23).</p> <p>Findings include:</p> <p>The clinical record for Resident 23 was reviewed on 4/16/24 at 2:40 p.m. The Resident's diagnosis included, but were not limited to, dysphagia (inability to swallow), aphasia (inability to speak), and gastrostomy (g-tube).</p> <p>A care plan, initiated 11/8/2018, indicated Resident 23 was at risk for complications related to enteral feedings. The goal was for him to be free from complications related to enteral feeding. The approaches included, but were not limited to, cleanse around site as ordered, initiated 11/8/2018, and elevate head of bed, initiated 11/08/2018.</p> <p>A physician's order, dated 1/28/2021, indicated to provide oral care every shift.</p> <p>A Quarterly MDS (Minimum Data Set) Assessment, completed 3/28/24, indicated his long- and short-term memory was intact. He was</p>			F 0693	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 23 was provided oral care and a physician's order was obtained to provide gastrostomy tube site care.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>No other residents have a G-tube in the facility.</p> <p>DNS/Designee will conduct an in-service with all staff on oral care and qualified nursing staff providing/performing treatments with tube feeding by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>DNS/Designee will conduct an in-service with all staff on oral care and qualified nursing staff providing/performing treatments</p>		05/10/2024

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	<p>independent with decision making and was dependent on staff for oral hygiene.</p> <p>On 4/16/24 at 2:40 p.m., Resident 23 was observed laying in his bed with his g-tube visible. There was dried brown drainage present on the base of his g-tube. His mouth had a white film present on his teeth and lips.</p> <p>On 4/18/24 at 12:04 p.m., Resident 23's g-tube site was observed with LPN (Licensed Practical Nurse) 3. LPN 3 removed an undated drainage sponge from Resident 23's g-tube site. LPN 3 indicated the g-tube site was care for on the night shift daily. The ostomy site had a brown dried crust at the base of the tube. Resident 23 indicated he had drainage at his g-tube site often by shaking his head yes and putting his thumb up. He indicated that his g-tube site was not cleansed each night by shaking his head no. Resident 23's mouth had a white film present on his teeth and lips.</p> <p>On 4/18/24 at 2:02 p.m., Resident 23 was observed with LPN 3. LPN 3 indicated that oral care was provided each shift by either the nurse or the certified nursing assistants. The bedside table drawers were observed to have an unopened toothbrush in a plastic wrapper. There were no oral swabs present in the bedside table. LPN 3 indicated that Resident 23 was in need of oral care. Resident 23 indicated that mouth care was not provided each shift by shaking his head no and indicated that he would like to have oral care done each shift by putting his thumb up and shaking his head yes.</p> <p>During an interview on 4/18/24 at 2:17 p.m., the DNS (Director of Nursing Services) indicated that Resident 23's medical record did not contain an order for g-tube site care and that oral care should</p>				<p>with tube feeding by 5/10/2024.</p> <p>Skills check off was completed by all nursing staff on oral care and enteral tube procedure.</p> <p>Interdisciplinary staff will ensure oral care is provided to residents by doing walking rounds daily and interviewing residents monthly with a set of quality assurance questions. Nursing managers will ensure that site care is provided per MD order by reviewing medication administration record and doing spot checks per audit tool.</p> <p>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?</p> <ul style="list-style-type: none"> ·G-tube/Oral Care QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 		

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F 0740 SS=D Bldg. 00	<p>be done as ordered by the physician.</p> <p>On 4/18/24 at 2:19 p.m., the DNS provided the Enteral Tube Skills Competency, last reviewed 9/2019, which read "...enteral Tube- Dressing Change and Site Care... Dressing or site care of enteral tube site should be done at least daily.</p> <p>3.1-44(a)(2)</p> <p>483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to adequately monitor and document behaviors for 1 of 1 resident reviewed for mood and behaviors and 2 of 5 residents reviewed for unnecessary medications. (Residents 38 and 45)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 45 was reviewed on 4/17/24 at 1:43 p.m. His diagnoses included, but were not limited to: schizoaffective disorder, bipolar disorder, insomnia, neurocognitive disorder, encephalopathy, and extrapyramidal and movement disorder. He was admitted to the facility on 1/5/24 from another skilled nursing facility.</p>			F 0740	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medication was discontinued for resident 38 on 4/17/2024. IDT collaborated with Speech in conjunction with psych services to assess resident 45 cognition – plan of care has been updated to reflect current status. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>		05/10/2024

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	<p>The 1/14/24 New/Worsening Behavior Communication Event indicated Resident 45 grabbed a female staff's "breast/buttocks" inappropriately. The intervention attempted in response to the behavior was to explain that it was inappropriate and encouraged not to do it again. The effectiveness of the interventions were "somewhat effective," but Resident 45 did it again after the first action. The interventions put into place to prevent another behavior was to redirect as needed.</p> <p>The 1/23/24 behavioral symptoms care plan indicated the goal was for him to be free of incidents of inappropriate behavior in touching female staff. An approach, starting 1/23/24, was to redirect him as needed and remind him when a behavior was inappropriate. The care plan did not reference or address the potential for him to have an inappropriate sexual behavior towards another resident.</p> <p>The 2/24/24 New/Worsening Behavior Communication Event indicated after dinner in the hallway, Resident 45 was "allegedly touching females breast." The interventions attempted in response to the behavior was a chair placed in the hallway by nurses station; redirection; and encourage resident to stay separate during meals and activities. The effectiveness of the interventions was indicated as helpful. Another resident was affected by this behavior and Resident 45 was removed from the other residents environment.</p> <p>On 4/22/24 at 9:30 a.m., the ED (Executive Director) provided the investigative file into the above 2/24/24 behavior event.</p>				<p>corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>All residents receiving psychotropic medications were reviewed to determine appropriateness of the medication and to ensure MD notified of any changes in behavior. All residents with new or worsening behaviors within the last 30 days were reviewed to ensure behaviors were addressed and care plan updated per policy.</p> <p>ED/Designee will conduct an in-service with all staff to review facility's Behavior Management Policy and the process for communicating behaviors.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>ED/Designee will conduct an in-service with all staff to review facility's Behavior Management Policy and the process for communicating behaviors.</p> <p>Interdisciplinary team (IDT) will review orders in daily clinical meeting to ensure new orders have appropriate documentation with corresponding careplan.</p> <p>IDT will review all behavior communications as well as new and worsening behavior events with corresponding event reviews and updating careplans with</p>		

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	<p>The file included the 2/28/24 follow-up incident report. The report indicated on 2/24/24, Resident B alleged that Resident 45 made contact with her chest during conversation. The residents were immediately separated. The ED, DNS (Director of Nursing Services,) and physician were notified and an investigation was initiated. The 2/28/24 follow up section of the report indicated Resident B went about her daily routine with no signs or symptoms of psychosocial distress. The root cause of Resident 45's behavioral expression was age and cognition.</p> <p>The file included a documented interview with Resident B conducted on 2/28/24 by the SSD (Social Services Director.) The interview indicated Resident B informed the SSD that Resident 45 tended to come into her room and watch television without asking. When Resident B redirected Resident 45 and asked him to leave, he would leave without incident. One day last week, Resident 45 was walking closely behind Resident B and she was talking with other residents. Resident 45 walked up closely to Resident B and said hello, that she was pretty, and grazed her breast with his open hand. Resident B stated that she screamed and told him to stop and informed nursing staff, who redirected Resident 45 and informed him that was not appropriate to touch peers in that manner.</p> <p>The file included an undated documented interview with RN (Registered Nurse) 6 conducted by the ED. It read, "Staff member reported to ED that [name of Resident B] was alleging inappropriate contact by [name of Resident 45.] When asked if she had witnessed this contact, [name of RN 6] stated no."</p> <p>The file included a documented interview with</p>				<p>communication to floor staff regarding interventions to prevent behavior.</p> <p>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?</p> <ul style="list-style-type: none"> ·Behavior Management QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·Psychotropic Management QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 		

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	<p>Resident 44 conducted on 2/28/24 by the ED. The interview indicated another resident was sitting in between him and Resident B. He saw Resident 45 approach Resident B and grab her breast. Resident B told Resident 45 he couldn't touch her. Resident 44 just stood there, looking at them.</p> <p>The 4/4/24 Quarterly MDS (Minimum Data Set) assessment indicated Resident 44 had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. He did not have any care plans referencing a history of making false allegations.</p> <p>An interview was conducted with Resident 44 on 4/22/24 at 11:25 a.m. He indicated RN 6 was doing paperwork in the conference room with the door open. He, another resident, and Resident B were in the hallway just outside of the conference room. Resident 45 was walking down the hallway towards them, and once he reached Resident B, he grabbed her breast. Resident 44 saw Resident 45 let go of his walker, stop, and grab Resident B's breast. Resident B "jumped back" when it happened. Then she went into the conference room and talked to RN 6 about it. Resident 44 saw Resident 45 touch a female staff member inappropriately once too.</p> <p>An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She indicated Resident 44, who witnessed Resident 45 grab Resident B's breast in the hallway, had no history of false allegations of which she was aware. If he said something, she was likely to believe him. "He's not one to make up a story."</p> <p>The 2/24/24, 4:15 p.m. progress note, recorded as a late entry by the SSD on 2/26/24 at 8:53 a.m., read, "This writer spoke with resident to see if she was</p>						

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	<p>displaying any s/s [signs/symptoms] of psycho-social distress due to inappropriate interaction with peer. This writer listened to resident's thoughts and feelings on situation and validated her perception of what transpired. Resident was calm stated see [sic] felt that she will just [sic] in her room and eat her meals for a couple of days. This writer encouraged her not to self-isolate and that this is her home and she is free to move about. Staff can address any issues or situations that arise."</p> <p>The 2/23/24 Quarterly MDS assessment for Resident 42 indicated she had a BIMS score of 15, indicating she was cognitively intact. She did not have any care plans referencing a history of making false allegations.</p> <p>An interview was conducted with Resident 42 on 4/17/24 at 11:07 a.m. She indicated Resident 45 would just walk into other residents' rooms uninvited. Her roommate, Resident 39, woke up one morning and he was standing at the foot of her bed claiming she was in his bed. Resident 45 was "fixated" on Resident 39. Earlier in the week, Resident 45 put his wheel chair in their doorway and wouldn't leave. She stated, "He doesn't know what he's doing." She'd never seen Resident 45 touch anyone, but he would follow Resident 39 around and ask if he could live with her. She stated, "Staff cant watch him 24 hours a day....We all have to watch him....It's not up to us to have to monitor him."</p> <p>The 2/24/24 Quarterly MDS assessment for Resident 39 indicated she had a BIMS score of 15, indicating she was cognitively intact. She did not have any care plans referencing a history of making false allegations.</p>						

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	<p>An interview was conducted with Resident 39 on 4/17/24 at 1:51 p.m. She indicated she woke up one night about a month ago at 3:00 a.m. to Resident 45 at the foot of her bed, telling her she was in his bed. She told the SSD about it, who informed her she was working with him on it. Another time, he was at her door and asked if he could live with her. The same day, he followed her down the hallway telling her he loved her. One day, he stood at the door and wouldn't leave.</p> <p>An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She reviewed Resident 39's and Resident 42's care plans and indicated she knew Resident 39 and Resident 42 had a history of "backing each other up, kind of move as one," but to her knowledge, neither Resident 39 nor Resident 42 had a history of making false allegations, and neither had a care plan referencing such.</p> <p>The 2/25/24 New/Worsening Behavior Communication Event indicated on 2/24/24 at 10:30 p.m., Resident 45 asked a female staff member to help him fix his television, and as she reached up to do so. Resident 45 tried to pull down her pants. The physician suggested a neuro-psyche stay.</p> <p>The 2/25/24 Physician Communication Tool Event indicated Resident 45 was transferred to a neuropsychiatric hospital for a psychiatric evaluation.</p> <p>The 2/25/24 psychiatric evaluation from the neuropsychiatric hospital read, "This provider reviewed clinical documentation provided by the skilled nursing facility and there is very minimal detail regarding his mood or sexual behaviors....There is no documentation that this</p>						

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	<p>patient has hit or harmed anyone nor harmed himself. The most documented behavior is the patient is noncompliant with use of his walker.</p> <p>An interview was conducted with the SSD on 4/22/24 at 11:38 a.m. She indicated in January, 2024 it was relayed to her that Resident 45 touched a female staff member's breast and buttocks over the weekend. As far as interventions put in place afterwards to address his sexually inappropriate behavior, there was a care plan approach to remind him the behaviors were inappropriate and to redirect him. No other interventions were put in place at that time, and there were no interventions to address a potential for him to be sexually inappropriate with residents too. After the 2/24/24 sexually inappropriate behavior towards staff, they added the intervention of care in pairs, effective 2/26/24. The care in pairs should have gone into place after the 1/14/24 event. Resident 45 was fairly new to the facility when the first incident happened with staff on 1/14/24, and they were still learning his behaviors at that time. Resident 45 wore a wanderguard, because when he first came to the facility, he was going up to doors, trying to get out. He'd gone into "quite a few" other residents rooms and started watching television, such as Resident 19, Resident 7, and Resident 28. The other residents would tell him to leave and he would just get up and walk out. The SSD had never seen him go in or come out of anyone's room. She knew Resident 45 was a concern for some of the other residents because he was younger.</p> <p>There were no progress notes or events in the electronic health record that referenced the frequent occurrences of Resident 45 going into other residents' rooms uninvited. Resident 45 had a care plan to address his potential for elopement,</p>						

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	<p>but none to address his wandering into other residents rooms uninvited.</p> <p>An interview was conducted with the SSD on 4/22/24 at 12:45 p.m. She indicated there was no care plan to address him going into other residents rooms uninvited. 2. The clinical record for Resident 38 was reviewed on 4/17/24 at 10:00 a.m. The diagnosis for Resident 38 included, but was not limited to, schizophrenia.</p> <p>A care plan dated 9/7/23 indicated "Resident gets agitated and will yell and cuss...Approach..Encourage resident to do an activity such as bingo...Encourage resident to communicate frustration in a positive way..Redirect resident to a calmer and quieter space..."</p> <p>A physician order dated 2/8/24 indicated resident was to receive 100 milligrams of zoloft daily. The medication was discontinued on 4/17/24.</p> <p>A physician order dated 3/8/24 indicated resident was to receive 50 milligrams of zoloft totaling 150 milligrams daily. The medication was discontinued on 4/17/24.</p> <p>A social services note for Resident 38 dated 3/12/24 indicated resident had became anger when the Executive Director checked for a missing item in his room per his family request. The resident was upset and cussing.</p> <p>The resident's clinical record did not include any other documented behaviors the resident had in March.</p> <p>A behavior progress note for Resident 38 dated 4/11/24 indicated "Date and Time of behavioral</p>						

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	<p>expression: 4/11/24 2:40 p.m. Location of expression: hallway, Describe the specific behavioral expression: cursing and using foul language towards staff, Interventions attempted: attempt to determine root cause, Effectiveness of Interventions: not effective, Suggestions/Other information: bx [behavior monitoring]..."</p> <p>The resident's clinical record did not include any other documented behaviors the resident had in April.</p> <p>During a resident council meeting on 4/16/24 at 2:00 p.m., Resident 38 was observed upset and left the meeting angry and cussing loudly down the hallway.</p> <p>The resident's clinical record did not include documentation of the incident on 4/16/24.</p> <p>A psych follow up visit note for Resident 38 dated 4/17/24 indicated "...He denies difficulty sleeping or changes in appetite. Per staff reports, resident does have episodes of verbal aggression, irritability, and outbursts due to anger...Plan...increase sertraline [Zoloft] to 200 mg [milligrams] daily due to reports of verbal aggression and irritability..."</p> <p>A physician order dated 4/17/24 indicated resident was to receive 200 milligrams of zoloft daily.</p> <p>An interview was conducted with Social Services Director on 4/22/24 at 2:39 p.m. She indicated when direct care staff observe residents having behaviors they need to report the behavior to a nurse. The behavior should be documented in the progress notes. If the behavior was new or worsening the staff would open an event in the resident's record.</p>						

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	<p>An interview was conducted with Executive Director (ED) on 4/22/24 at 2:27 p.m. She indicated there are occasions Resident 38 exhibits aggression and irritability. There should be documentation in the progress notes if staff observe the resident's behaviors. The staff are not following the facility's behavior management policy.</p> <p>A behavior management policy was provided by the Infection Preventionist Float on 4/22/24 at 2:36 p.m. It indicated "...Policy: It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions...Procedure:...3. When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix. 4. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or Worsening Behaviors include: a. Behaviors that are new for the resident, b. Behaviors that are directed at another resident (Note: follow abuse reporting and prohibition protocols), c. Behaviors that are increasing in either frequency or severity, d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care. The IDT [Interdisciplinary] team is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentations of new interventions if applicable and an assessment of</p>						

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F 0759 SS=D Bldg. 00	<p>any underlying causes of the behavior (ie pain,, environmental stressor, medical illnesses, etc.) The root cause and preventative interventions will be included in the resident's care plan. 5. If the behavior expression is not new, worsening or high risk; the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT Behavior Review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective interventions..."</p> <p>3.1-43(a)(1)</p> <p>483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent for 1 of 5 residents observed during medication pass. There were 34 opportunities with 2 errors resulting in a 5.88% medications error rate. The errors involved 1 resident (Resident 43) in the sample of 5.</p> <p>Findings include:</p> <p>The clinical record for Resident 43 was reviewed on 4/17/24 at 1:00 p.m. The diagnosis for Resident 43 included, but was not limited to, type 2 diabetes mellitus.</p>			F 0759	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 43 was monitored with no side effects related to insulin administration. MD notified with no additional orders added.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>		05/10/2024

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	<p>A care plan dated 2/27/24 indicated staff was to obtain blood sugars as ordered.</p> <p>The Annual MDS (Minimum Data Set) Assessment dated 2/9/24 indicated Resident 43 was cognitively intact.</p> <p>A physician order dated 1/9/24 indicated the staff was to obtain blood sugars four times a day. The scheduled times were 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.</p> <p>A physician order dated 4/16/24 indicated the resident was to receive 22 units of lantus insulin.</p> <p>A physician order dated 4/17/24 indicated the resident was to receive 12 units of lispro insulin three times a day.</p> <p>An observation was made of breakfast room trays delivered to residents' rooms on 4/18/24 at 9:06 a.m.</p> <p>During medication administrations, an observation was made of Resident 43's blood sugar obtained by License Practical Nurse (LPN) 3 on 4/18/24 at 9:37 a.m. LPN 3 was observed removing a glucometer from the medication cart, and then entered Resident 43's room. At that time, the resident was at the bedside eating her breakfast tray. The resident had consumed half of the meal that was on the tray. LPN 3 obtained Resident 43's blood sugar, and then left the room. After, LPN 3 returned back to the medication cart. LPN 3 was observed pulling Resident 43's lantus flex pen from the medication cart and dialing up 22 units. There was no observation of priming the lantus flex pen at that time. After collecting the lispro from the medication supply room, LPN 3</p>				<p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Other residents receiving insulin were reviewed by DNS/designee to ensure residents blood sugars are checked per MD order. MD was notified with any concerns identified.</p> <p>DNS/Designee will conduct an in-service with all qualified nursing staff on Medication Administration by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>DNS/Designee will conduct an in-service with all qualified nursing staff related to Medication Administration times and proper administration of insulin by 5/10/2024.</p> <p>Check off for insulin flex pen and blood glucose procedure was completed with all qualified nursing staff by 5/10/2024.</p> <p>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?</p> <p>·Insulin Pen Administration QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance</p>		

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F 0804 SS=E Bldg. 00	<p>then was observed administering the 22 units of lantus and 12 units of lispro to Resident 43 in her right arm.</p> <p>An interview was conducted with LPN 3 on 4/18/24 at 9:45 a.m. She indicated she still needed to obtained Resident 3 and Resident 18's blood sugars that morning.</p> <p>An interview was conducted with the Director Nursing Services (DNS) on 4/19/24 at 11:46 a.m. She indicated LPN 3 should obtain blood sugars prior to the reidents eating their meals, and the insulin flex pens should be primed prior to dialing up the insulin dosage.</p> <p>An interview was conducted with Resident 43 on 4/22/24 at 3:23 p.m. She indicated the staff frequently check her blood sugar after she eats her meals.</p> <p>"How to use your Lantus SoloStar pen" manufacture instructions at website www.lantus.com dated 8/2022, was retrieved on 4/22/24. It indicated "...Step 3. Perform A Safety Test. Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test...Always perform the safety test before each injection..."</p> <p>3.1-48(c)(1)</p> <p>483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp</p>				<p>Improvement Committee overseen by the Executive Director</p> <p>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, the facility failed to serve breakfast at safe and palatable temperatures with the potential to affect 54 of 55 residents residing at the facility.</p> <p>Findings include:</p> <p>During a Resident Council meeting on 4/16/24 at 3:00 p.m., 8 of 10 residents who attended indicated that breakfast was often served cold.</p> <p>During an interview on 4/17/24 at 11:06 a.m., Resident 43 indicated that breakfast was served cold most days.</p> <p>A grievance form, dated 4/10/24, indicated that Resident B had a concern that the food was sometimes cold.</p> <p>On 4/18/24 at 8:25 a.m., breakfast service was observed in the facility kitchen. Three plates of fried eggs and 1 plate of scrambled eggs were observed sitting on the counter in back of the steam table. Seven plates of fried eggs were observed sitting on the shelf above the stove. FC (Facility Cook) 5 was observed taking a plate of fried eggs from the counter behind the steam table and placing them on a tray to be served. The tray</p>			F 0804	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Eggs were remade and sausage was reheated prior to serving.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Culinary staff to be in-serviced, topics will include steps to assure all equipment is used and operating properly to maintain acceptable food temperatures throughout meal service, Food temp policy including guidelines for checking and recording food temperatures by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to</p>		05/10/2024

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F 0921 SS=E Bldg. 00	<p>was taken from the serving area and served to a resident. At 8:35 a.m., the DM (Dietary Manager) obtained the temperature of the scrambled eggs sitting on the counter behind the steam table at 100 degrees Fahrenheit. The temperature of one plate of fried eggs from the shelf above the stove was obtained at 86 degrees Fahrenheit. The temperature of the sausage patties on the steam table was 109 degrees Fahrenheit. FC 5 indicated that the fried eggs had been cooked about 5 to 7 minutes before serving had started. The DM indicated that the fried eggs should be microwaved prior to being served and the sausage would be reheated prior to serving any more of them.</p> <p>At 9:35 a.m., the IPF (Infection Preventionist Float) provided a breakfast tray containing scrambled eggs, sausage patties, oatmeal, and toast from the hallway food cart. The temperature of the food upon delivery were obtained. The sausage patty was 129.3 degrees Fahrenheit, and the oatmeal was 130.5 degrees Fahrenheit.</p> <p>On 4/18/24 at 2:03 p.m., the Executive Director provided the Food Temperatures Policy, last revised 6/23, which read "... The facility will maintain proper food temperature control to prevent food borne illness... Hot foods that are potentially hazardous will be held for service at or above 135 degrees Fahrenheit... All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food...."</p> <p>3.1-21(a)(2)</p> <p>483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions</p>				<p>ensure that the deficient practice does not recur?</p> <p>Culinary staff to be in-serviced, topics will include steps to assure all equipment is used and operating properly to maintain acceptable food temperatures throughout meal service, Food temp policy including guidelines for checking and recording food temperatures by 5/10/2024.</p> <p>Food temperatures checked each meal by CM/designee.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</p> <p>Culinary Manager / designee will complete the Food and Nutrition Test Tray QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED.</p> <p>If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain the first-floor shower room in good condition and to timely repair a leaking pipe for the pot filler in the kitchen with the potential to affect 55 of 55 residents residing at the facility.</p> <p>Findings include:</p> <p>1. On 4/16/24 at 12:00 p.m., the facility kitchen was observed with the RD (Registered Dietician) and the (DM) Dietary Manager. A pipe located to the side of the stove was observed to have a clear pasty substance present at the joints and rusted joint clamps. The copper pipe had a heavy patinated appearance. There was a puddle of water present under the pipe. The DM indicated the water on the floor was because the pipe of the pot filler was leaking and believed a work order had been done. The RD indicated that due to the appearance of the pipe and the rust present on the pipe clamps, the pipe had been leaking for "a while".</p> <p>On 4/18/24 at 2:03 p.m., the Executive Director provided a service request, dated 4/16/24, requesting service to the water leak in the kitchen.</p> <p>2. During an interview on 4/17/24 at 11:04 a.m., Resident 42 indicated that the shower room on the first floor was often dirty and smelled of urine.</p> <p>On 4/22/24 at 1:35 p.m., the first-floor shower room was observed. The tile floor in the shower room appeared dingy and appeared that it had dirt on the floor. There were 2 bags of soiled linen sitting</p>			F 0921	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>First-floor shower room was scrubbed with the floor scrubber. Pipe work order was entered and pipe was repaired on 5.8.2024.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>ED/designee to inservice all staff on shower room cleanliness expectations and how to input work orders by 5/10/2024.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>ED/designee to inservice all staff on shower room cleanliness expectations and how to input work orders by 5/10/2024.</p> <p>Maintenance will check in with all departments daily to ensure no work orders are needed. Paper work orders are available at the nurse station for those staff members that do not have TELS access.</p>		05/10/2024

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	<p>on the floor.</p> <p>On 4/22/24 at 3:11 p.m., the first-floor shower room was observed with the ED (Executive Director) and MS (Maintenance Supervisor). The shower room tile was dry but appeared stained and dirty. There were dried dark brown tracts present on the floor from the wheels of the shower chair. There were stained tiles that appeared dirty around the shower drain and a dark brown stain against the wall of the shower by the floor. The ED indicated that the shower room floor looked stained.</p> <p>3.1-19(f)(5)</p>				<p>Maintenance/designee will scrub shower room floor with floor scrubber weekly to ensure clean, sanitary environment.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</p> <p>Maintenance will complete the Quality Control Environmental Checklist QAPI (QA) tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED.</p> <p>If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		