STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE	809 W FREEMAN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 29, 30, 31 and September 1, 2023. Facility number: 000192 Provider number: 155295 AIM number: 100291120 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 2 Medicaid: 63 Other: 12 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 12, 2023.	F 0000	9-24-2023 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 CCN/Provider Number 155295 AIM Number 100291120 Facility ID 000192 Event TZH211 Re: Recertification and State Licensure Annual Survey Clinton House Rehabilitation and Healthcare Center 809 West Freeman St Frankfort, IN 46041-2994 Dear Ms. Buroker: On September 1, 2023, a Recertification and State Licensure Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracey Wells		09/22/2023

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

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			of Correction of September 24, 2023 Please feel free to call me with any further questions at 765-654-8783. Respectfully submitted, Tracey Wells Executive Director	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or			

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	her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and interview, the facility failed to ensure a resident was dressed in her own clothing, a resident's bed was not in the lowest position and sitting on the floor and a resident was assisted to eat with the staff sitting next to her for 3 of 3 residents reviewed for dignity. (Resident 14, 52 and 40) Finding includes: 1. During an observation, on 8/27/23 at 3:18 p.m., Resident 14 was lying in bed with her eyes closed and the bed was so low to the floor it was almost touching the floor with only about one inch between the floor and bed. The bed appeared like it was floor level and the resident appeared to be lying on the floor. The record for Resident 14 was reviewed on 8/3/23 at 11:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, major depressive disorder, and a mood disorder. A care plan, dated 7/11/23, indicated the resident was at a risk for impaired safety and injury related to a fall risk. The interventions included, but were	F 0550	F 550 D Resident Right/Exercise Rights The facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • No adverse reactions were identified to residents #14, #52, and #40. Residents were assessed, and care plans updated for accuracy. 2)How the facility identified other	09/24/2023

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	not limited to, keep the bed in the lowest position. During an interview, on 9/1/23 at 10:09 a.m., LPN 14 indicated the bed position when a care plan indicated for the bed to be in the lowest position would depend on the resident. The beds placed in the lowest position which was almost touching the floor would prevent a resident from falling out of the bed. Other beds were placed in a low position although not close to touching the floor. 2. During an observation, on 8/27/23 at 3:45 p.m., Resident 52 was lying in bed and was wearing a hospital gown. During an observation, on 8/28/23 at 12:29 p.m., the resident was lying in bed in her room and was wearing a hospital gown. During an observation, on 8/29/23 at 11:28 a.m., the resident was lying in bed in her room, her eyes were closed, and she was wearing a hospital gown. During an observation, on 9/1/23 at 10:10 a.m., Resident 52 was lying in bed. The bed was so low it appeared as though the resident was sleeping on the floor. The record for Resident 52 was reviewed on 8/30/23 at 2:29 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with agitation, chronic kidney disease and depression. A care plan, dated 6/13/23, indicated the resident had an activities of daily living (ADL) self-care deficit and was at a risk for functional declines related to depression, impaired mobility, and dementia. The interventions included, but were not limited to, encourage participation in daily		residents: • An audit was conducted to determine if any resident utilized a low bed; and wore hospital gowns. Any resident identified was reassessed for preferences, and care plan updated. Staff were educated not to stand while assisting a resident with feeding. No resident was identified to have had a negative effect. 3)Measures put into place/ System changes: • DON/Social Services/Designee will observe through rounding 3 times weekly (to include all shifts) to ensure resident dignity is maintained, residents are dressed appropriately, bed height appropriate, and staff sit beside resident when feeding • Any identified issues will be immediately corrected. • Nursing staff educated on resident rights/dignity. 4)How the corrective actions will be monitored: • The responsible party for this plan of correction is Social Services with Administrative oversight. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make	

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	care and provide positive reinforcement for activities attempted and/or partially achieved. The care plan did not include the resident would wear a hospital gown. A care plan, dated 6/13/23, indicated the resident was at a risk for impaired safety/injury related to being a fall risk. The interventions included, but were not limited to, keep the bed in the lowest position. The care plan did not indicate if the lowest position was at the floor level or in the regular lower bed position (not elevated position for when staff provided care). An Activity Preferences form, dated 7/30/23, indicated it was somewhat important for the resident to be choose her clothes. During an interview, on 8/29/23 at 12:26 p.m., RN 12 indicated the resident always wore a hospital gown. There were a few times the resident would wear regular clothes. During an interview, on 8/30/23 at 3:39 p.m., the Clinical Support Nurse indicated she was not able to locate documentation in the electronic health record (EHR) for the reason the resident always wore a hospital gown. The preferences were not marked for wearing a hospital gown and the care plan did not include wearing a hospital gown. During an interview, on 8/31/23 at 10:39 a.m., the Social Services Designee (SSD) indicated the resident was combative with care at times and she assumed the resident would not let staff change her clothes. The resident did have her own clothing.		recommendations to revise the plan of correction as indicated. 5) Date of compliance: 9-24-2023	

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	During an interview, on 8/31/23 at 4;15 p.m., the Executive Director (ED) indicated she was not aware the residents' beds were in such a low position at the floor level. The beds were not in the lowest position to keep the resident's from getting up and were not supposed to be on the floor.3. During an observation, on 8/27/23 at 12:33 p.m., QMA 7 was standing next to Resident 40 feeding her. CNA 8 took over feeding the resident and she remained standing until the resident finished. During an observation, on 8/29/23 at 12:33 p.m., the Activity Director was assisting the resident to eat while she was standing next to her. She kneeled on the floor beside the resident at 12:36 p.m., then stood back up to assist her to eat. The record for Resident 40 was reviewed on 8/27/23 at 1:00 p.m. Diagnoses included, but were not limited to, dysphagia and Alzheimer's disease. A care plan, dated 8/15/23, indicated eating may fluctuate throughout the day, but usual performance was supervision or touching assistance. During an interview, on 8/30/23 at 3:30 p.m., the Activity Director, who was also a CNA, gave a copy of the items reviewed in the state approved curriculum for dining assistants (used to train feeding assistants to assist residents to eat). She indicated the staff were taught to sit next to the resident and not across from them. She was not sure why this was not listed on the state approved curriculum for dining assistants. During an interview, on 8/31/23 at 2:47 p.m., CNA 10 indicated when she fed a resident, she would			

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	sit on the affected side at eye level with the resident. She was taught to sit next to the resident when feeding them during the CNA training. A current policy, titled "Castle Healthcare Fall Prevention Program," reviewed on 6/9/21 and received from the ED on 9/1/23 at 4:30 p.m., indicated "...It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible...Standard Fall/Safety Precautions For All Residents...The bed will be maintained in a position appropriate for resident transfers...." A current policy, titled "Resident Rights," revised on 11/2022 and received from the Director of Nursing (DON) on 9/1/23 at 12:30 p.m., indicated "...To promote the exercise of rights for each resident, including any who face barriers [such as communication problems, hearing problems and cognition limits] in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability...These rights include the resident's right to...Retain and use personal possessions to the maximum extent that space and safety permit...." 3.1-3(t)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to update the care plan for a resident after acquiring a pressure ulcer on his heel for 1 of 3 residents reviewed for pressure ulcers. (Resident 73) Finding includes: The record for Resident 73 was reviewed on 8/29/23 at 10:02 a.m. Diagnoses included, but were not limited to, severe calorie malnutrition, traumatic brain injury, need for assistance with personal care, anemia, and lower back wound. A skin and wound progress note, dated 6/28/23 at 12:32 p.m., indicated Resident 73 had developed a new pressure ulcer on his right heel. A care plan, dated 6/15/23, indicated to monitor	F 0657	F657 D Care Timing and Revision The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Identified resident #73 was	09/24/2023

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	the progress of the resident's skin condition, notify the nurse of new areas of skin breakdown, provide a pressure redistribution mattress to the bed, and provide incontinence care as needed. The care plan did not include the new pressure ulcer on the right heel. During an interview, on 9/1/23 at 9:47 a.m., the Clinical Support Nurse indicated there was no care plan with revisions for the resident's new pressure ulcer for his right heel. During an interview, on 9/1/23 at 11:07 a.m., the Director of Nursing (DON) indicated the facility did not have a care plan with revisions for the resident's new pressure ulcer for his right heel. A current policy, titled "CARE PLANS PROTOCOL," received from the DON on 9/1/23 at 12:30 p.m., indicated "...The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool the comprehensive care plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care...." 3.1-35(d)(1)		assessed and the care plan reviewed and revised. 2) How the facility identified other residents: • An audit was conducted on those residents that have pressure areas. No resident was identified to have had a negative effect. Any issue identified was immediately corrected. 3) Measures put into place/ System changes: • In-service conducted for the interdisciplinary team to review procedures for development of comprehensive care plan and implementation of interventions. • Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed. • Care plans are initiated/reviewed upon admission-readmission, annually, quarterly, for significant change and as needed. • Care plans are additionally reviewed and updated as needed during scheduled care plan meetings. 4) How the corrective actions will be monitored: • The Director of Nursing /designee will randomly review 5 residents 'care plan records weekly ensuring that care plans have been developed that accurately reflect resident status.	

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			• IDT will review during scheduled care plan meetings to ensure care plans are reflective of resident's status. • Any issues identified will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 9-24-2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure a resident was getting her teeth brushed twice daily as ordered by the dentist for 1 of 1 resident reviewed for dental care. (Resident 40) Finding includes: During an observation, on 8/28/23 at 12:25 p.m., Resident 40 was talking and there was a very foul odor noted from the resident's mouth. The record for Resident 40 was reviewed on 8/29/23 at 11:30 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), anxiety, Alzheimer's disease, and age-related	F 0677	F 677 D ADL Care Provided for Dependent Residents This facility requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	09/24/2023

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	cataract. A dental note, dated 4/4/23, indicated the resident's oral hygiene was poor. A dental note, dated 7/18/23, indicated the resident had heavy generalized plaque (a sticky film coating teeth which contains bacteria), heavy calculus (hardened dental plaque) and generalized bleeding. The gingival (tissue surrounding the teeth) tissue was red and inflamed. The instructions included for the staff to please assist the resident to brush her teeth twice daily and to focus on the gumlines. A care plan, dated 8/15/23, indicated the resident had an activities of daily living (ADL) self-care deficit. The resident's oral hygiene may fluctuate throughout the day and usual performance was supervision or touching assistance. The care plan did not include the instructions from the dentist for the staff to assist the resident with brushing her teeth twice daily or to focus on the gumlines. The daily documentation of ADL care from the CNAs did not include if the resident's teeth were brushed. During an interview, on 8/30/23 at 2:30 p.m., RN 12 indicated it was hit or miss if the resident would let staff assist with oral care. She was not aware of the recommendations from the dentist. During an interview, on 8/30/23 at 2:47 p.m., the Clinical Support Nurse indicated the resident's care plan did not include the recommendations from the dentist and should be updated. Social services would usually read the dental notes and		required by the provisions of federal and state law. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents #40 was provided oral care. The care plan was updated to reflect provision of oral care based upon the instructions provided from the dentist. • Documentation will reflect refusals. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. • Any residents residing in the facility have the potential to be affected. • Review of most recent dental recommendations was conducted to ensure provision of dental care based upon instructions provided by the dentist. • Identified issues were immediately addressed and the care plan updated to reflect oral care. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. • Social Service Director will provide the Director of Nursing a copy of dentist recommendations for follow up within 72 hours	

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	acknowledge the recommendations from the dentist. During an interview, on 8/31/23 at 10:30 a.m., the Social Services Designee (SSD) indicated she would tell the nurse the recommendation from the dentist and then it was out of her hands. It would be up to the nurses to make a task for the Certified Nursing Assistants (CNAs) to complete the task. The nursing staff would also need to update the care plan since teeth brushing would be a nursing care plan. A current policy, titled "Dental Services and Loss or Damage of Dentures," dated 11/28/17 and received from the Executive Director (ED) on 9/1/23 at 4:38 p.m., indicated "...The facility will, if necessary or requested by the resident, assist with scheduling appointments for dental services...." A current policy, titled "Physician Orders Policy/Guidelines," revised on 11/2022 and received form the Clinical Support Nurse on 8/28/23 at 2:00 p.m., indicated "...Physician orders are reviewed and noted accordingly per licensed nursing staff...." A current policy, titled "Activities of Daily Living [ADLS] Maintain Abilities," revised on 11/2022 and received from the ED on 9/1/23 at 4:40 p.m., indicated "...It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's		• In-service education will be provided to nursing staff members to include ADL Provision for Dependent residents. • Medical Records will review ADL documentation 3 days weekly. • CNAs will document using POC for the provision of ADL care during their shift and or prior to completing shift. • Care Plans will reflect specific ADL care for those residents who are dependent. • New orders will be reviewed in daily scheduled clinical meetings. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. • DON/Designee to audit 3 times weekly the provision of ADL care for dependent residents. • Any concerns or issues identified will be addressed to appropriate staff with additional training. • Documentation will be reviewed during scheduled clinical morning meetings. • The DON will report the results of audit at the QAPI Committee Monthly times 6 months or until 100% compliance is met for 3 months. The QAPI committee will then determine if compliance is achieved or if ongoing monitoring is required. 5) D.O.C 9-24-2023	

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	155295	A. BUILDING 00 B. WING	09/01/2023

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	preferences, choices, values and beliefs...The facility will provide care and services for the following activities of daily living...hygiene-bathing, dressing, grooming, and oral care...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." 3.1-38(a)(2)(A) 3.1-38(b)(1)			
F 0684 SS=D Bldg. 00	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. Based on observation, interview and record review, the facility failed to ensure assessments and documentation of care were completed for a resident with sutures after a surgical procedure, assessments were completed for a resident with a head injury after a fall, and the physician was notified of weight changes for a resident with congestive heart failure for 2 of 2 residents reviewed for skin conditions and 1 of 1 resident reviewed for congestive heart failure. (Resident 42, 66, and 33) Finding includes: 1. During an observation, on 8/27/23 at 3:06 p.m., Resident 42 had a scabbed area on the right side	F 0684	F 684 Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	09/24/2023

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	of his mouth about 2 inches in length. During an observation, on 8/31/23 at 11:07 a.m., the resident was sitting up in the recliner in the common area, the scabbed area to the right side of the mouth remained the same and was about 2 inches in length. The record for Resident 42 was reviewed on 8/30/23 at 2:33 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and basal cell carcinoma of the skin of the nose. A care plan, initiated on 11/20/2020 and revised on 2/22/21, indicated the resident had a potential for impairment to his skin integrity related to fragile skin. The interventions included, but were not limited to, document location, size and treatment of skin injury and report failure to heal. A dermatology visit note, dated 8/22/23, indicated the resident had surgery to his right cheek to repair a flap. The total repair area was 4.04 cm (centimeters) by 2 cm. The wound was closed with sutures and a petrolatum and pressure dressing was applied. The suture removal would be in 14 days. A physician's order, dated 8/22/23, indicated no ointments or creams aside from Vaseline should be applied to the surgery, hold baby(?) for 5 days after surgery. The physician order did not include the site of the surgery or indicated there were sutures from the surgery. There was no explanation of what "hold the baby" indicated. A weekly skin review, dated 8/26/23, indicated the resident had skin impairment to the face. The weekly skin review did not include the location on the face or the size of the skin impairment. It also		1.) Immediate actions taken for those residents identified: • Residents #42 and #66 and #33 were assessed and care plans updated. • Physician notified of any changes. Orders reviewed. 2) How the facility identified other residents: • Any resident residing in the facility had the potential to be affected. • Facility skin sweep was conducted by Director of Nursing/Designee to review current skin issues and identify any unidentified skin conditions. • Treatment Orders were reviewed, and care plans were updated as needed. • Weights obtained facility wide, physician notified as required. • Any new identified issues were reported to primary physician for review. 3) Measures put into place/ System changes: • Licensed Nursing staff educated on the completion of Weekly Skin Observation Assessments, Completion of Non-Pressure Assessments, Procedure for Wound Documentation and Skin Condition Assessments and Monitoring. • Wound Physician will round weekly to address residents with wounds and skin concerns and any new areas identified. • Non-Pressure skin conditions	

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	did not include the resident had sutures to the right side of his mouth. During an interview, on 8/31/23 at 11:12 a.m., Certified Nursing Assistant (CNA) 13 indicated the resident had seen a dermatologist and there were sutures to the right side of his mouth with a big, scabbed area. During an interview and observation, on 9/1/23 at 12:28 p.m., LPN 14 indicated the resident had 5 sutures to the right side of his mouth. The electronic health record (EHR) did not include the resident had sutures and if treatment was supposed to be done to the sutures or when the sutures would need to be removed. During an interview, on 9/1/23 at 2:19 p.m., the Director of Nursing (DON) indicated the resident's skin condition to the right side of his mouth was not listed in the EHR, there were no measurements of the skin condition, no physician orders for care of the sutures and no information on when the sutures were to be removed. The sutures were placed on 8/22/23 and the follow up appointment with the dermatologist was scheduled for 9/5/23. The skin assessment completed, on 8/26/23, did not include the sutures or the measurements of the skin condition and should have included them. The word "baby" on the physician order should have been hold "bathing" for 5 days after surgery. 2. The record for Resident 66 was reviewed on 8/29/23 at 2:26 p.m. Diagnoses included, but were not limited to, dementia without a behavioral disturbance, type 2 diabetes mellitus, cerebral infarction, peripheral vascular disease, chronic obstructive pulmonary disease, and congestive heart failure.		(bruises/contusions etc.) will be assessed for healing progress and signs of complications and documented on non-pressure assessment weekly until healed. Care plans reviewed and updated as required. • Pressure Wound Assessments will be completed and measured weekly until healed. Care plans updated as required. • Weekly skin assessments will be completed on current residents. • Nurses educated on Physician Notification, ordered weights and re-weight requirements. • Education provided on Care Planning. 4) How the corrective actions will be monitored: • Director of Nursing is the responsible party for this Plan of Correction with Executive Director oversight. • Director of Nursing/designee will review UDA 3 days a week to determine Weekly Skin Assessments; Non-Pressure and Pressure assessments are completed timely and accurately. • Wound Physician will round weekly and review with Director of Nursing/designee concerns for immediate address or changes in treatment orders. • Care Plans will be reviewed to ensure they reflect resident's status and or changes in resident	

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	A care plan, dated 7/8/23, indicated the resident was at a risk for impaired safety and injury related to a fall risk. The goal was for the resident to have a minimized risk for falls and minimized injuries related to falls. A progress note, dated 8/9/23 at 1:55 p.m., indicated at 6:15 a.m., the resident was yelling from the bathroom and requesting help. The staff found the resident lying on her stomach in the bathroom. She had a 5-centimeter (cm) bump on her right forehead which was starting to bruise. A progress note, dated 8/9/23 at 1:56 p.m., indicated the resident was sent to the emergency room for evaluation and treatment. A 72-hour fall follow up, dated 8/10/23, indicated the resident had a fall, there was a bump to the right forehead. The follow up did not include measurements to the bump on the right forehead and did not include if the bump was resolving or worsened. A Nurse Practitioner (NP) note, dated 8/10/23, indicated the resident was seen for follow up after a fall and emergency room visit. The resident fell and hit her head. The NP note did not include any information about a bump to the right forehead. An Interdisciplinary Team (IDT) note, dated 8/10/23 at 9:34 a.m., indicated the resident had a fall during a self-transfer, was sent to the emergency room for evaluation, and had a bump on her forehead with slight bruising.		condition. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	The IDT note did not include the measurement of the bump to the forehead. The electronic health record (EHR) did not include when the bump on the forehead had resolved. During an interview, on 8/30/23 at 2:57 p.m., the Clinical Support Nurse indicated the resident had a fall on 8/9/23, went to the emergency room (ER), and returned to the facility. The ER notes indicated the resident had a contusion although the location of the contusion and the measurements were not documented. The facility did not have further documentation of the bump on the resident's forehead including when it was resolved.3. During an observation, on 8/29/23 at 3:40 p.m., Resident 33 was sitting in her wheelchair, in the dining room, her legs were dangling to the floor and both lower legs were swollen. During an observation and interview, on 8/31/23 at 9:55 a.m., the resident indicated her legs were swollen and they were heavy. The resident's legs appeared to have edema. The record for Resident 33 was reviewed on 8/29/22 at 12:12 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and hypertension. A care plan, dated 6/22/22, indicated the resident had an alteration in her nutritional status related to congestive heart failure. The interventions included, but were not limited to, obtain weight as indicated and report to the Registered Dietician, Physician, and family of significant weight changes. A physician's order, dated 6/14/21, indicated to			

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	call the Cardiologist if the resident had a 5 or more-pound (lb.) weight gain in one week. The resident was to be weighed on Mondays and before breakfast. A physician's order, dated 7/17/22, indicated to give furosemide (a diuretic) tablet 40 milligram (mg), 1 tablet in the morning. The resident's weights were reviewed and indicated the following: a. On 8/21/22, the resident weighed 191.6 pounds. On 8/28/22, the resident weighed 206.6 pounds. This was a weight gain of 15 pounds in week. b. On 10/3/22, the resident weighed 215 pounds. On 11/1/22, the resident weighed 235.0 pounds. This was a weight gain of 20 pounds within the month. There was no documentation the resident's medical record to indicate the Cardiologist was notified of the weight increases as ordered. During an interview, on 8/31/23 at 12:03 p.m., the Director of Nursing (DON) did not know if the cardiologist was notified of the weight increases. The cardiologist should be notified according to the order. During an interview, on 8/31/23 at 1:50 p.m., the Clinical Support Nurse indicated the resident went to the cardiologist in July and they discussed weights. She was not sure if the Cardiologist was notified of the August weight increase. A current policy, titled " Wound Documentation Policy," dated 2022 and received from the Executive Director on 9/1/23 at 4:30 p.m., indicated "...Process...Wounds will be assessed weekly and documented on the skin pressure and/or non			

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	pressure UDAs [user defined assessment] until healed by a Licensed Nurse...When a skin impairment is healed the MD and family will be notified and plan of care updated. The skin pressure and/or non pressure UDA[s] will be completed to note healing of the wound[s] by Licensed Nurse...If areas are identified after admission the licensed nurse will assess the area and complete applicable skin pressure and/or non pressure UDA[s]. The Licensed Nurse will notify the Medical provider for orders, notify the resident/resident representative, and implement applicable new care plan interventions...Weekly Skin Assessment will be complete by a licensed nurse and documented in the medical record MAR/TAR and/or weekly skin observation UDA...." A current policy, titled "Physician Orders Policy/Guidelines," revised 11/2021 and received from the DON on 8/29/23 at 2:21 p.m., indicated "...Medical care problems are communicated to the attending physician in a timely, concise, and thorough matter...The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate medical intervention...Should the physician not be available, the alternate physician should be contacted...If neither of these physicians are available, the Medical Director should be notified...." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to notify the physician, implement interventions timely and to include re-weights with a date completed in the electronic record (EHR) for significant weight changes for 2 of 5 residents reviewed for nutrition. (Resident 14 and 42) Finding includes: 1. The record for Resident 14 was reviewed on 8/30/23 at 11:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, iron deficiency anemia, and major depressive disorder. A physician's order, dated 10/13/22, indicated to give a regular diet with mechanical soft texture and regular liquids. A physician's order, dated 10/1/22, indicated a monthly weight and vital signs.	F 0692	F F692 D Nutritional/Hydration Status Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for	09/24/2023

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	The resident had the following weights: 1. On 7/17/23, the weight was 127.6 pounds. 2. On 8/2/23, the resident's weight was 119 pounds which was a 6.74% weight loss in less than one month. A nutrition note, dated 8/16/23 at 10:42 a.m., indicated a weight warning. The resident had a 5% change from the last weight and was a noted significant weight loss. A re-weight would be requested. The Memory Care Unit (MCU) staff indicated the resident ate well at breakfast and had been refusing lunch and dinner. The resident did accept mighty shakes. The mighty shakes would be increased from twice daily to three times daily. The nutrition note and intervention was 14 days after the significant weight loss occurred. The EHR did not include a notification to the physician for the significant weight loss. The EHR did not include a nutrition care plan. A Nurse Practitioner (NP) progress note, dated 8/15/23, indicated the resident's weight was stable. The NP note did not include the significant weight loss from 8/2/23. During an interview, on 8/30/23 at 3:21 p.m., the Director of Nursing (DON) indicated the Registered Dietician had requested a re-weight and the staff sometimes completed the re-weights and did not get them entered in the EHR. She had not seen the re-weights yet because she had been gone the week of 8/9/23. During an interview, on 8/30/23 at 3: 51 p.m., the		those residents identified: • Residents # 14 and # 42 were reweighed. • The registered dietician assessed the nutritional status of residents. • Care plans were updated. • The physician was notified of weights. 2)How the facility identified other resident: • Residents residing in the facility had the potential to be affected. 3)Measures put into place/ System changes: • Education was provided to nursing staff on the policy for Weighing residents. • Weights will be obtained on every admission and re-admission. • Admission/re-admission weights will be reviewed daily in clinical meetings with the IDT team. • Weight loss of 5# or more will be reviewed daily in the clinical meeting to ensure completion of assessment of nutritional status and to determine nutritional needs, physician notification, and re-weight completion. 4)How the corrective actions will be monitored: • Responsible party for this plan of correction is the Director of Nursing with Administrative oversight. • New admissions and re-admissions audits reviewed within 48-72 hours to ensure accurate weight is obtained and	

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	DON indicated she located the re-weight for the resident although it was not dated so she was not sure when the re-weight had occurred. During an interview, on 8/30/23 at 4:29 p.m., the Clinical Support nurse indicated the facility did not know for sure the date of the re-weight and had not entered the re-weight into the computer, she thought the re-weight was okay and this was the reason the resident was not put on the Nutrition at Risk (NAR). The DON was not working the week of August 10th. The documentation did not show the physician had been notified of the significant weight change. 2. The record for Resident 42 was reviewed on 8/30/23 at 2:33 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction, anemia, and vitamin deficiency. A care plan, dated 11/11/20 and last revised on 8/16/22, indicated the resident had a nutritional problem related to a risk for unplanned weight loss and significant weight fluctuations. The interventions included, but were not limited to, diet as ordered, the Registered Dietician to evaluate and make diet change recommendations and weights as ordered. A physician's order, dated 1/29/21, indicated to give a regular diet with large portion, regular texture, and regular liquids. A physician's order, dated 1/19/23, indicated to give fortified foods when available. The resident had the following weights:		assessment complete. • Director of Nursing/designee will also review any weight gain/loss of 5 lbs. or more in clinical meeting to ensure assessment of nutritional status is addressed and physician has been notified. • Results of audits will be reported to the monthly Quality Assurance Performance Improvement committee for review for 6 months until 100% compliance has been met for 3 consecutive months. • The QA team will review trends and patterns and determine the need for further continued actions. 5)Date of compliance: 9-24-2023	

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	1. On 4/24/23, the weight was 180.4 pounds. 2. On 5/1/23, the weight was 161.6 pounds which was a significant weight loss of 10.24% in less than one month. 3. On 6/5/23, the weight was 163.6 pounds. 4. On 6/26/23, the weight was 162 pounds. This weight was documented 21 days after the significant weight loss on 6/5/23. 5. On 7/3/23, the weight was 182.4 pounds which was a 12.59% significant weight increase in less than one month. 6. On 8/3/23, the weight was 183.2 pounds. This weight was documented 30 days after the significant weight increase on 7/3/23. A nutritional assessment, dated 5/11/23, indicate the resident was noted to have a recent significant weight loss and it was questionable if the current weight was accurate. A re-weight would be requested. The nutritional assessment was 10 days after the significant weight loss occurred. The documentation did not include notification to the physician of the significant weight loss. The next resident weight was not documented in the EHR until 6/5/23/23 and was 163.6 pounds which was more than a month after the significant weight change. A nutrition note, dated 7/12/23 at 5:36 p.m., indicated a weight warning. The resident showed a significant weight gain. It was uncertain the cause of the weight fluctuations. The resident did eat well and was also on Depakote (a seizure medication also used for mood stabilization) which could increase appetite. The nutrition note was 9 days after the significant			

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	155295	A. BUILDING 00 B. WING	09/01/2023

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	weight gain occurred. The EHR did not include notification to the physician of the significant weight gain and did not include a re-weight of the resident after the 7/3/23 significant weight gain. During an interview, on 9/1/23 at 2:18 p.m., the Clinical Support Nurse indicated the physician was not notified of the significant weight changes and there were no re-weights documented in the EHR. A current policy, titled "Weights," last reviewed on 5/1/23 and received from the Clinical Support Nurse on 8/30/23, indicated "...Resident should be routinely weighed on the same type of scale...Current standards of practice recommend weighing the resident on admission or readmission [to establish baseline weight], weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as insidious [gradual] weight loss...Residents identified as nutritional risk by be weighed weekly or bi-weekly per physician order or IDT [interdisciplinary team] recommendations...Re-weight should be obtained if there is a difference of 5 pounds or greater [gain or loss]since previous recorded weight...Re-weight should be obtained after an unanticipated weight change and prior to calling the physician. [within 72 hours] ...Weights and re-weights should be obtained and documented by the 10th of the month...Unanticipated weight gains or losses of 5%/30 days, 7.5%/3 months, or 10% in 6 months shall be reported to the physician, dietician, and dietary manager as appropriate...." 3.1-46(a)(1)			

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F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure an enteral (a feeding directly into the stomach) feeding tube was unclamped and connected to the feeding 1 of 1 resident reviewed for tube feeding. (Resident 50) Finding includes: During an observation, on 8/29/23 at 9:55 a.m., Resident 50's floor had a large puddle of enteral (refers to intake of food via the gastrointestinal (GI) tract) feeding on the right side of the bed. The resident's sheet and pad were soaked with the feeding.	F 0693	F 693 Tube Feeding Management/Restore Eating skills The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	09/24/2023

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	The record for Resident 50 was reviewed on 8/29/22 at 1:05 p.m. Diagnoses included, but were not limited to, Wernicke's encephalopathy (caused by a thiamine deficiency), gastrostomy status, and anxiety disorder. A physician's order, dated 6/8/23, indicated to give Nutren 2.0 (for the nutritional management of those with limited fluid tolerance and/or increased energy needs) at 84ml (milliliters)/hr for 20 hours and a water flush of 40ml/hr for 20 hours. The formula ran from 3 p.m. to 11 a.m. At 11a.m., disconnect the feeding and restart feeding at 3 p.m. A care plan indicated the resident had a nutritional problem related to dependence on gastral tube feeding. The interventions included, but were not limited to, feeding as ordered and to provide and serve diet as ordered. During an interview, on 8/29/23 at 10:00 a.m., CNA 16 indicated the tube was clamped when she went to breakfast around 7 a.m. The CNA assisted the resident back to bed between 8-9 a.m., and the feeding tube was clamped. During an interview, on 8/29/23 at 10:00 a.m., LPN 2 entered the resident's room. She indicated she would clean the feeding up off the floor. She removed the sheet and uncovered the tubing. The tubing was not all the way into her gastronomy tube (tube surgically placed into the stomach). LPN 2 pushed the end of the feeding tube into the tubing attached to the feeding machine and indicated it should be fine. She indicated she did not notice the clamp was closed and said it should have been opened. During an interview, on 8/29/23 at 11:00 a.m., the		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Immediate actions taken for those residents identified: • Resident #50 was assessed, physician orders reviewed regarding tube feeding, care plans reviewed and updated. 2.) How the facility identified other residents: • Any resident with a feeding tube residing within the facility has the potential to be affected, however no other residents were identified to have been affected. 3.) Measures put into place/ System changes: • Facility licensed nursing staff were educated on following physician orders, g-tube feeding administration with completed g-tube competencies. • New nurses will be educated on g-tube administrations during orientation. • Residents with enteral feeding orders will be reviewed to determine physician orders are followed and the correct tube feeding amount is being administered correctly. 4.) How the corrective actions will be monitored:	

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	DON indicated the clamp should be opened and she was told by the nurse it was clamped and leaking on the bed and floor. A current policy, titled "Enteral Feeding," revised 11/2022 and received from the DON on 8/29/23 at 2:21 p.m., indicated "...A resident who is fed by a gastronomy tube shall receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea and vomiting...." 3.1-44(a)(2)		• The Director of Nursing / Designee will be the responsible party for this plan of correction. • Audits will be conducted 3 times weekly for those residents that have a g-tube to include all shifts to determine correct enteral orders for administration are in place and followed and documented correctly. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 9-24-2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure a resident had a physician's order for the administration of	F 0695	F 695D Respiratory, Tracheostomy, Care and Suctioning	09/24/2023

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	oxygen (02) and failed to ensure an oxygen saturation (02 sat) was obtained prior to setting the liter per minute (LPM) flow rate of the oxygen for 1 of 1 resident reviewed for oxygen. (Resident 66) Finding includes: During an observation, on 8/27/23 at 3:26 p.m., Resident 66 was lying in bed in her room and had 02 in place per nasal cannula at 3 LPM. The resident's physician's orders did not include oxygen administration. During an interview and observation, on 8/27/23 at 3:29 p.m., QMA 3 indicated she could not find During an observation, on 8/28/23 at 11:40 a.m., Resident 66 was lying in bed in her room and had 02 per nasal cannula in place. The oxygen was set at 0 which indicated no oxygen was being administered through the nasal cannula. QMA 4 confirmed the resident's 02 was set at 0 and she would call the nurse from the other unit to set the 02. The resident had returned from the hospital early in the morning and it was scary her 02 had not been turned on when she returned. The resident had gone to the hospital for shortness of breath. During an observation and interview, on 8/28/23 at 11:43 a.m., Registered Nurse (RN) 11 set the 02 at 2 LPM. She did not check a 02 sat and said she thought the resident's 02 was set at 2 LPM before she left for the hospital. She did not look at the physician's orders prior to setting the 02 at 2 LPM. The record for Resident 66 was reviewed on 8/29/23 at 2:26 p.m. Diagnoses included, but were		This facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Corrective actions accomplished for those residents found to be affected by the alleged practice: • Resident #66 reviewed with physician, order written for oxygen usage, obtaining oxygen saturation orders, any notification parameters if required and care plan updated to reflect the amount of oxygen to be used. 2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: • All residents using oxygen had the potential to be affected by this alleged practice. • Audit conducted for those residents using oxygen to determine orders are present their care plan is reflective of oxygen use. • Any identified issues were	

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	not limited to, unspecified dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD), and congestive heart failure. A progress note, dated 8/18/23 at 4:46 p.m., indicated the residents 02 sat was 85% at 2 LPM and the Nurse Practitioner indicated to increase the oxygen to 3 LPM and to send the resident to the hospital. A progress note, dated 8/23/23 at 8:43 p.m., indicated the resident had 02 on at 2 LPM per nasal cannula. A progress note, dated 8/25/23 at 11:15 p.m., indicated the resident had 02 on at 2 LPM with the nasal cannula. A progress note, dated 8/27/23 at 4:46 p.m., indicated the resident was to be on as needed oxygen since 8/9/23 and the oxygen could be titrated to keep the 02 sat above 90%. The 02 could be titrated between 1-4 LPM. A physician's order, dated 8/27/23, indicated oxygen at 1-4 LPM via nasal cannula as needed and may titrate to keep 02 sat above 90%. A progress note, dated 8/27/23 at 7:37 p.m., indicated the resident was having trouble breathing even while on oxygen and was being sent to the emergency room. An Indiana University Health emergency department note, dated 8/28/23, indicated the resident was admitted with shortness of breath. The diagnoses included, but were not limited to, congestive heart failure and pulmonary edema.		immediately addressed. 3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: • Licensed nursing staff were educated on the the requirement that those residents that require respiratory care is provided such care. Orders must be present for oxygen and care plans must be reflective of oxygen use. • Admission/readmission audits will be conducted to determine physician orders are present for those residents that admit with oxygen use. Care plans will reflect oxygen orders. 4.) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: • Responsible party for this plan of correction is the Director of Nursing/designee with Executive Director oversight. • Audits per Director of Nursing/Designee will be conducted weekly for five residents who use oxygen to determine an order is present for LPM and Oxygen saturation. • Identified issues will result in further education. • Audit results will be reported, reviewed, and trended for compliance thru the Quality Assurance Committee for a minimum of 6 months and or until compliance is met at 100% for	

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	A current policy, titled "Respiratory, Oxygen Therapy, General Standard," revised on 11/2022 and received from the Executive Director on 9/1/23 at 4:30 p.m., indicated "...Purpose...To provide adequate tissue oxygenation for problems associated with...Reduced oxygen carrying capacity of blood...Decreased cardiac output...To provide for safe oxygen administration...Standards...Oxygen is administered in accordance with a physician's order and on an emergency basis...A licensed nurse will conduct ongoing resident assessments for oxygen administration. Assessments will be conducted prior to administering oxygen when a resident is in distress...Assessment will include...Lung sounds...Vital signs and oxygen saturation level...A pulse oximeter will be used to determine oxygen saturation levels. The oxygen liter flow will be increased or decreased depending on physician protocol/orders for COPD or other residents...A physician's order must be obtained for the continued use of oxygen...." 3.1-47(a)(6)		consecutive 3 months, at which time QA committee may determine/recommend altering plan of correction. . 5.) Date of compliance: 9-24-2023	
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).			

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	§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on record review and interview, the facility failed to have Certified Nursing Assistants (CNA) coverage for the evening shift to ensure residents on the Memory Care Unit (MCU) received showers during the evening shift for 3 of 3 residents reviewed for evening showers. (Residents 14, 40 and 15) Findings include: 1. The Facility Assessment tool indicated the facility was staffed daily by the following: a. Day shift required 9 QMAs or CNAs. b. Evening shift required 8 QMAs or CNAs c. Night shift required 5 QMAs or CNAs The Daily Nursing Schedule indicated on 8/20/23 the evening shift had a total of 7 QMAs and CNAs. The Facility Assessment called for a total of 8 QMAs and CNAs. The Daily Nursing Schedule indicated on 8/30/23 the evening shift had a total of 5 QMAs and CNAs with 1 CNA in orientation. The Facility Assessment called for a total of 8 QMAs and	F 0725	F 725D Sufficient Nursing Staff This facility respectively requests Desk Review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Immediate actions taken for those residents identified: • Staffing patterns were reviewed/revised to ensure appropriate staffing levels were	09/24/2023

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	CNAs. During an interview, on 9/1/23 at 3:30 p.m., the Scheduler indicated the Eastside of the facility had 3 CNAs during day and the QMA worked 12 hours a day. The Westside was staffed with a QMA from 6 a.m.-6 p.m., and two CNAs from 6-2 p.m. If there was not a nurse on the Westside, then the Memory Care nurse would come out and help. On 8/30/23, there was a CNA and an Activity Aide in the MCU. The activity aide goes home at 7 p.m. The MCU would have only one CNA for 10 p.m. to 6 a.m. There were 18 residents on the memory care. 2. During an observation, on 8/27/23 at 4:24 p.m., the shower room on the Memory Care Unit (MCU) had a sign which indicated the room was out of order. During an interview, on 8/29/23 at 11:14 a.m., the Maintenance Director indicated the MCU shower had been out of order since last week. He was replacing some floor tiles and had put new grout around the shower. There were 4 shower rooms with 8 showers for the facility for 77 residents. Since the MCU shower room was out of order, it left 3 shower rooms and 6 shower stalls for 77 residents. The shower sheets for residents on the MCU were reviewed and the following was noted: a. Resident 14 had received 8 showers for the month of July 2023 and only 5 showers for the month of August 2023. The showers were to be completed on the evening shift. The shower sheets did not include any refusals. b. Resident 40 had 8 showers completed for the month of July 2023 and only 5 showers for the month of August 2023. The showers were to be completed on the evening shift. The shower sheets did not include any refusals.		met for the memory care unit. • Residents # 14, #40, and #50 received a shower. • Care plans reviewed and updated to reflect ADL requirement. 2.) How the facility identified other residents: • Any resident that resides on the memory care unit had the potential to be affected, however no adverse effects were identified. 3.) Measures put into place/ System changes: • The Facility Assessment will be reviewed and updated. • Staffing will be reviewed daily by the Administrator/Director of Nursing and Scheduler to determine appropriate staffing available to meet the needs of the residents. • Facility Managers that provide direct resident care will be placed on the daily schedule. • The manager on duty for weekend rotation will review and ensure staffing is appropriate. • If problems are noted the Administrator/On Call staff will be contacted. • Education provided on the provision of ADL care for those residents that are unable to provide their own ADL's. • Refusals of ADL care, (i.e, showers, bathing, grooming, dressing and oral hygiene) will be documented in the clinical record. 4.) How the corrective actions will be monitored:	

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	c. Resident 15 had 6 showers with 2 documented refusals for the month of July and only 5 showers for the month of August with no documented refusals. The showers were to be completed on the evening shift. Residents 14, 40 and 15 were all scheduled to receive two showers weekly on the evening shift for at least 8 showers for each month. During an interview, on 8/31/23 at 11:12 a.m., CNA 13 indicated the residents on the MCU would have to be taken off the unit to get a shower since the MCU shower room was out of order. After 6:00 p.m., there might only be one staff on the MCU, and the residents scheduled for evening showers would not get a shower since the one staff scheduled could not leave the MCU to go to another unit's shower room. So, on the shift when there was only one staff during the evening the residents' showers would not be completed. During an interview, on 9/1/23 at 3:30 p.m., the Executive Director (ED) indicated the MCU shower room had been shut down since the week of 8/21/23. Usually, the MCU would have one activity aide and one CNA on the evening shift. The activity staff would leave the unit at 7:00 p.m. The facility had not given the surveyors the correct as worked staff and had not completed changes when the staff called off work. The MCU evening shift was only staffed with one CNA, and it was not documented if any of the evening shifts on the MCU were without an activity aid on the evening shift. Usually, MCU evening shift showers were completed from 4:00 p.m. through 7:00 p.m., when the activity staff was still on the unit. A current policy, titled "Nursing Services-Nurse		• Daily review (5 days weekly) of staffing patterns to determine an adequate staffing pattern to meet resident needs per Administrator and Director of Nursing and Scheduler • Director of Nursing/designee will randomly audit 3 times weekly to include all shifts concern related to provision of ADL care on the memory unit. • Medical Records will review documentation of ADL care and report during regularly scheduled clinical meetings. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the committee may make recommendations to revise the plan of correction. 5) DOC 9-24-2023	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Staffing Information," revised on 11/2022 and received from the ED on 9/1/23, indicated "...Intent...It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time...The facility will post the following information daily...The total number and the actual hours worked by the following categories...Registered nurses...Licensed practical nurses...Certified nurse aides...." A current policy, titled "Activities of Daily Living [ADLS] Maintain Abilities," revised on 11/2022 and received from the ED on 9/123 at 4:40 p.m., indicated "...It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs...The facility will provide care and services for the following activities of daily living...hygiene-bathing, dressing, grooming, and oral care...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." 3.1-17(a)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse			

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	155295	A. BUILDING 00 B. WING	09/01/2023

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	for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there was RN coverage for multiple days for the 2nd Quarter of 2023 from 1/1/2023 to 03/31/2023. Finding includes: The Staffing information was reviewed on 8/31/23 at 1:40 p.m. The Payroll Based Journal (PBJ) report for the 2nd Quarter during 2023, indicated the following area was triggered. a. No RN coverage for 8 consecutive hour/day and triggered for the dates of 1/1, 1/2, 1/8, 1/9, 1/14, 1/21, 1/22, 1/23, 2/4, 2/5, 2/7, 2/11, 2/18, 3/19, 3/22, 3/23, 3/24, 3/25, 3/27, 3/28, 3/31/23. The Facility Assessment tool indicated the facility was staffed daily by the following: a. Day shift required 2 RNs. b. Evening shift required 2 RNs. c. Night shift required 1 RN. During an interview, on 9/1/23 at 3:30 p.m., the Executive Director (ED) indicated she was given the Certification and Survey Provider Enhanced Reports 3 (CASPER 3) at the entrance conference. The areas triggered in the Payroll Based Journal (PBJ) was the facility was one-star, low weekend	F 0727	F 727D D RN 8 HRS/7 days/wk Full time DON Facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • No resident was identified to have been affected. 2) How the facility identified other residents: • No resident was identified to have been affected. 3) Measures put into place/ System changes: • Staffing will be reviewed daily by	09/24/2023

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	staff and no RN coverage for 8 consecutive hour/day for the dates of 1/1, 1/2, 1/8, 1/9, 1/14, 1/21, 1/22, 1/23, 2/4, 2/5, 2/7, 2/11, 2/18, 3/19, 3/22, 3/23, 3/24, 3/25, 3/27, 3/28, 3/31/23 was correct. The one-star rating was probably due to no RN coverage. The facility was down a Unit Manager and an Assistant Director of Nursing. They both need to be RNs and they were currently using Licensed Practical Nurses. The facility did not have RN coverage for those dates. 3.1-17(b)(3)		the Administrator/Director of Nursing and to ensure RN coverage is available per requirement. • The provision of On-Call rotation to support RN coverage is reviewed during daily morning meetings to ensure coverage. • Facility will accurately report RN coverage hours per requirement. 4) How the corrective actions will be monitored: • Staffing patterns and RN coverage are reviewed daily per Executive Director/designee. • Facility will submit direct care staffing information on specified schedule per CMS but no less than frequently than quarterly. • PBJ will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance:	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review and	F 0744	F-744D Treatment and	09/24/2023

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	interview, the facility failed to provide a consistent program of cognitively stimulating activities for a resident with dementia for 1 of 4 residents reviewed for dementia care. (Resident 52) Finding includes: During an observation, on 8/27/23 at 3:45 p.m., Resident 52 was lying in bed in her room and was wearing a hospital gown. Several other residents were sitting in the common area with the staff, and they were getting ready to play bingo. During an observation, on 8/28/23 at 12:29 p.m., the resident was lying in bed in her room. Several other residents were in the common area and eating lunch together. During an observation, on 8/29/23 at 11:28 a.m., the resident was lying in bed in her room, her eyes were closed, and she was wearing a hospital gown. Several other residents were in the common area playing balloon toss and listening to music with the activity staff. During an observation, on 8/29/23 at 4:06 p.m., the resident was lying in bed in her room. Several other residents were playing bingo with the activity staff. During an observation, on 8/20/23 at 10:50 a.m., the resident was lying in bed with her eyes closed. There were four residents in the common area with the television on. During an observation, on 8/31/23 at 11:06 a.m., the resident was sitting up in a wheelchair next to the bed in her room. Several other residents were in the common area and eating lunch.		Services/Dementia Care The facility respectively requests a Desk Review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Resident #52 was assessed, and care plans reviewed and revised specifically related to individualized interventions related to activity program. • Care conferences were scheduled for any identified concerns. 2. How the facility identified other residents: • All residents residing in the memory care unit have the potential to be affected. • Audit conducted for all residents residing in memory care unit for activities program. 3. Measures put into place/ System changes: • Education provided to facility staff on Dementia Care Admission/Discharges and Circadian. • Assess residents on memory	

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	The record for Resident 52 was reviewed on 8/30/23 at 2:29 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, dementia with agitation, depression, and chronic kidney disease. A care plan, dated 5/4/23, indicated the resident would be a long term stay at the facility for custodial care. The goal included the resident would adjust to the facility and participate in care to return to the prior level of care. The interventions included, but were not limited to, encourage the resident to participate in activities of her choice and to provide the resident with emotional and spiritual needs. A care plan, dated 5/6/23, indicated the resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's. The resident resided on the locked Memory Care Unit (MCU). The goal was for the resident to maintain the current level of cognitive function through the next review date. The interventions included, but were not limited to, cue, reorient and supervise as needed, ask yes or no questions to determine the resident's needs and to communicate with resident/family/caregivers regarding the resident's capabilities. A care plan, dated 5/7/23, indicated the resident had impaired activity and recreational pursuits related to social, physical, and cognitive impairments. The goal included the resident would engage in activities which matched her skills, abilities and/or interests. The interventions included, but were not limited to, encourage, and invite participation in activities of interest like bingo and provide a calendar of events to the resident.		care unit for activity preferences. • Care Plans updated to reflect new preferences. • Psychosocial assessment completed on memory care residents. • Activity log will indicate those activities residents participate in and those activities residents' refuse. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Activity Director/ Social Services and the Executive Director. • Audits will be conducted on 5 residents, 3 times weekly to determine activities are scheduled 7 days weekly with participation. • Evening activities are scheduled at least 2 days weekly. • Outdoor activities are scheduled monthly. • Residents who refuse to attend activities are provided alternate programs. • Audits will be reviewed monthly during Quality Assurance and will continue for 6 months or until 95% compliance is achieved for 3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. DOC 9-24-2023	

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	A care plan, dated 6/13/23, indicated the resident had activities of daily living (ADL) self-care deficits and was at a risk for functional decline related to depression and dementia. The interventions included, but were not limited to, encourage participation in daily care and to provide positive reinforcement for the activities attempted. An Activity/Quarterly/Annual Review, dated 7/30/23, indicated the resident's favorite activities included chef's hour, coca cola, and exercise time. An Activity Preferences, dated 7/30/23, indicated it was somewhat important for the resident to listen to music, be around animals, and to go outside. During an interview, on 8/29/23 at 12:26 p.m., RN 12 indicated the resident usually ate meals in her room. During an interview, on 8/31/23 at 11:11 a.m., the Activity Staff 15 indicated the resident liked exercise and bingo. She would participate maybe three times a week in the activities. During an interview, on 8/31/23 at 10:39 a.m., the Social Services Designee (SSD) indicated the resident was combative with care, verbally aggressive, and would make inappropriate comments to staff. The facility attempted to bring the resident out of the (MCU) to the main floor and it lasted only a day. The resident was making inappropriate remarks and reaching out to touch other people. The resident had to be moved to back to the MCU. If the resident was being aggressive, it was best just to leave her alone for the day.			

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	During an interview, on 8/31/23 at 10:41 a.m., the Activity Director indicated the resident would sometimes participate in bingo and other times would participate in activities if she would get a cola. She could not give a percentage of activity participation for the resident since participation was so unpredictable. A current policy, titled "Castle Healthcare Admission Process-Dementia Units," revised on 5/12/22 and received from the Clinical Support Nurse on 8/30/23 at 4:40 p.m., indicated "...Healthcare has developed specialized areas of our campuses to serve those living with dementia and the associated challenges. It has been shown that individuals living with dementia benefit from specialized environments to meet their unique needs. Castle has adopted dementia specific interactions and interventions to increase quality of life for the residents we serve. In doing this there are certain criteria to enter such a unit to determine the environment remain therapeutic...Prior to admission, the potential resident shall have a physician's diagnosis of some type of irreversible dementia or dementia related illness. As well as a physician order stating potential resident needs a secured environment to be documented in their medical record...The IDT[interdisciplinary team] shall assess whether the potential resident's current cognitive, medical, physical, and emotional state can be appropriately served, given current resources available, that the resident can benefit from the cognitively/socially oriented services provided on the memory care unit...The potential resident shall demonstrate that they can benefit, even passively from the specialized memory care activity programming...."			

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	3.1-33(a) 3.1-37(a)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record	F 0755	F 755E Pharmacy	09/24/2023

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	review, the facility failed to ensure the reconciliation of controlled drugs in 3 of 3 medication carts reviewed for controlled drugs and to maintain insulin medication integrity for 2 of 2 residents reviewed for insulin medication distribution. (Residents 15 and 4) Findings include: 1a. During the record review of controlled drug records, on 8/30/2023 at 3:01 p.m., the Medication Cart 200, Shift Change Controlled Substance Inventory Count Sheet (narcotic count record-reconciliation) was incomplete for the Month of August 1 through 27, 2023. The narcotic count record -reconciliation sign in and sign out documentation record for August 1 through 27, 2023 was missing 48 of 124 entries. b. During the record review of controlled drug records, on 8/30/2023 at 3:08 p.m., the Medication Cart 400, Shift Change Controlled Substance Inventory Count Sheet (narcotic count record-reconciliation) was incomplete for the Month of August 1 through 27, 2023. The narcotic count record -reconciliation sign in and sign out documentation record for August 1 through 27, 2023 was missing 13 of 104 entries. c. During the record review of controlled drug records, on 8/30/2023 at 3:15 p.m., the Medication Cart for the Memory Care Unit (MCU), Shift Change Controlled Substance Inventory Count Sheet (narcotic count record- reconciliation) was incomplete for the Month of August 1 through 27, 2023. The narcotic count record -reconciliation sign in		Srvcs/Procedures/Pharmacist/Records The facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident #15 and #4 unrefrigerated medications were destroyed. • Medication carts were audited by DON\designees and medications with no open dates were discarded per policy and medications were reordered. • Controlled drugs were reconciled in all facility med carts. 2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: • Any resident that receives medication had the potential to be affected no adverse outcomes were identified.	

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	and sign out documentation record for August 1 through 27, 2023 was missing 37 of 108 entries. During an interview, on 8/28/2023 at 11:40 a.m., LPN 2 indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for the shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse/QMA and must be accurate or it was reported to the supervisor. She indicated the staff must have forgotten to do the documentation. During an interview, on 8/28/2023 at 11:55 a.m., QMA 3 indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for the shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse/QMA and must be accurate or it was reported to the supervisor. She indicated the staff must have forgotten to do the documentation. During an interview, on 8/28/2023 at 1:40 p.m., the Director of Nursing (DON) indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for the shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse/QMA and must be accurate or it was reported to her. She indicated the staff must have forgotten to do the documentation. During an interview, on 8/28/2023 at 3:10 p.m.,		• Nursing staff educated on Labeling and Storage of medications, shift of shift narcotic counts. 3)What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: • DON or designee will re-educate the Licensed Nurses / QMAs on the following policy: Labeling and Storage of Medications. • Medication Carts and Medication storage room will be audited three times weekly (to include all shifts) per the DON/designee to ensure labeling and dating are correct, and nurses are completing shift to shift narcotic counts correctly. • Facility will implement Clean Friday Cart Audits every Friday to determine accurate acquiring, receiving, dispensing and administration of all drugs. Identified areas of concern will result in re-education. 4)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: The responsible party for this plan of correction is the Director of Nursing with Executive Director oversight. • Implementation of ongoing audits will be conducted by the Director of Nursing/designee on all medication carts and medication	

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	QMA 4 indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for the shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse/QMA and must be accurate or it was reported to the supervisor. She indicated the staff must have forgotten to do the documentation. 2. During an observation of the medication cart on the Memory Care Unit, three insulin medications were observed to be in the cart, unopened, and not refrigerated. The manufacture label indicated the medication was to be refrigerated until opened. a. The record for Resident 15 was reviewed on 8/30/2023 at 4:05 p.m. Diagnoses included, but were not limited to, atrial fibrillation, depression, anxiety, and type 2 Diabetes Mellitus. The Medication Administration Record (MAR) for Resident 15 indicated the resident was to receive Insulin Glargine Solution 100 UNIT/ML inject 15 unit subcutaneous at bedtime for diabetes. The resident's medication was found unopened and in the MCU cart on 8/28/2023 at 3:11 p.m. b. The record for Resident 4 was reviewed on 8/30/2023 at 4:15 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus (DM), cardiac pacemaker, dementia, mood disturbance, and anxiety. The Medication Administration Record (MAR) for Resident 4 indicated the resident was to receive Insulin Glargine Solution 100 UNIT/ML inject 28		room 3 times per weekly to include all shifts for 6 months until 100% compliance has been met for 3 months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of Correction	

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	unit subcutaneous in the morning for diabetes. The MAR for Resident 4 indicated the resident was to receive Insulin Aspart FlexPen 100 UNIT/ML solution pen-injector inject as per sliding scale subcutaneous three times a day for or DM. The resident's medication was found unopened and in the MCU cart on 8/28/2023 at 3:11 p.m. During an interview, on 8/28/2023 at 3:15 p.m., RN 6 indicated the insulin medications for Residents 4 and 15 should have remained in the refrigerator until the medication was to be opened and utilized. During an interview, on 8/28/2023 at 4:22 p.m., the DON indicated the medications had been removed from the refrigerator the morning of 8/28/2023 for utilization. The medications had not yet been utilized and should have been returned to the refrigerator when they were not given to the residents. A current policy, titled "Controlled Medication Storage," effective 2/1/2018 and received on 8/30/2023 at 4:18 p.m., from the DON indicated "...physical inventory of all controlled medication(s), including emergency supply is completed at each shift change of two (2) licensed nurses and is documented on the controlled medication accountability record per facility procedure...." A current policy, titled "Insulin Storage," effective 11/2020 and received on 8/30/2023 at 9:15 a.m., from the DON indicated "...All insulins are sensitive to temperatures that are too high or too low. Once you receive your insulin prescription,			

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	you should store all supplies you've received in the refrigerator...Keep an insulin pen refrigerated until you open it; after that, you can store at room temperature...." 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(m)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to prepare pureed foods according to the recipes in the kitchen for 5 of 5 residents who were ordered a pureed diet. Finding includes: During the observation of pureed foods, on 8/27/23 at 11:38 a.m., the Dietary Manager (DM) was observed to do the following: a. The DM put 3/4 cup of juice into the Robo coupe (a machine to puree foods). She placed 10 peaches into the Robo coupe. Then the DM placed 2/3 cup of thickener into the machine. b. The DM put an unmeasured amount of California blend vegetables into the Robo coupe with an unmeasured amount of margarine and	F 0804	F 804 Nutritive Value/Palatable/Prefer Temp The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it	09/24/2023

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	added 2/3 cup of thickener. c. The DM poured a 1/2 cup of chicken broth into the Robo coupe, added 2 scoops of alfredo, and then added 2/3 cup of thickener. d. The DM added 4 bread sticks into the Robo coupe and poured in 1 and 1/2 cups of milk and added 2/3 cup of thickener. The recipe the DM used for the Pureed Peach Cobbler indicated for 5 servings of peaches cobbler to blend 5 servings of prepared peach cobbler and 1/2 cup of juice and blend until smooth. The DM used 3/4 cup of juice instead of 1/2 cup. The recipe the DM used for the pureed California blend vegetables indicated for 5 servings of California blend vegetables to use 2 and 1/2 cups of California Vegetables and 2 tablespoons of solid margarine. Place prepared vegetables and margarine in a sanitized food processor and blend until smooth. The DM did not measure the California blend vegetables. The recipe the DM used for the chicken alfredo indicated for 5 servings of chicken alfredo combine chicken base and water to make chicken broth (water and base). Remove portions needed from regular prepared recipe, gradually add broth, and blend until smooth in texture. The DM used 1/2 cup of chicken broth instead of 1 cup. The recipe the DM used for the bread sticks indicated for 5 servings of bread sticks combine 5 bread sticks, 3/4 cup of milk and 2 tablespoons of		is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • No resident was identified to have had an adverse effect. 2) How the facility identified other residents: • Any resident that resides in the facility and receives a pureed diet had the potential to have been affected, however no resident was identified. 3) Measures put into place/ System changes: • Education to dietary staff on following recipes. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. • Audits will be conducted 3 times weekly per dietary manager/designee to determine menus are being followed (to include breakfast, lunch and dinner). • Executive Director will randomly, (two times weekly) review dietary audits for accuracy. • Identified areas of concern will be immediately addressed with re-education. • The results of these audits will	

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	melted margarine and blend until smooth. The DM used 4 bread sticks, 1 and 1/2 cup of milk and 2/3 cups of thickener and the recipe did not indicate to use thickener. During an interview, on 8/27/23 at 11:38 a.m., the DM indicated the facility had 5 residents on a pureed diet. She should had used the correct measurements when preparing the food. A current policy, titled "Pureed Diet," dated 2022 and received from the Clinical Support on 8/31/23 at 11:06 a.m., indicated "...The Pureed Diet is designed for individuals who cannot chew foods of the Dental Soft (Mechanical soft) consistency and/or difficulty swallowing...The Pureed Diet follows the Regular Diet with alterations in the consistency of foods to a pureed consistency as needed...The actual process to pureed food is a simple task when the right equipment is used. The following gives a few basic guidelines that should guarantee success...Weigh and measure the number of drained portions required for the standardized recipe...Add measured amounts of hot liquid for cooked foods and cold liquid (if required) for cold foods and process until a smooth consistency is achieved...." A current policy, titled "Therapeutic/Specialized Diets and Nutritional Adequacy," revised on 11/21/21 and received from the Executive Director on 9/1/23 at 4:38 p.m., indicated "...The residents will receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and, or assessed by the interdisciplinary team, which maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that it is not possible and received a		be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 9-24-2023	

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	therapeutic/specialized diet when there is a nutritional problem...." 3.1-21(a)(1) 3.1-21(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the refrigerator did not contain employee drinks, the dishwasher was washing at the recommended temperature and the sanitizing solution bucket levels were in range. This deficient practice had the potential to affect 77 of 77 residents who received food from the kitchen.	F 0812	F812 E Food Procurement, Store/Prepare/Serve-Sanitary The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	09/24/2023

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	Findings include: During the kitchen observation, on 8/27/23 at 11:06 p.m., with the Dietary Manager (DM) the following were observed: a. The reach-in refrigerator contained a medium size fast-food cup with a brown drink and a straw. b. The red sanitizer bucket was tested twice. The DM placed a test strip into the bucket and the strip did not change colors. She tested the bucket again using a strip from a different container and the strip did not change color. c. The dishwasher was put through the wash and rinse cycle twice. The first time the rinse temperature was 117 degrees Fahrenheit and the second time the rinse temperature was 116 degrees Fahrenheit. An Installation and Operation Manual from [name of appliance company] indicated the water requirements for the dishwasher rinse was a minimum of 120 degrees Fahrenheit and a recommended temperature of 140 Fahrenheit. During an interview, on 8/27/23 at 11:06 a.m., the DM indicated the fast-food cup was a staff's drink. The refrigerator should not contain staff food or drinks. During an interview, on 8/27/23 at 11:10 a.m., the DM indicated the red bucket contained sanitizing solution (used to wipe tables and surfaces). None of the testing strips turned colors and the test strip should change to green to indicate the amount of sanitizer was appropriate for cleaning surfaces. The green color would indicate a range of 200-400. During an interview, on 8/27/23 at 11:20 a.m., the DM indicated the temperature of the dishwasher		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • No resident was identified to have been affected. 2) How the facility identified other residents: • Any resident residing in the facility had the potential to be affected. however, no resident was identified to have been affected. 3) Measures put into place/ System changes: • Dietary staff was educated following recipes, dish machine temps and no employee food stored in kitchen med room or resident refrigerators. • The Executive Director/ designee will conduct random observations 3 times weekly of reach in fridge for employee food, dish washer temps, sanitizer buckets concentrations, and review of pureed recipes for accuracy. • Identified issues will be immediately addressed with	

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	should be above 120 degrees and the temperatures were 116 and 117 degrees. The dishwasher not reaching the right temperature and could leave bacteria on the dishes. A current policy, titled "QRT Warewashing," dated 9/1/21 and received from the Clinical Support Nurse on 8/27/23 at 3:14 p.m., indicated "...All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. A current policy, titled "Resident Food-Safe Storage," revised 11/20/22 and received from the Clinical Support on 8/27/23 at 3:14 p.m., indicated "...Employee food items shall be placed in the employee refrigerator...." A current policy, titled "How to Sanitize," not dated and received from the Clinical Support on 8/27/23 at 3:14 p.m., indicated "...Buckets should be changed every 2-4 hours or more as needed to keep the water clean and the sanitizer effective in use...Buckets that are easily identifiable (e.g. red buckets) and not used for any other purposes do not require labels...Replace solutions when the concentration gets weak or when the solution becomes cloudy...Quaternary Ammonia (QUAT) per manufacture instructions usually 0-500 PPM...The test strip should be in the range of 200 to 400). 3.1-21(i)(3)		additional education 4)How the corrective actions will be monitored: • The responsible party for this plan of correction is the Dietary Manager with Executive Director oversight. • Issues identified will be immediately addressed with 1-1 education and disciplinary action as required. • The results of these audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 9-24-2023	