STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155183	A. BUILDING 00 B. WING	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MARTINSVILLE, THE	2055 HERITAGE DR MARTINSVILLE, IN 46151

(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. This visit included the Investigation of Complaints IN00434583, IN00435737, IN00436480, IN00439005, and IN00439635. Complaint IN00434583 - No deficiencies related to the allegations are cited. Complaint IN00435737 - Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00436480 - No deficiencies related to the allegations are cited. Complaint IN00439005 - No deficiencies related to the allegations are cited. Complaint IN00439635 - No deficiencies related to the allegations are cited. Survey dates: July 28, 29, 30, 31, August 1 and 2, 2024 Facility number: 000096 Provider number: 155183 AIM number: 100290890 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 1 Medicaid: 36 Other: 14 Total: 51	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Wilson	Administrator	08/23/2024

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 6, 2024.			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)			

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	(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a			

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	mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 2 of 4 residents reviewed for hospitalization. (Resident 1, Resident 31) Findings include: 1. Residents 1's clinical record was reviewed on 8/1/24 at 3:02 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease.	F 0623	F623 **Notice Before Transfer/Discharge** It is the policy of the facility to provide the Resident, Resident's family member and/or the Resident's legal representative, if applicable, in written form and/or by a telephone conversation prior to transfer to a hospital, another facility or residence. **1.What corrective action(s)**	08/19/2024

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	Resident 1's progress notes indicated the resident was sent to the hospital on 4/19/24. The clinical record lacked documentation of the written Notice of Transfer and Discharge forms having been provided to the resident. 2. On 7/30/24 at 9:47 a.m., Resident 31's clinical record was reviewed. Diagnoses included but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), dysphagia (difficulty swallowing), cognitive communication deficit (trouble reasoning and making decisions while communicating), and unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality). Resident 31's transfer form, indicated the resident was sent to the hospital on 4/10/24. The clinical record lacked documentation of the written Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. On 8/1/24 at 10:35 a.m., the DON provided the facility's policy,"Guidelines for Discharge/Transfer" dated 8/26/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... 2. Notification will be made to the resident, their responsible party ... as appropriate and indicated. The notification will be documented in the resident's medical record ..." The policy did not indicate sending the Transfer and Discharge form in writing to the resident and the resident representative. During an interview on 8/1/24 at 1:10 p.m., the Interim Director of Nursing (DON) indicated the facility did not provide the residents nor the		**will be accomplished for those residents found to have been affected by the deficient practice?** ·The Social Service Director/Designee sent written notification of the Transfer/Discharge policy on for resident 1 for April 19, 2024 hospitalization and resident 31 f hospitalization on April 10, 2024. **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?** ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** ·An in-service has been completed by the DON/Designee on August 16, 2024 for all nursing staff on the transfer/discharge policy. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	resident representatives the Notice of Transfer and Discharge forms in writing. They sent the forms with the resident when they were transferred to another facility. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		**recur, i.e. what quality assurance program will be put into place?** The DON/Designee will audit residents transferred to the hospital to verify notification of transfer form and transfer/discharge was given to the resident or resident representative 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **1.By what date the systemic changes for each deficiency will be completed?** August 19, 2024	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic			

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	leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident for 2 of 4 residents reviewed for hospitalization. (Resident 1, Resident 31) Findings include: 1. Residents 1's clinical record was reviewed on 8/1/24 at 3:02 p.m. Diagnosis included, but were not limited to chronic obstructive pulmonary disease. Resident 1's progress notes indicated the resident was sent to the hospital on 4/19/24. The clinical	F 0625	It is the policy of the facility to provide the Resident, Resident's family member and/or the Resident's legal representative, if applicable, in written form and/or by a telephone conversation prior to transfer to a hospital or prior to a Resident beginning therapeutic leave, for a duration of 24 hours or longer; certain information regarding the Resident's facility bed status and how the bed will be "held." **1.What corrective action(s)**	08/19/2024

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	record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident. 2. On 7/30/24 at 9:47 a.m., Resident 31's clinical record was reviewed. Diagnoses included but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), dysphagia (difficulty swallowing), cognitive communication deficit (trouble reasoning and making decisions while communicating), and unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality). Resident 31's transfer form, indicated the resident was sent to the hospital on 4/10/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident and/or the resident representative. During an interview on 8/1/24 at 1:10 p.m., the Interim Director of Nursing (DON) indicated the facility did not provide the residents the notification of Bed-Hold forms in writing. They sent the forms with the resident when they were transferred to another facility. On 8/1/24 at 3:10 p.m., the DON provided the facility's policy,"Bed Hold" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " Policy: It is the policy of the facility to provide the Resident ... in written form and/or by telephone conversation prior to transfer to a hospital ..." 3.1-12(a)(25) 3.1-12(a)(26)		**will be accomplished for those residents found to have been affected by the deficient practice?** ·The SSD/Designee provided the notification bed hold policy to resident 1 and 31 on August 19, 2024 **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. **2.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** ·An in-service has been completed by the DON/Designee on August 16, 2024 for all nursing staff on the bed hold policy. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **3.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?**	

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			The DON/Designee will audit residents transferred to the hospital to verify letter of bed hold policy was given to the resident or resident representative 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **5 By what date the systemic changes for each deficiency will be completed?** August 19, 2024	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure an accurate assessment, reflective of the resident's status at the time of the assessment for 2 of 21 residents reviewed for MDS (Minimum Data Set) assessment accuracy. (Resident 31, Resident 3) Findings include:	F 0641	**F-641** **Accuracy of Assessments. The assessment must accurately reflect the resident's status** **It is the policy of this facility to ensure accurate assessments are reflective of the residents status at the time of the**	08/19/2024

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	1. On 7/30/24 at 9:47 a.m., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), dysphagia (difficulty swallowing), cognitive communication deficit (trouble reasoning and making decisions while communicating), and unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality). The Annual MDS assessment, dated 2/8/24, section A1500, was marked NO for PASARR (PRE-ADMISSION SCREENING AND RESIDENT REVIEW) Level II. Section A1510 (Level II Preadmission Screening and Resident Review (PASARR) Conditions) was not completed. A Notice of PASARR Level II Outcome, dated 10/20/23, indicated, "Final Determination By:.. Determination Date: 10/20/2023, Level II Outcome: Long Term Approval without Specialized Services." On 8/1/24 at 11:30 a.m., the Resident Assessment Instrument (RAI),Version 3.0 User's Manual, 10/2023 was reviewed. For section A1500 of MDS, "Code 1, yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID (Intellectual disability)/DD (Developmental disability) or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASARR) Conditions." During an Interview with the MDS Coordinator on 8/1/24 at 11:40 a.m., she indicated section A1500 on Annual MDS Assessment dated 2/8/24, was		**assessment.** 1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Resident #31 □ MDS were modified by the MDS nurse/designee on August 16, 2024** 2 **How other residents having the potential to be affected by the safe deficient practice will be identified and what corrective action(s) will be taken?** **The MDS nurses/designee completed an audit of MDS assessments for residents with PASARR Level II and resident received parenteral/IV feeding of nutrition outside of the gastrointestinal trac to ensure proper coding on the most recent MDS assessment. Any resident that has an improperly coded MDS will have a correction submitted by 8/19/2024.** **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** **The Regional MDS Nurse/Designee in-service the MDS nurse on MDS accuracy for PASARR Level II and parental/IV feeding on**	

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	marked no and should have been marked as yes. She indicated section A1510, was not completed. She indicated section A1510 should have been completed due to resident having PASARR Level II. 2. On 7/31/24 at 9:27 a.m., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia and spina bifida with hydrocephalus The Quarterly MDS assessment, dated 7/3/24, indicated, section K0520 (Nutritional Approaches), resident received parenteral/IV (intravenous) feeding (intravenous administration of nutrition outside of the gastrointestinal tract) as yes. During an interview with the MDS Coordinator on 8/1/24 11:40 a.m., she indicated the Quarterly MDS assessment dated 7/3/24, section K0520, was marked yes and should have been no, since the resident had not received IV nutrition, since being a resident. 3.1-31(d)		**8/16/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** **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 DON/Designee will audited the MDS assessment for accuracy for residents with a Level II PASARR and resident receiving parental/IV feeding a weekly x 6 months. If the facility is 95% complaint at the end of 6 months, then monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.** **5. By what date systemic changes for each deficiency will be completed?** **August 19, 2024**	

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F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent the development and worsening of facility acquired pressure ulcers for 2 of 6 residents reviewed for pressure ulcers. This deficient practice resulted in worsening and possible infection of an unstageable pressure ulcer and the development of a Stage III pressure ulcer. (Resident 34, Resident 5) Findings include: 1. On 7/31/24 at 2:06 p.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, overactive bladder, and diabetes mellitus. The Braden Scale for Predicting Pressure Ulcer, dated 4/25/24 at 7:52 a.m., indicated the resident was a mild risk for developing a pressure ulcer. The Annual Minimum Data Set (MDS)	F 0686	**TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER** It is policy of this facility to implement interventions and treatment for those residents “at risk” for pressure wounds. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The DON/Designee completed a new Braden Assessment for resident #34 and interventions and care plan updated on August 1, 2024. Resident #5 discharged from the facility on August 1, 2024 2 **How other residents having the potential to be affected by the same deficient**	08/19/2024

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	assessment, dated 5/6/24, indicated she had severe cognitive impairment; was always incontinent of urine; frequently incontinent of bowel movements; was at risk for skin breakdown; did not currently have any pressure ulcers; had no impairments for mobility with the left lower extremity; and was independent with moving in bed from left to right. A care plan, dated 5/9/22, indicated she required assistance with activities of daily living (ADLs) due to dementia. Her interventions were for staff to assist with transfers, toileting, and bed mobility as needed. A care plan, dated 5/16/22, indicated she was at risk for skin breakdown due to diagnosis of overactive bladder and decreased mobility. The interventions were Braden scale quarterly and as needed; keep resident clean and dry; pressure relieving mattress per facility policy; and skin assessment per facility policy. Wound 1: A weekly wound evaluation, dated 6/5/24 at 4:25 p.m., indicated a stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising) wound was identified on the resident's left heel and measured 2.0 centimeters (cm) length (L) X (by) 1.0 cm width (W) X less than (<) 0.1 cm depth (D). The evaluation did not include documentation to indicate a new intervention to provide pressure relief to the left heel was initiated. A nursing progress note, dated 6/5/24 at 4:53 p.m., indicated a wound was identified to the left heel. The note did not include documentation to		**practice will be identified and what corrective action(s) will be taken?** The DON/Designee completed a Braden Assessment for residents, residents that were determined to be a high risk for pressure ulcers were reviewed and interventions and care plans were implemented on August 19,2024 The DON/Designee completed an audit of residents with pressure ulcers on August 19, 2024and interventions and care plans were updated.. 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practices does not recur?** Nursing staff was in-serviced by the DON and/or designee on August 16, 2024 on the policy “Skin Assessments” and “Skin Condition Monitoring” and “ Guidelines for Prevention Treatment of Pressure Injuries “. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 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.** Audit entitled “Pressure Wounds” will be completed by the	

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	indicate a new intervention to provide pressure relief to the left heel was initiated. A nursing progress note, dated 6/12/24 at 4:18 p.m., indicated the facility-acquired stage two pressure ulcer on the left heel deteriorated to an unstageable (the stage of the wound is unclear, the base of the wound is covered by a layer of dead tissue that may be yellow, green, gray, brown or black) pressure ulcer and measured 1.5 cm L X 1.0 cm W X < 0.1 cm depth (D). The wound base was 75 to 99 percent eschar (dead tissue). The note indicated the Nurse Practitioner (NP) recommended for staff to initiate pressure relief interventions to the left heel and bony prominence's but did not include documentation to indicate pressure relief was provided to the left heel. A Care Plan, dated 6/13/24, indicated the resident had an unstageable pressure injury to the left heel with interventions for diet as ordered, low air loss mattress to resident bed, skin checks weekly and as needed, and treatments as ordered. The plan did not include documentation to show interventions for pressure relief were provided to the left heel. The care plan was not developed until eight days after the pressure ulcer was found. A weekly wound evaluation, dated 6/13/24 at 10:23 a.m., indicated the measurements of the wound did not change. The evaluation did not include interventions to provide pressure relief to the left heel were initiated. A nursing progress note, dated 6/19/24 at 6:37 a.m., indicated the facility-acquired unstageable pressure injury on the left heel was stable.		DON/Designee weekly for residents with pressure ulcers. If the facility is within 95% compliance at the end of the 6 months, then monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. 5 **By what date the systemic changes for each deficiency will be completed?** August 19, 2024	

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	A weekly wound evaluation, dated 6/19/24 at 11:33 a.m., indicated the measurements of the wound did not change. The evaluation indicated Medihoney (a debriding dressing) should be applied to the wound. The evaluation did not include interventions to provide pressure relief to the left heel were initiated. A nursing progress note, dated 6/26/24 at 6:39 a.m., indicated the NP identified the facility-acquired unstageable pressure injury on the left heel deteriorated and measured 2.0 cm L X 2.0 cm W X 0.1 cm D. The note indicated the NP recommended for staff to provide pressure relief to the left heel using heel boots when the resident was in bed. A weekly wound evaluation, dated 6/26/24 at 11:54 a.m., indicated the measurement and treatment of the wound did not change. The evaluation did not include interventions for a heel boot or pressure relief to the left heel were implemented. A nursing progress note, dated 7/3/24 at 6:47 a.m., indicated the facility-acquired unstageable pressure injury on the left heel deteriorated and measured 2.0 cm L X 3.0 cm W X 0.1 cm D. The wound base was 50 to 74 percent slough (dead tissue) and 50 to 74 percent eschar. The note indicated pressure relief should be provided with heel boots. The nursing progress did not indicate the interventions for a heel boot or pressure relief to the left heel were implemented. A weekly wound evaluation, dated 7/4/24 at 11:37 a.m., indicated the measurement of the facility-acquired unstageable pressure injury did not change, but the treatment changed to Hydrogel (a primary dressing indicated for			

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	hydrating dry, necrotic, and sloughy wounds). A nursing progress note, dated 7/10/24 at 6:30 a.m., indicated the facility-acquired unstageable pressure injury on the left heel was stable and measured 1.5 cm L X 3.0 cm W X 0.1 cm D. The wound base was 100 percent eschar. The note indicated pressure relief should be provided with heel boots. The nursing progress note did not include documentation the interventions for a heel boot or pressure relief to the left heel were implemented. A weekly wound evaluation, dated 7/11/24 at 11:09 a.m., indicated the facility-acquired unstageable pressure injury measured 1.5 cm L X 1.0 cm W X 0.1 cm D, but the treatment changed to Hydrogel (a primary dressing indicated for hydrating dry, necrotic, and sloughy wounds). A nursing progress note, dated 7/17/24 at 6:41 a.m., indicated the facility-acquired unstageable pressure injury on the left heel improved and measured 1.5 cm L X 2.5 cm W X 0.1 cm D. The wound base was 75 to 99 percent slough and 25 to 49 percent eschar. The note indicated pressure relief should be provided with heel boots. The nursing progress note did not include documentation to indicate the interventions for a heel boot or pressure relief to the left heel were implemented. A weekly wound evaluation, dated 7/17/24 at 3:49 p.m., indicated the facility-acquired unstageable pressure injury measured 1.5 cm L X 2.5 cm W X 0.1 cm D. A nursing progress note, dated 7/24/24 at 6:34 a.m., indicated the NP identified the facility-acquired unstageable pressure injury on			

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	the left heel deteriorated, exhibited signs and symptoms of infection, and measured 3.0 cm L X 2.0 cm W X 0.1 cm D. The note indicated new orders for antibiotic (ATB) therapy, pressure relief with a heel boot at all times, a wound culture, and a low air loss mattress were received. The nursing progress note indicated the wound exudate was foul smelling, 1 to 24 percent slough and 75 to 99 percent eschar. They documentation did not indicate the interventions for a heel boot or pressure relief to the left heel were implemented. A weekly wound evaluation, dated 7/26/24 at 3:25 p.m., indicated the facility-acquired unstageable pressure injury measured 3.0 cm L X 2.0 cm W X 0.1 cm D and the treatment changed to Santyl (a medication for debriding necrotic tissue from wounds). On 7/28/24 at 12:16 p.m., Resident 34 was observed at the dining room table feeding herself. She was observed to be wearing socks on both feet with her feet resting on the floor. No pressure relieving devices were observed on the resident's feet or beside the wheelchair. During an observation on 7/28/24 at 12:16 p.m., Resident 34 was observed sitting at a dining table without a heel boot on the left foot. The left heel was resting on the floor and observed to not have pressure relief. A nursing progress note, dated 7/31/24 at 6:48 a.m., indicated the NP identified the facility-acquired unstageable pressure injury on the left heel deteriorated and measured 5.0 cm L X 3.5 cm W X 0.1 cm D. The wound bed was 1 to 24 percent and 75 to 99 percent eschar. The nursing progress note did not indicate the interventions for a heel boot, pressure relief to the left heel, or a			

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	low air loss (LAL) mattress were implemented. During a continuous observation on 7/30/24 from 10:14 a.m. through 12:16 p.m., Resident 34 was observed sitting in a wheelchair with a wound dressing on the left heel. The resident was observed to not have pressure relieving devices on or near the bilateral lower extremities. The resident was observed to unsuccessfully make significant changes in position to relieve pressure from the left buttock or heel, was observed to bear weight directly on the left heel, and was observed to use the left heel to propel the wheelchair. RN 1 and CNA 1 were observed to help the resident without providing significant position changes or devices to relieve pressure to the left buttock and heel. During an observation on 7/30/24 at 1:40 P.M., Resident 34 was observed lying in bed with the left heel resting on the mattress. A pressure relieving device for the heels was observed in the recliner. During an observation on 7/31/24 at 9:30 a.m., Resident 34 was observed seated in the wheelchair without a heel boot or pressure relief to the left heel. During an interview on 7/31/24 at 10:16 a.m., CNA 4 indicated Resident 34 had a decline in her ADLs. She used to ambulate per self and now required extensive assistance with toileting, transfers, and bed mobility. She had a "large" pressure ulcer to her left heel. Her interventions were a "heels-up" cushion while in bed. During an interview on 7/31/24 at 10:20 a.m., LPN 1 indicated Resident 34's left heel pressure ulcer was worse.			

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	During an observation, on 7/31/24 at 10:27 a.m., Resident 34 was observed to not have a pressure relieving device on the left heel. CNA 3 and CNA 4 were observed to transfer Resident 34 from the wheelchair to the bed and the resident was observed to bear weight on the left heel during the transfer. The bed did not have a low loss air mattress. CNA 4 indicated Resident 34 "had gotten up early and had been up for a while." During an observation on 7/31/24 at 10:30 a.m., the NP indicate the facility-acquired unstageable pressure ulcer on the left heel looked worse, was bigger in size, was approximately the size of a golf ball, was black in the center, and the peri wound was red. During an observation on 8/1/24 at 10:29 a.m., Resident 34 was seated in the wheelchair without a heel boot or pressure relief to the left heel. On 8/1/24 at 11:36 a.m., Resident 34's clinical record was reviewed. - A weekly wound evaluation, dated 8/1/24 at 9:25 a.m., indicated Resident 34 had an in-house acquired unstageable pressure ulcer to left heel. The length was 5 cm L X 3.5 W cm X 0.1 cm D. During an observation on 8/1/24 at 2:48 p.m., Resident 34 was observed to not have a heel boot on the left heel. Resident 34 was observed to propel the wheelchair using both feet. During an interview on 8/1/24 at 2:48 p.m., CNA 5 indicated Resident 34 propels the wheelchair using both feet all the time. During an interview on 8/2/24 at 10:45 a.m., the			

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	ADON indicated that wound culture ordered on 7/24/24 for Resident 34 was not completed due to the facility did not have culture supplies to collect. The ADON indicated the culture tube was expired. The facility called the lab to get another culture tube and the lab indicated they would bring on next lad day. During an interview on 8/2/24 at 11:15 a.m., LPN 1 indicated lab was here today but did not bring a culture tubes. Wound 2: A nursing progress note, dated 7/24/24 at 6:34 a.m. indicated the resident developed a new, facility acquired area of skin impairment on the left buttock (Wound 2) that measured 0.7 cm L X 1.5 cm W X 0.0 cm D. The wound base was 100 percent eschar. A weekly wound evaluation, dated 7/26/24 at 3:37 p.m., indicated Wound 2 was a facility-acquired unstageable pressure injury and measured 0.7. cm L X 1.5 cm W X 0.0 cm D and the treatment was Santyl (a medication for debriding necrotic tissue from wounds). The evaluation did not include sufficient documentation to show interventions for pressure relief to the left buttock were implemented. The pressure relief interventions were pressure redistribution mattress and wheelchair cushion A care plan for an unstageable pressure injury on the left buttock, dated 7/29/24, indicated interventions to administer medications and treatments as ordered, assess, record, and monitor wound healing weekly and report improvements and declines to the physician were implemented. The plan of care did not include documentation to			

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	indicate interventions to provide pressure relief to the left buttock were implemented until 8/1/24 that was when the low air loss mattress was added to the care plan. The care plan was not developed until six days after the pressure injury was discovered. During an observation on 7/30/24 at 1:40 P.M., Resident 34 was observed lying in a supine position (on the back) on the bed with the left buttock resting on the mattress without pressure relief of low loss air mattress A nursing progress note, dated 7/31/24 at 6:48 a.m., indicated the NP identified the facility-acquired unstageable pressure injury on the left buttock measured 1.0 cm L X 1.8 cm W X 0.0 cm D. The note did not indicate the interventions for pressure relief to the left buttock or a low air loss (LAL) mattress were implemented. During an observation on 7/31/24 at 10:30 a.m., the NP indicated the facility-acquired pressure ulcer on the left buttock looked better and was about the size of a quarter. The pressure ulcer was observed to be white surrounding the area and a pink center. During an interview on 7/31/24 at 10:16 a.m., CNA 4 indicated Resident 34 had a decline in her ADLs. She used to ambulate per self and now required extensive assistance with toileting, transfers, and bed mobility. Resident 34 required assistance from staff to relieve pressure of her buttocks while in the wheelchair. Her interventions were to be checked every hour and half for incontinence. During an interview on 7/31/24 at 10:20 a.m., LPN 1 indicated Resident 34's left buttock pressure ulcer was better.			

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	On 8/1/24 at 11:36 a.m., Resident 34's clinical record was reviewed. A weekly wound evaluation, dated 8/1/24 at 9:23 a.m., indicated the facility-acquired unstageable pressure injury on the left buttock measured 1.0 cm L X 1.8 cm W X 0.0 cm D and the treatment did not change. During an interview on 8/1/24 at 11:37 a.m., CNA 6 indicated Resident 34 had a health decline for the last 2 weeks and had spent a lot of time in bed. Resident 34 did not have any pressure relieving devices on her feet while she was in her wheelchair. During an interview on 8/1/24 at 12:45 p.m., the Assistant Directors of Nursing (ADON) indicated on 7/24/24 they had completed skin assessments on all the residents. At that time, they found the pressure ulcer to Resident 34's left buttock. Since the pressure ulcer on left heel had gotten worse, they started the Santyl. She did not indicate any pressure relieving interventions to the left heel while the resident was in the chair or during transfers. On 8/1/24 at 3:45 p.m., the Director of Nursing (DON) provided the facility's policy, "Guidelines for Prevention/Treatment of Pressure Injuries," dated 10/9/23, and indicated it was the policy being used by the facility. A review of the policy indicated,"...Turn and reposition resident who are "at risk" for pressure injury often unless contraindicated. At least every 2 hours is recommended...Pressure ulcers/Pressure injuries are most common on the heels and sacrum.." 2. During an interview on 7/29/24 at 10:15 a.m., Resident 5 indicated she had an open area on her			

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	left upper back from her bra strap. She indicated she had bought new bras, the straps were too tight, and it caused a wound on her left upper back. Resident 5's clinical record was reviewed on 8/1/24 at 12:04 p.m. The diagnosis included, but was not limited to, chronic diastolic congestive heart failure. The Quarterly MDS assessment, dated 6/3/24, indicated Resident 5 had mild cognitive impairment, rolled from left to right independently, and was at risk for developing pressure ulcers. A Weekly Skin Check, completed by the nurse, dated 7/24/24 at 3:58 p.m., indicated the resident did not have loss of skin integrity new or existing. A Skin and Wound Progress Note, from the Nurse Practitioner (NP), dated 7/24/24 at 4:58 p.m., indicated the NP identified a facility-acquired Stage III pressure ulcer on the left upper back size 0.5 cm (centimeters) x 1 cm x 0.1 cm. The NP nurse debrided necrotic tissue from the area, provided wound care, and placed a dressing. The plan for Resident 5 indicated to cleanse with normal saline, apply collagen to the base of the wound, secure with bordered gauze, and change three times per week and prn (as needed). The nursing staff were given detailed ulcer care instructions and asked to monitor the ulcer for any signs or symptoms of prolonged bleeding or debridement intolerance. Recommend ongoing pressure reduction and turning and repositioning precautions per protocol including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with staff at the time of visit.			

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	A Care Plan, initiated 7/25/24, indicated a pressure wound was present to resident left upper back, The interventions included, but were not limited to, treatments as ordered, pressure reducing mattress/cushion in chair, skin checks weekly and as needed. A Weekly Wound Evaluation, dated 7/26/24 at 4:24 p.m., indicated "... Current Treatment: Collagen. Date Treatment Ordered: 7/24/24 ..." The MAR (Medication Administration Record) and the TAR (Treatment Administration Record), dated from 7/24/24 through 7/29/24 did not include documentation to show the wound treatment was administered in accordance with the NP orders until 7/29/24. During an interview on 8/1/24 at 11:25 a.m., CNA 2 indicated Resident 5 did not have a wound on her back. During an interview on 8/1/24 at 11:54 a.m., LPN 2 indicated Resident 5 did not have a pressure on her back. She recently had a biopsy done which was why she had a dressing on. The clinical record lacked any indication Resident 5 had a biopsy to the left upper back. During an interview on 8/1/24 at 12:53 p.m., the Assistant Director of Nursing (ADON) indicated she did not know much about the wound on Resident 5's upper left back. The NP came in and found it. She did not know what it was from and thought possibly it was from the bra or the back of the chair and had been unsure what the interventions were to prevent the wound from getting worse.			

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	155183	A. BUILDING 00 B. WING	08/02/2024

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	An email from the NP to the facility provided by the ADON on 8/1/24 at 3:15 p.m., was reviewed. The e-mail, dated 7/24/24 at 6:02 p.m., indicated, " ... [Resident name] ... Stage III pressure injury on left upper back. See orders: Order date 7/24/24, cleanse with normal saline, collagen, bordered gauze, 3 times per week and as prn ..." During an interview, on 8/1/24 at 3:30 p.m., the DON indicated the treatment order for the facility-acquired unstageable pressure injury on the left upper back was received, on Friday, 7/26/24 at 4:22 p.m. and the receiving nurse scheduled the treatment to be administered on Monday, Wednesday, and Friday day shifts. The DON indicated the facility did not ensure the treatment was initiated between 7/24/24 and 7/28/24. Active physician orders, dated 8/1/24 at 9:38 a.m., for Resident 5 indicated "... Left upper back: cleanse with normal saline. Apply collagen to wound bed only. Cover with bordered gauze every day shift every Monday, Wednesday, Friday for wound healing ..." The order date was 7/26/24 and the start date was 7/29/24. During an interview on 8/2/24 at 10:17 a.m., the NP indicated she found a Stage III pressure ulcer on Resident 5's left upper back, on 7/24/24, while performing rounds with LPN 3. The NP indicated a verbal order was given to LPN 3 and instructions were provided to LPN 3 for the care of the Stage III pressure ulcer. The NP sent an email with written orders in the evening of 7/24/24, for Resident 5's wound care treatment to the upper left back. The NP did not send anything on 7/26/24, as the DON indicated. The facility was responsible for inputting the information from the email into their system so orders can be started.			

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	During an interview on 8/2/24 at 10:42 a.m., LPN 3 indicated she rounded with the NP on 7/24/24, when the Stage III wound was found on Resident 5's upper left back. The NP showed her how to do the dressing change and gave her a verbal order. The NP sent an email later that evening, but she was not sure what time she received it. The facility was responsible for putting the order in the computer when the e-mail comes. She was not sure why the order said 7/26/24 at 4:22 p.m. During an interview on 8/2/24 at 11:54 a.m., the ADON and Minimum Data Set (MDS) Coordinator indicated the facility did not do an IDT meeting nor a Root Cause Analysis when a resident gets a pressure ulcer. The clinical record lacked documentation of an IDT meeting nor a Root Cause Analysis to determine how Resident 5 sustained a Stage III pressure ulcer on her upper left back. On 8/2/24 at 10:15 a.m., the Registered Nurse Consultant provided the facility's policy, "Wound Nurse: What to do for New Skin issues and Week to Week Monitoring" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... Obtain all physician notes from rounds ... Information related to wounds must be taken to the weekly SWAT meeting for review with the IDT team ... Upon notification of the physician, obtain a treatment order ..." A copy of the Interdisciplinary Team Meeting (IDT) notes were asked for from the ADON and not received by survey exit. 3.1-40(a)(1)			

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	3.1-40(a)(2)			
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 provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care. (Resident 44) Findings include: On 7/29/24 at 11:00 a.m., Resident 44 was observed to have her nasal cannula oxygen tubing up on top of the bridged of her nose and it was not labeled with a date or time. On 7/29/24 at 11:30 a.m., the Resident 44's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), chronic obstructive pulmonary disease (COPD), cognitive communication deficit, and dementia. A 1/10/24 physician's order indicated the resident was ordered oxygen via a nasal cannula flowing at a rate of 2 liters per minute.	F 0695	**Respiratory/Tracheostomy Care and Suctioning** **1 What corrective action(s) will be accomplished for those residents found to heave been affected by the deficient practice?** The resident #44 that was affected, the O2 tubing was changed and dated immediately. August 2, 2024 **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents receiving oxygen therapy have the potential to be affected by the deficient practice. **3 What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.**	08/19/2024

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	A 1/14/24 physician's order indicated the resident's oxygen tubing was to be changed weekly on Sunday nights. A Quarterly Minimum Data Set (MDS) assessment, dated 6/7/24, indicated the resident required oxygen therapy. During an observation on 7/30/24 at 10:43 a.m., the resident's oxygen tubing was not labeled. During an observation on 7/31/24 at 9:20 a.m., the resident was observed in the dining room and indicated she was feeling great and she was in a very good mood. Her oxygen tubing was not labeled. During an observation on 8/2/24 at 11:03 a.m., the resident's oxygen tubing was not labeled. During an interview on 8/2/24 at 11:23 a.m., LPN 2 indicated the resident's oxygen tubing was not labeled and was in need of labeling. She further indicated the facility did not have a respiratory therapy department, so it was likely the nursing staff's responsibility, and she did not know when the tubing was changed. On 8/2/24 at 12:24 p.m., the Regional Nurse Consultant provided the facility policy, "OXYGEN ADMINISTRATION," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 4. Tubing ... each will be labeled with date, time and initialed by staff completing this service to equipment ..." 3.1-47(a)(6)		The DON/Designee in-serviced the nursing staff on changing and dating of oxygen tubing, and humidification on a weekly basis and PRN August 16, 2024. Additionally, any staff that fails to comply with points of this will be further educated/disciplined as indicated. **4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.** The DON/Designee will audit 5 residents 5 days a week for 4 weeks, 5 residents 3 days a week for 8 weeks and then 5 residents one day a week for 3 months, with oxygen tubing and humidification dating. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **5 By what date the systemic changes for each deficient will be completed.** August 19, 2024	

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F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 4 residents reviewed for hospitalization. (Resident 31). Finding includes: On 7/30/24 at 9:47 a.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), dysphagia (difficulty swallowing), cognitive communication deficit (trouble reasoning and making decisions while communicating), unspecified dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), and unspecified psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality). The Physician's Orders included, but were not limited to: - Tamsulosin (medication to treat men who have symptoms of an enlarged prostate gland) 0.4 mg (milligrams) 1 capsule by mouth one time a day. - Olanzapine (medication to treat schizophrenia) 10 mg by mouth at bedtime - Olanzapine 5 mg, every morning. The Quarterly MDS (Minimum Data Set) assessment, dated 5/9/24, indicated Resident 31 had moderate cognitive impairment.	F 0760	**Residents are Free of Significant Med Errors** It is the policy of the facility to ensure Residents are free from significant medication errors. Including failing to prevent significant medication errors related to right resident. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #1 was evaluated by the staff in facility and was sent to the hospital for further monitoring related to receiving the wrong medication. Resident did return to the facility with no adverse effects related to receiving wrong medication. April 10, 2024 **2 How other residents having the potential to affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents who reside in the facility have the potential to be affected by this finding. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient**	08/19/2024

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	A History and Physical from the hospital, dated 4/11/24 1:31 p.m., indicated Resident 31 was given another resident's medication. Resident 31 was was given Lyrica (medication to treat nerve and muscle pain, including fibromyalgia. It can also treat seizures) 100 mg; Hydralazine (medication to treat high blood pressure) 50 mg; Oxycontin (a narcotic pain medication to treat moderate to severe pain) 30 mg; Cymbalta (medication to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain) 60 mg; Coreg (medication to treat high blood pressure and heart failure) 12.5 mg; Calcium (medication to treat and prevent low blood calcium, osteoporosis, and rickets) 600/400 mg; Senna (medication to relieve occasional constipation in adults and children) 8.6 mg; Eliquis (an anticoagulant medication) 5 mg. Progress notes included, but were not limited to: - On 4/13/24 at 12:43 a.m., resident was readmitted to facility. - On 4/13/24 at 1:16 p.m., "follow up on incident...resting in bed...will continue to monitor." - On 4/14/24 at 4:11 a.m., "... resident returned to facility following hospital stay, patient appears to be at baseline." During an interview with Executive Director on 8/1/24 10:05 a.m., he indicated the medication error occurred on 4/10/24 for Resident 31. An agency nurse administered the wrong medications to Resident 31.		**practice does not recur?** A facility education completed with staff regarding the five rights of medication administration. **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 will monitor 10 medication passes weekly on random shifts for 4 weeks, then 5 medication passes weekly on random shifts for 4 weeks, and then 5 medication passes weekly on random shifts for 4 months. If the facility is within a 100% compliance rate at the end of the 6 months then monitoring will be stopped. **At an in-service held by the DON/Designee beginning on August 16,2024 for all nurses the following was reviewed:** The five rights of medication administration. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be	

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	During an interview with the Director of Nursing (DON) on 8/1/24 2:54 p.m., she indicated Resident 31 was given the wrong medications on 4/10/24. On 8/1/24 2:54 p.m., DON provided policy and procedure for Medication Administration and UnitedRx Long Term Care Pharmacy Medication Administration Guidelines (dated 2/2017), indicated both policy and guidelines were currently being used by the facility. A review of the policy indicated "Purpose: To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration." Policy indicated ..."1. Licensed professional nurses administer medications according to times documented on the Medication Administration Record (MAR)..., "4. Medication Administration Record will be signed after for each medication administered to the resident..." A review of medication administration guidelines indicated "Purpose: To administer all medications safely and appropriately to aid residents..." ... "3. review the resident's Medication Administration Record." ..."14. Identify resident before administering medication."... 3.1-48(c)(2)		written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **5 By what date the systemic changes for each deficiency will be completed?** **August 19, 2024**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe and sanitary environment 6 of 6 days during the survey. A biohazard room was not secured, the nursing supply room air conditioner vent cover was not free from a dark,	F 0921	**Safe/Functional/Sanitary/Comfortable Environment** **It is the policy of the facility to ensure that the environment provided by the facility is safe,**	08/19/2024

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	damp, powder-like substance, a resident room electrical outlet was not in good repair, resident bathrooms were not free of an odor of urine and feces, and resident toilets were not free of a dark substance around the toilet base. (Nursing Supply Room, Biohazard Room, Resident 29, Resident 36, Resident 42, Resident 1, Resident 8, Resident 6, Resident 49, Resident 30, Resident 41, Resident 35) Findings include: 1. On 7/28/24 at 11:04 a.m. and 7/30/24 at 11:45 a.m., the vent covering on the air conditioner in the nursing supply room was observed to have a dark, moist, powder-like substance on it. During an interview on 7/30/24 at 11:45 a.m., the Administrator indicated there was a dark, damp, black powder-like substance on the air conditioning vent cover. 2. On the following dates and times, the biohazard room near the south nursing station was unsecured and unattended by staff. Inside the room were multiple containers of liquid cleaners, an unlocked refrigerator which contained 4 tubes of resident biological specimens, and a biohazard bin which contained 3 full sharps containers: - 7/28/24 at 11:05 a.m. - 7/29/24 at 1:52 p.m. - 7/30/24 at 10:55 a.m. - 8/2/24 at 10:20 a.m. - 8/2/24 at 11:15 a.m. During an interview on 7/30/24 at 11:15 a.m., the Director of Nursing indicated the biohazard room door was in need of repair in order to be secured when not attended by staff.		**sanitary, functional and comfortable. The surroundings for the residents must also be "homelike" de-emphasizing the institutional character of the setting to the greatest extent possible. The resident is encouraged and assisted to use those personal belongings that support a homelike environment. A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression and encourages links with the past and with family members.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Residents #36, #42, #49, #42, #6, #30, #41,#35, #1 and #8 resident's bathrooms were deep cleaned immediately. Air conditioning vent cover in the nursing supply room was cleaned immediately. **2. How other residents having the potential to be affected by**	

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	3. On 7/29/24 at 10:55 a.m. and 7/31/24 at 2:05 p.m., the electrical outlet between the beds in Resident 29's room was observed to be loose and pulling away from the wall. 4. On the following dates and times the bathroom of Resident 36 and Resident 42 was observed to have a strong odor of urine and feces and a dark substance around the base of the toilet: - 7/29/24 at 12:01 p.m. - 7/30/24 at 2:10 p.m. - 7/31/24 at 2:20 p.m. 5. On the following dates and times the bathroom of Resident 1 and Resident 8 was observed to have a strong odor of urine and feces and a dark substance around the base of the toilet: - 7/29/24 at 12:03 p.m. - 7/30/24 at 2:12 p.m. - 7/31/24 at 2:22 p.m. 6. On the following dates and times the bathroom of Resident 49 and Resident 6 was observed to have a strong odor of urine and feces and a dark substance around the base of the toilet: - 7/29/24 at 12:08 p.m. - 7/30/24 at 2:17 p.m. - 7/31/24 at 2:27 p.m. 7. On the following dates and times the bathroom of Resident 30 and Resident 41 was observed to have a strong odor of urine and feces and a dark substance around the base of the toilet: - 7/29/24 at 12:10 p.m. - 7/30/24 at 2:19 p.m.		**the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the deficit practice, therefore this plan of correction applied to all residents of the facility. **3. What measurses will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All resident rooms will be placed on a deep clean schedule on a monthly basis, as well as all air conditioning vents within the facility will be cleaned and inspected on a monthly basis. **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 Housekeeping supervisor/Designee will audit 3 residents bathrooms 5 days a week for 4 weeks, 3 resident bathrooms 3 days a week for 4	

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	- 7/31/24 at 2:29 p.m. 8 On the following dates and times the bathroom of Resident 35 was observed to have a strong odor of urine and feces and a dark substance around the base of the toilet: - 7/29/24 at 12:11 p.m. - 7/30/24 at 2:20 p.m. - 7/31/24 at 2:30 p.m. During an interview on 7/31/24 at 2:50 p.m., the facility Administrator indicated the resident bathrooms had an odor of urine and feces, toilet caulking was in need of cleaning and repair, and the electrical outlet was loose and in need of repair. This citation relates to Complaint IN00435737. 3.1-19(f)		weeks and then 3 resident bathrooms 1 day a week for 3 months. The housekeeping supervisor/ designee with audit 3 air conditioner vents 5 days a week for 4 weeks, then 3 air conditioner vents 3 days a week for 4 weeks, and then 3 air conditioner vents once a week for 3 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring will be stopped. **5. By what date the systemic changes for each deficiency will be completed?** **August 19,2024**	