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	155290	A. BUILDING 00 B. WING	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00431985 and IN00431697. Complaint IN00431985- No deficiencies related to the allegations are cited. Complaint IN00431697-No deficiencies related to the allegations are cited. Survey dates: April 15, 16, 17, 18 and 19, 2024. Facility number: 000187 Provider number: 155290 AIM number: 100267300 Census Bed Type: SNF/NF: 49 SNF: 9 Residential: 26 Total: 84 Census Payor Type: Medicare: 10 Medicaid: 39 Private: 9 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 26, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by St. Elizabeth Healthcare Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Elizabeth Healthcare Campus. The facility recognizes its obligation to legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0565 SS=D	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristen Patz	Executive Director	05/15/2024

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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Bldg. 00	§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility	F 0565	All resident concerns voiced on	05/10/2024

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	failed to ensure resident council concerns and grievances were addressed and the resolutions to the concerns/grievances were documented in the meeting minutes for 4 of 12 months reviewed for resident council meeting minutes. (July 2023, January 2024, February 2024, March 2024. Finding includes: During the resident council meeting, on 4/17/24 at 10:00 a.m., the residents indicated the call lights continued to be an ongoing concern. The resident council meeting minutes were reviewed and indicated the following: a. On 7/14/23, there were concerns voiced with the call light response times. The resident council meeting minutes, dated 8/14/23, did not indicate the call light concerns from 7/14/23 were discussed and no resolution was included in the meeting minutes. b. On 1/15/24, there were concerns voiced about the call light response times at night being extended. c. On 2/19/24, there were concerns voiced about the call lights in the evening. The minutes did not include the call light concerns from 1/15/24 were reviewed or resolved. d. On 3/18/24, 1 of 2 residents indicated there were still concerns about the call lights. The minutes did not include the call light concerns from 2/19/24 were reviewed or resolved. e. On 4/15/24, the minutes did not include the call light concerns from 3/18/24 were reviewed or resolved.		July 2023, January 2024, February 2024, and March 2024 were addressed with the appropriate department leader and followed up on as appropriate. All residents had the potential to be affected by this alleged deficient practice. Department leaders will be re-in serviced on the policy titled "Resident Council" by Home Office Clinical Support or designee. The Executive Director or designee will audit resident council minutes monthly to ensure grievances are being addressed by the appropriate department leader. The Executive Director or designee will report findings to QAPI for 6 months or until 100% compliance is obtained.	

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	During an interview, on 4/17/24 at 10:09 a.m., Resident 28 indicated she had to put her call light on several occasions for her roommate. The call light would stay on for an hour or more. The call lights have continued to be an ongoing issue. During an interview, on 4/17/24 at 10:11 a.m., Resident 41 indicated the call lights would stay on for 30 minutes to 1 hour before they were answered. There were times the lights were not answered, and she would provide her own care. During an interview, on 4/17/24 at 10:20 a.m., Resident 3 indicated during several resident council meetings the call lights concerns were discussed. The resident considered his call light as his lifeline and there were times the staff would exit the room without making sure the call light was within his reach. During an interview, on 4/18/24 at 10:39 a.m., the Activity Director indicated she helped the residents fill out the grievances when they had a concern, and she did not know why the call light concerns had not been addressed. During an interview, on 4/18/24 at 3:10 p.m., the Director of Nursing Services (DNS) indicated she did not have documentation call light audits were completed. A current policy, titled "Resident Council," dated 6/2/16 and received from Executive Director on 4/19/24 at 4:53 p.m., indicated "...Patients are informed of council meetings and are encouraged to utilize the complaint resolution process...The group facilitator will determine the pervious of the concerns/recommendations voiced to determine appropriate follow-up. The group's grievances and recommendations will be brought to the			

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	attention of the Executive Director who will forward the concerns to the appropriate department leader for attention and response. Responses regarding resolutions will be documented, reviewed by the Executive Director, and kept with Resident Council minutes...Actions taken and/or considerations given to issues will be reported back to the Resident Council at the next meeting. A current policy, titled "Your Rights and Protections as a Nursing Home Resident," not dated and received from Executive Director at entrance indicated "...Make Complaints: You have the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment. The nursing home must address the issue promptly...." A current policy, titled "Resident Concern Process," dated 11/13/19 and received from Executive Director on 4/19/24 at 4:59 p.m., indicated "...To provide a process of handling, tracking and resolving customer concerns to provide excellence in customer service...The facility staff will follow these basic steps in responding to a complaint: Listen to the concern without interruption...Take steps to correct the problem. Make the problem their own by following up to make sure it is resolved and stays resolved...Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution...The Executive Director will review and manage the follow up of the concerns...The QAPI team will review the trends of the concerns and the action plans to resolve concerns on a monthly basis...." 3.1-3(l)			

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

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	the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to ensure the Notice of Medicare Non-Coverage was given 48 hours prior to the Medicare benefits ending date for 2 of 3 residents reviewed for beneficiary notices. (Resident 38 and 101) Findings include: 1. The Notice of Medicare Non-Coverage (NOMNC) for Resident 38 indicated the Medicare services would end on 3/13/24 and Medicare probably would not pay for Skilled Nursing and Therapy after 3/13/24. Resident 38 signed the NOMC on 3/12/24. This was only a 24-hour notice prior to the end of the Medicare covered services. 2. The NOMNC for Resident 101 indicated the Medicare services would end on 3/5/24 and Medicare would probably not pay for Skilled Nursing and Therapy after this date. Resident 101 signed the NOMNC on 3/4/24. This was only a 24-hour notice prior to the end of the Medicare covered services.	F 0582	Residents #38 and #101 were affected by the alleged deficient practice. There were no adverse effects related to alleged deficient practice. An audit was completed immediately of all resident Notices of Non-Coverage. No additional deficiencies were found. An audit was completed immediately of all resident Notices of Non-Coverage. No additional deficiencies were found. Notices of Non-coverage will be completed and reviewed with each corresponding resident and/or POA. The letter will be reviewed by the Business office Manager (BOM)/Administrator for complete documentation prior to issuing. As a measure of on-going compliance, the BOM or designee will review all Notices issued	05/10/2024

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	During an interview, on 4/19/24 at 12:43 p.m., the Executive Director (ED) indicated the staff who completed the notices was out of the facility on leave and was not able to be interviewed. The ED did not know the reason the notices were only given with a 24-hour notice instead of the 48-hour notice required. A current policy, titled " NOMNC Completion SOP [Standard Operating Procedure]," dated last reviewed on 12/31/23 and received from the ED on 4/19/24, indicated "...In order to streamline communication for completion of Notice of Medicare Non-Coverage [NOMNC]...this SOP outlines the expectations for completion...For residents being notified of discontinuation of their Medicare coverage, the NOMNC is required to be issued 2 calendar days prior to the actual discharge from Medicare...." 3.1-4(f)(3)		weekly X 4 weeks, then monthly X 5 months and report to the facility QAPI committee. The results of the audits will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months. On-going monitoring will continue beyond 6 months, if warranted until 100% compliance is achieved.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents			

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	and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure a revised Preadmission Screen and Resident Review (PASARR) level I was completed after psychotropic medications were prescribed for 1 of 5 residents reviewed for PASARR. (Resident 40) Finding includes: The clinical record for Resident 40 was reviewed on 4/16/24 at 4:39 p.m. The diagnoses included, but were not limited to, depression, anxiety disorder, dementia, congestive heart failure, and hypertension. A PASARR level I, dated 3/1/24, indicated the resident did not require a level II. The PASARR level I indicated the resident was not taking any mental health medications and did not have a mental health diagnosis. The level I screen indicated if changes occurred or new information refuted these findings a new screen must be submitted. A physician's order, dated 3/27/24, indicated duloxetine delayed release (an antidepressant) 30 milligram (mg), give one capsule twice a day for depression. A care plan, dated 3/27/24, indicated the resident was at risk for developing adverse effects from the use of antidepressant medications. The approaches included, but were not limited to, administering medication per the physician's order.	F 0644	Resident 40 remains in the campus and did not experience any adverse effects. Residents receiving antipsychotic medications will be reviewed for PASARR completion and documentation and appropriate diagnosis. SSD has been educated on PASARR screening requirements. All referrals will be assessed for a need of a PASARR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASARR completed and ensure they have an appropriate dx for the medication(s). As a measure of ongoing compliance, SSD will review 5 residents 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a quality measure, the	05/14/2024

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	During an interview, on 4/18/24 at 3:34 p.m., the Executive Director indicated the Social Service Director was on vacation and she would have to look at the resident's PASARR information. During an interview, on 4/18/24 at 4:57 p.m., the Clinical Support Nurse indicated the level I was completed on 3/1/24 and the medication was not started until 3/27/24. The facility policy indicated the facility had a total of 14 days to complete a new PASARR level I and they were beyond 14 days. A new PASARR level I should have been completed. The facility did not have a PASARR policy. The facility used the Indiana PASARR Standard Operating Procedure Revenue Billing & Collections. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0684 SS=E 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 assess and document the progress of a non-pressure skin wound, to assess and document the skin condition of a resident with a splint in place, to notify the	F 0684	Residents 16, 29, 31,23, and 37 all remain in campus. Residents were immediately assessed with any findings updated in their record and provider notifications	05/14/2024

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	physician when blood sugar readings were elevated, failed to follow the physician's orders for medications and to notify the physician per the physician's order for 5 of 5 residents reviewed for quality of care. (Resident 23, 37, 31, 29 and 16) Findings include: 1. During an observation, on 4/16/24 at 11:13 a.m., Resident 23 had a bandage on her right and left elbows and another bandage on her left forearm. She indicated the bandages on the elbows were used as a preventative. She had an area of open skin on the left forearm. The clinical record for Resident 23 was reviewed on 4/17/24 at 11:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, depression, chronic obstructive pulmonary disease, and congestive heart failure. A progress note, dated 2/25/24 at 7:33 p.m., indicated the resident had an open area on her left arm which measured 3.1 centimeter (cm) in length and 2 cm in width. A physician's order, dated 2/26/24, indicated to clean the left forearm skin tear with cleanser or normal saline, apply skin prep to the peri wound, apply aquacel AG (an antimicrobial wound dressing) to the wound bed and to cover with a foam dressing every 5 days. The electronic health record (EHR) had no documentation of the open skin area since 2/25/24. During an interview, on 4/17/24, the Director of Nursing Services (DNS) indicated the resident had		made. Residents did not experience any adverse effects related to alleged deficient practice. All residents have the potential to be affected. All nurses educated on skin impairment guidelines, medication administration guidelines, and physician-provider notification guidelines. All residents were assessed for any skin impairments with any findings updated in the record and appropriate notifications made. All residents with medication orders with administration parameters have been reviewed to ensure MD notification and parameters followed with provider updated of findings. As a measure of on-going compliance, the Director of Health Services (DHS) or designee will complete audits of 3 residents, as available, requiring medication administration with parameters in addition to appropriate notification 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. The DHS or designee will complete head to toe skin assessments for any impairments on 5 residents 3 times weekly x 4	

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	a skin issue which was caused from a hospitalization. She was not sure if the EHR had any documentation about the skin area after the initial measurements were entered on 2/25/24. During an interview, on 4/19/24 at 2:41 p.m., the DNS indicated she measured the left forearm wound two days ago and put in a late note. The wound should have been assessed and measured weekly since 2/25/24 when it was identified, and it had not been measured. 2. During an observation, on 4/16/24 at 12:04 p.m., Resident 37 had a left hand/wrist splint device in place which was wrapped with an elastic bandage. The resident's left wrist, hand and fingers were swollen. The resident indicated she broke her hand, and it was hurting. During an observation, on 4/17/24 at 11:25 a.m., the resident's left hand and fingers remained swollen. The clinical record for Resident 37 was reviewed on 4/18/24 at 2:09 p.m. The diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance and hypertensive heart disease with heart failure. A physician's order, dated 4/8/24, indicated to monitor for blanching, color and odor related to the non-removable splint/cast three times a day. The electronic health record (EHR) did not have any documentation of edema for the resident's left wrist, hand, and fingers. During an interview, on 4/18/24 at 3:11 p.m., the Executive Director (ED) indicated the resident had self-ambulated in the hallway, had an unwitnessed		weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	

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	fall, and sustained a fracture of the left radius (one of two bones of the forearm). During an interview, on 4/19/24 at 3:04 p.m., the DNS indicated the resident was followed by the orthopedic physician. She could not find documentation about the resident's swollen fingers and hand. The facility did not have any notes from the orthopedic physician. There was no care plan in place for the resident's fracture. During an observation with the DNS, on 4/19/24 at 3:27 p.m., the resident was lying in bed in her room. The resident's left hand and left fingers were very swollen. There was an open area on the left hand near the thumb which was about the size of a dime. The DNS indicated an edema event should have been initiated in the EHR and the open skin should have been measured and documented in the EHR. The DNS could not find any documentation in the EHR about the swelling.3a. The clinical record for Resident 31 was reviewed on 4/18/24 at 12:22 p.m. The diagnoses included, but were not limited to, pneumonia, type 2 diabetes mellitus, chronic anemia, dementia, pleural effusion, atelectasis (partial collapse or closure of part of the lung), and diastolic congestive heart failure. A care plan for Resident 31, dated 3/27/24, indicated the resident was at risk for hypo/hyperglycemia related to diabetes mellitus. A long-term goal indicated the resident would be free of symptoms of hypo/hyperglycemia through the next review. A physician's order, dated 3/8/24, indicated insulin Aspart U-100 per sliding scale and to call MD if blood sugar was greater than 400 mg/dL.			

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	155290	A. BUILDING 00 B. WING	04/19/2024

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	A progress note, dated 3/8/24 at 5:20 p.m., indicated Resident 31 had a blood glucose level of 591 prior to dinner. The physician was called and gave a new order for NovoLog 6 units now and to recheck the blood glucose in 2 hours. If the repeat blood sugar was in normal range, the nurse did not need to call the provider. A vitals record, dated 3/8/24 at 4:49 p.m., indicated a blood sugar of 591 mg/dL. A vitals record, dated 3/8/24 at 7:52 p.m., indicated a blood sugar of 460 mg/dl. The listed acceptable (normal) range was 45-300 mg/dl. A vitals record dated 3/8/24 at 9:18 p.m. indicated a blood sugar of 460 mg/dl. The listed acceptable (normal) range was 45-300 mg/dl. The electronic medical record did not contain any physician notifications for the repeat blood sugars. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification of the abnormal repeat blood sugars of 460 mg/dL. 3b. A physician's order, dated 2/29/24 and discontinued 3/8/24, indicated Novolin 70-30 FlexPen (insulin nph and regular human) give 8 units subcutaneous each morning and 3 units each evening. A physician's order, dated 3/8/24 and discontinued 3/19/24, indicated Levemir FlexPen (insulin detemir u-100) insulin pen give 10 units subcutaneous twice a day.			

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	The electronic medical record did not contain hold orders for the Novolin 70-30 or the Levemir. A vitals record, dated 3/7/24 at 10:57 a.m., indicated a blood sugar of 349 mg/dL. The acceptable range listed was 45-300 mg/dL. A vitals record, dated 3/7/24 at 4:38 p.m., indicated a blood sugar of 286 mg/dL. The Medication Administration Record (MAR) for Resident 31 indicated the Novolin 70-30 insulin was held on 3/7/24 in the morning and the evening due to poor intakes. The MAR for Resident 31 indicated the Novolin 70-30 insulin was held on 3/8/24 in the morning due to poor intakes. The electronic medical record did not contain any physician notifications for the held insulin. During an interview, on 4/19/24 at 12:02 p.m., LPN 1 indicated she was not sure when or if 70/30 or Levemir should be held if there was not a specific order. She would look it up with her resources or ask the physician before holding it. The physician should be notified if a medication was held. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification for the held insulin. The endocrinology textbook chapter by Robert J Rushakoff, MD in Inpatient Diabetes Management (01/07/19) from https://www.ncbi.nlm.nih.gov/books/NBK278972/, accessed on 04/19/24, indicated basal insulin, such as Novolin 70-30 and Levemir, was needed			

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	even when a patient was not eating. 4. The clinical record for Resident 29 was reviewed on 4/16/24 at 3:52 p.m. The diagnoses included, but were not limited to, type 2 diabetes with diabetic chronic kidney disease, acute kidney failure, and atrophy (wasting away) of the kidney. A physician's order, with a start date of 5/23/23 and an end date of 7/26/23, indicated the resident received insulin glargine (insulin which works over a longer period of time) 12 units before breakfast. Hold the insulin if the blood sugar was less than 150. Resident 29's MAR (Medication Administration Record) indicated the following blood sugars: a. On 7/3/24, the blood sugar was 139. Insulin was administered. b. On 7/4/24, the blood sugar was 124. Insulin was administered. c. On 7/7/24, the blood sugar was 138. Insulin was administered. d. On 7/8/24, the blood sugar was 146. Insulin was administered. e. On 7/11/24, the blood sugar was 112. Insulin was administered. f. On 7/13/24, the blood sugar was 148. Insulin was administered. g. On 7/14/24, the blood sugar was 137. Insulin was administered. h. On 7/15/24, the blood sugar was 148. Insulin was administered. During an interview, on 4/18/24 at 10:47 a.m., the DHS (Director of Health Services) indicated they should not have administered the insulin. 5a. The clinical record for Resident 16 was reviewed on 4/17/24 at 9:42 a.m. The diagnoses			

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	included, but were not limited to, long term current use of insulin, bradycardia (slow heart rate), paroxysmal atrial fibrillation, ventricular premature depolarization, and type 2 diabetes mellitus. A physician's order, dated 7/9/21, indicated digoxin tablet (used to treat heart failure and heart rhythm problems), give 125 micrograms (mcg) every other day, with special instructions to hold the medication if her pulse was less than 60 and to notify the physician. The Medication Administration Record (MAR) indicated, on 3/19/24, Resident 16's pulse was 51 and the digoxin tablet was given. The MAR indicated, on 4/12/24, Resident 16's pulse was 56 and the digoxin tablet was given. The MAR indicated the digoxin was held due to a pulse rate less than 60 on 3/23/24, 3/31/24, and 4/14/24. The clinical record did not indicate the provider was notified of the pulse rate less than 60 or when the digoxin was given and not given according to the physician's order. During an interview, on 4/18/24 at 10:27 a.m., LPN 1 indicated staff would call or notify the physician in person for an abnormal vital sign, blood sugar, or if a medication was held. The staff should notify the provider as soon as they could. During an interview, on 4/18/24 at 1:30 p.m., the Clinical Support Nurse indicated the facility could not provide any documentation of the physician notification of the heart rate or the medication being held.			

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	2b. A physician's order, dated 1/15/24, indicated insulin aspart U-100 insulin pen, give 5 units subcutaneous prior to meals, with special instructions to hold if the blood sugar was less than 110 mg/dL. The MAR, dated 3/19/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 105 at 7:05 a.m. The MAR, dated 3/26/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 83 at 7:17 a.m. The MAR, dated 3/27/24, indicated 5 units of insulin were given at breakfast with a blood sugar of 108 at 7:48 a.m. A current policy, titled "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines," dated as revised on 5/10/16 and received from the Executive Director on 4/19/24 at 4:00 p.m., indicated "...One weekly follow-up assessment may be completed to ensure rash/lesion is resolved, healing, or becomes a chronic skin condition. If further follow-up is needed, documentation may be placed in a progress note...." A current policy, titled "Medication Administration- General Guidelines," dated as revised on 11/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated "...Medications are administered in accordance with written orders of the prescriber...." A current policy, titled "Physician-Provider Notification Guidelines," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated "...To			

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	ensure the resident's physician or practitioner...is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care....Attempts to notify the physician/provider and their response should be documented in the resident electronic medical record...." 3.1-37(a)			
F 0695 SS=E 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 oxygen tubing was dated, oxygen canisters were filled, and the oxygen was set on the flow liter as ordered by the physician for 3 of 4 residents reviewed for respiratory care. (Resident 23, 31 and 20) Findings include: 1. During an observation, on 4/16/24 at 11:06 a.m., Resident 23's oxygen (02) was set at 3 liters per minute by nasal cannula and there was no date on the tubing. The resident indicated her 02 was supposed to be set at 3 liters per minute. During an interview, on 4/16/24 at 11:08 a.m.,	F 0695	Resident 23, 31, 20 were affected by the alleged deficiency. The affected residents' tubing were properly dated, filled with oxygen, and set at the ordered flow liter on 4/19/24. All residents on oxygen have the potential to be affected. Audit of all residents on oxygen to ensure the oxygen tubing is properly dated, o2 canisters are filled, and o2 is set at the ordered flow liter by May 14, 2024 by the DHS/designee. Nursing and care staff have been educated on the dating of oxygen	05/14/2024

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	Qualified Medication Aide (QMA) 2 indicated the oxygen tubing was not dated. During an observation, on 4/18/24 at 3:31 p.m., with the Clinical Support Nurse, Resident 23's 02 was set at 1.5 liters. During an interview, on 4/18/24 at 4:02 p.m., the Clinical Support Nurse indicated the resident's 02 was to be set at 2 liters during the day and 3 liters at night. The 02 should have been set at 2 liters instead of the 1.5 liters or 3 liters. The clinical record for Resident 23 was reviewed on 4/17/24 at 11:40 a.m. The diagnoses included, but were not limited to, chronic congestive heart failure, chronic obstructive pulmonary disease, chronic respiratory failure, shortness of breath, sarcoidosis (an inflammatory disease which affects the lungs), cerebral infarction, and dependence on supplemental oxygen. A care plan, dated 3/26/24 and last reviewed on 4/16/24, indicated the resident had a potential for shortness of breath related to the chronic obstructive pulmonary disease and required supplemental oxygen to maintain 02 saturations. The approaches included, but were not limited to, administer 02 as ordered by the medical doctor. A care plan, dated 3/26/22 and last reviewed on 3/28/24, indicated the resident had a potential for complications related to congestive heart failure. The approaches included, but were not limited to, oxygen as ordered by the medical doctor. A physician's order, dated 1/19/23 and open ended, indicated to change the 02 tubing monthly on the first day of the month.		tubing, ensuring o2 portables are filled, and setting o2 at flow liter as ordered on May 8. 2024. As a measure of ongoing compliance, the DHS or designee will complete rounding audit on 5 residents receiving oxygen weekly x 4 weeks to ensure all tubing is properly dated and oxygen is set on correct dosage as ordered, then every other week for 2 months, then monthly for 3 months The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	

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	A physician's order, dated 3/8/23 and open ended, indicated 02 at 3 liters during the night. A physician's order, dated 4/16/24 and open ended, indicated 02 at 2 liters per nasal cannula continuous.2. During an observation, on 4/15/24 at 12:45 p.m., Resident 31 was wearing oxygen tubing connected to an empty portable oxygen tank. During an interview, on 4/15/24 at 12:49 p.m., CNA 10 indicated the portable tank was empty and the resident relied on supplemental oxygen. CNA 10 indicated she would fill up the tank. During an observation, on 4/16/24 at 10:28 a.m., the portable oxygen tank for Resident 31 was empty and the flow rate dial was set on 2.5 liters while he was sitting in the activities room in his reclining wheelchair (Broda chair). The nurse was notified. LPN 9 took the portable oxygen tank off Resident 31's Broda chair and refilled tank. LPN 9 returned the refilled portable oxygen tank to Resident 31 and reconnected the oxygen tubing. The flow rate remained at 2.5 liters of oxygen. During an observation, on 4/16/24 at 3:53 p.m., the oxygen tubing was not dated, and the flow rate was set at 3 liters. During an observation, on 4/17/24 at 3:31 p.m., Resident 31 was in bed, the oxygen tubing was not dated, and the flow rate was set at just under 3 liters of oxygen. During an observation, on 4/18/24 at 10:07 a.m., Resident 31 was asleep in his Broda chair in the activities room with the portable oxygen tank dial set at a flow rate of 2.5 liters.			

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	During an observation, on 4/18/24 at 2:36 p.m., Resident 31 was asleep in his room with the oxygen set on a flow rate of 2.5 liters. The clinical record for Resident 31 was reviewed on 4/18/24 at 12:22 p.m. The diagnoses included, but were not limited to, pneumonia, type 2 diabetes mellitus, chronic anemia, dementia, pleural effusion, atelectasis (partial collapse or closure of part of the lung), and diastolic congestive heart failure. A physician's order, dated 3/26/24, indicated 2 liters of continuous oxygen. A care plan, dated 4/16/24, indicated the resident required supplemental oxygen to maintain oxygen saturation. Interventions included, but were not limited to, administering oxygen per the physician's order. During an interview, on 4/18/24 at 10:23 a.m., LPN 1 indicated Resident 31 was on 2 to 3 liters of oxygen, only the nurses were allowed to adjust the oxygen flow rate, and the rate was to be set on the flow rate ordered by the physician. 3. During an observation, on 4/16/24 at 10:04 a.m., Resident 20's oxygen was at a flow rate of 5 liters with extended tubing which was not labeled with a date. During an observation, on 4/16/24 at 4:15 p.m., Resident 20 was wearing oxygen at a flow rate of 4 liters via nasal canula tubing which was not labeled with a date. During an observation, on 4/17/24 at 10:10 a.m., Resident 20 was wearing oxygen at a flow rate of 5 liters.			

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	During an observation, on 4/17/24 at 3:28 p.m., Resident 20 continued to wear oxygen at a flow rate of 5 liters. During an interview, on 4/17/24 at 10:10 a.m., Resident 20 indicated he would ask staff to turn up his oxygen when he was having trouble breathing, which happened a lot. The clinical record for Resident 20 was reviewed on 4/17/24 at 4:56 p.m. The diagnoses included, but were not limited to, type 2 diabetes, morbid obesity, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), paroxysmal atrial fibrillation, anxiety, cardiomegaly, dependence on continuous supplemental oxygen, pneumonia, pulmonary edema, and anemia. A profile care guide in the resident's care plan, dated 7/21/23, indicated an intervention of oxygen at 3 liters. A physician's order, dated 4/7/24, indicated 3 liters of continuous oxygen. During an interview, on 4/18/24 at 10:23 a.m., LPN 1 indicated Resident 20's oxygen order prior to his last hospital visit was for 3 to 5 liters for his comfort. LPN 1 indicated she did not realize it had changed to 3 liters. A current policy, titled "Administration of Oxygen," dated as approved on 5/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated "...Verify physician's order for the procedure...Date the tubing for the date it was initiated...Adjust the oxygen delivery device so that...the proper flow of oxygen is			

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	administered...." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure expired medications were removed from the medication cart and medications were labeled for 1 of 3 medication carts reviewed for medication storage. (500 back hall medication cart)	F 0761	No residents were affected by alleged deficient practice. All nurses educated on medication storage. All medication carts were immediately reviewed with all	05/14/2024

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	Finding includes: During an observation, on 4/18/24 at 11:08 a.m., the 500 back hall medication cart had a partial bottle of Robitussin DM with an expiration date of 2/22/24, and a partial bottle of Geri tussin Liquid 100/5 with an expiration date of 3/18/24. The bottom drawer contained a partial bottle of Tums unlabeled, 2 tubes of Diclofenac sodium topical gel 1% unlabeled, and a partial bottle of Childrens Tylenol with a resident's name in marker and not labeled. During an interview, on 4/18/24 at 11:30 a.m., QMA 11 indicated she did not know what resident(s) were receiving the Tums and Diclofenac gel. The expired medications should have been removed. She took expired medications to the Director of Nursing Services for destruction. A current policy, titled "Medication and Storage in the facility," received from the Clinical Support Nurse on 4/19/24 at 9:30 a.m., indicated "...outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or with secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal...." A current policy, titled "Medication Administration-General Guidelines," dated 11/2018 and received from the Clinical Support Nurse on 4/18/24 at 1:30 p.m., indicated "...label, container and contents are checked for integrity, and compared against the medication administration record by reviewing the 5 rights...prior to administration of any medication, the medication and dosage schedule on the resident's medication		expired or unlabeled medications removed and destroyed per policy. As a measure of ongoing compliance, Director of Health Services or designee to check 2 medication carts for appropriate medication storage 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	administration record are compared with the medication label...." 3.1-25(l)(1) 3.1-25(o)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			

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	(ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure staff followed	F 0880	Residents 2 and 21 were affected by alleged deficient	05/14/2024

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	infection control standards related to handwashing during food service, following enhanced barrier precautions during wound care, during incontinence care, for urinary catheters, for storing linens and clothes in rooms, and disposing of soiled linens for 6 of 6 staff and 3 of 3 residents randomly observed for infection control practices. (Assistant Food Director, Guest Relations 5, Director of Health Services, RN 6, QMA 2, Resident 40, Resident 5, Resident 149 and CNA7) Findings include: 1. During an observation, on 4/15/24 at 12:12 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:15 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:17 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/15/24 at 12:21 p.m., the Assistant Food Director served a plate of food to a resident without washing his hands between serving plates. During an observation, on 4/18/24 at 12:19 p.m., Guest Relations 5 was waving her apron towards her face as a fan and scratched her arm while she was waiting to serve food. During an observation, on 4/18/24 at 12:23 p.m.,		practice. Residents remain in the campus and did not experience any adverse effects related to alleged deficient practice. All residents have the potential to be affected. All staff were educated on hand hygiene. All clinical staff were educated on Enhanced Barrier Precautions, indwelling catheters, and perineal care. As a measure of ongoing compliance, Director of Health Services (DHS) or designee will observe high contact care requiring enhanced barrier precautions to ensure proper infection control practices are followed on 2 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. The Executive Director (ED) or designee will observe meal service on varying days and times for appropriate hand hygiene 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. The DHS or designee to observe perineal care for appropriate hand hygiene and linen handling on 2 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months.	

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	Guest Relations 5 served a plate of food to a resident without washing her hands. During an interview, on 4/18/24 at 12:28 p.m., the Assistant Food Director indicated he did notice he was not washing his hands between serving plates and he should have been washing his hands. Staff should also not touch their arms or surfaces before delivering trays. 2. During an observation, on 4/18/24 at 2:43 p.m., the DHS (Director of Health Services) and RN 6 went to complete wound care for Resident 2 who had a stage 3 or 4 pressure wound, a urinary catheter, and was in enhanced barrier precautions. The DHS and RN 6 walked into the room and put on gloves. They completed wound care and then changed the resident's brief, handling the resident's catheter tubing in the process. The DHS and RN 6 did not have a gown on during wound care. The clinical record for Resident 2 was reviewed on 4/18/24 at 3:00 p.m. The diagnoses included, but were not limited to, stage 3 pressure ulcer of the left buttocks, unstageable pressure ulcer of the sacral region, paraplegia, and osteomyelitis. A physician's order, with a start date of 4/1/24, indicated staff were to use enhanced barrier precautions, wearing gloves and a gown at a minimum during high-contact care activities. During an interview, on 4/18/24 at 3:06 p.m., the DHS indicated they should have put on gowns on for enhanced barrier precautions.3. During an observation of incontinence care for Resident 21, on 4/15/24 at 1:43 p.m., Qualified Medication Aide (QMA) 2 wiped the resident's peri-area with a		The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	

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	disposable wipe. QMA 2 did not remove her gloves. She then pulled up the resident's blankets and tucked them in around her neck and chest area and handed the resident her touch pad call light. She had touched the blankets and the call light with the same gloves she used to wipe the resident's peri-area. During an interview, on 4/15/24 at 1:53 p.m., QMA 2 indicated she did not realize she had left the same gloves on and touched the resident's blankets and call light. The DNS was present and QMA 2 and the DNS walked away and did not go back into the resident's room to sanitize the touch pad call light.4. During an observation, on 4/15/24 at 11:32 a.m., Resident 40's catheter bag was laying on the floor. During an interview, on 4/15/24 at 11:38 a.m., the Executive Director indicated the catheter bag was not to be on the floor and she would get someone to assist the resident. 5. During an observation, on 4/15/24 at 11:49 a.m., Resident 5 had two pillows, a blanket, and one blue sock on the floor next to the bed. In the recliner next to the resident's bed, there were folded linen sheets, a quilt, a shirt, a gown, a blanket and two blue cushions. During an interview, on 4/15/24 at 11:54 a.m., CNA 8 indicated the pillows, the blanket, and the sock should not be on the floor and the other items should not be stored on the chair. 6. During an observation, on 4/15/24 at 11:58 a.m., Resident 149 had a soaked brief laying on the resident's bed. During an interview, on 4/15/24 at 11:47 a.m., the			

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	Minimum Data Set (MDS) Coordinator indicated she did not know why the brief was on the resident's bed. The resident was dependent on all incontinence care and the dirty brief should not have been left on the resident's bed. 7. During an observation, on 4/15/24 at 3:08 p.m., CNA 7 exited Room 518 carrying a large amount of rolled up linen not in a bag down the 500 hall. The linen was touching the staff's left side while she carried the linen. CNA 7 then entered Room 516 and left the room with the linen in a trash bag. During an interview, on 4/15/24 at 3:10 p.m., CNA 7 indicated she had just finished changing a resident and forgot to put the linen in a trash bag and she probably should not be carrying dirty linens down the hall without being in a trash bag. A current policy, titled "Enhanced Barrier Precautions (EBP) Standard Operating Procedure," dated as approved 4/1/24 and received from the Clinical Support Nurse on 4/18/24 at 5:00 p.m., indicated "...Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO acquisition which include i. All Residents with chronic wounds, including but not limited to, pressure ulcers...All residents with indwelling medical devices 1. Includes but not limited to: catheters...At minimum, staff shall wear gloves and gowns during high-contact care activities...." A current policy, titled "Preserving Dignity with Indwelling Catheter," dated as revised 4/19/24 and received from the Executive Director on 4/19/24 at 4:55 p.m., indicated "...Urinary drainage bags and catheter tubing should be kept from touching the			

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	floor surface...." A current policy, titled "Guidelines for Handwashing/Hand Hygiene," dated as revised 2/9/17 and received from the Executive Director on 4/19/24 at 4:55 p.m., indicated "...All health care workers shall utilize hand hygiene frequently and appropriately...Health Care Workers (HCW) shall utilize hand hygiene at times such as: Reporting to work; before/after eating...Before/after preparing/serving meals, drinks, tube feedings, etc...before/after having direct physical contact with residents...After removing gloves worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes...." A current policy, titled "Perineal Care for Incontinence," dated as revised 11/9/17 and received from the Executive Director on 4/16/24 at 10:38 a.m., indicated "...Residents may be cleaned using washcloths, wet wipes or dry wipes...Pay particular attention to infection prevention and control techniques when performing peri care, to prevent introduction of contamination that may lead to a urinary tract infection...." 3.1-18(b)(1) 3.1-18(l)			
F 0921 SS=D 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, interview and record review, the facility failed to ensure resident rooms and hallways were in good repair and rooms were free of odors for 5 of 28 rooms observed for environment on the 500 hall. (Room 509, 512, 517,	F 0921	Residents in room 509, 512, 517, 518, 519 were affected by the alleged deficiency. The facility conducted a whole house, on April 19, 2024, of observing facility	05/14/2024

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	518 and 519). Findings include: 1. During an observation, on 4/15/24 at 11:20 a.m., the doorway of Room 509 was missing approximately 18 inches of carpet. The hall between Rooms 514 and 516 had two gold floor plates which were missing pieces of carpet around them. During an interview, on 4/15/24 at 3:37 p.m., the Maintenance Director indicated there were no purchase orders for the carpet in Room 509 or the 500 hall. 2 During an observation, on 4/15/24 at 3:37 p.m., Room 512's bed was very loud when moving up and down. During an interview, on 4/15/24 at 3:38 p.m., the Maintenance Support and the Maintenance Director indicated there were approximately 50 beds like Room 512's bed. The Maintenance Support indicated the bed sounded like it was "getting ready for take-off". The reason the bed made loud noises was the grease on the bottom of the bed frame dried. They would spray WD 40 (a type of lubricant) on the bed frame to correct the loud noise. The beds were old. The company who manufactured the beds was no longer in business. 3. During an observation, on 4/15/24 at 12:27 p.m., Room 517, 518 and 519 had a strong urine odor. The odor was carried out into the hallway. During an interview, on 4/15/24 at 12:30 p.m., Certified Nursing Assistant (CNA) 8 indicated the 500 hall always had a strong odor. Room 517 had a really bad smell, and they did not know why.		bed's functions to identify beds that made loud noises. The identified beds were fixed and/or replaced. All Residents have the potential to be affected. Campus has been approved for Health Center Refurb that includes replacing carpet in the identified rooms and hallways with a projected start date of 5/13/24. The carpets in the identified rooms have been thoroughly cleaned. The following audit will be conducted by the ED or designee of 5 rooms a week x4 weeks, 5 rooms every other week x4 weeks, then 5 rooms a month x4 months. The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 10% compliance is achieved.	

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	During an interview, on 4/15/24 at 12:50 p.m., the Assistant Director of Nursing Services (ADNS) indicated she did not know what was being done about the strong odors on the 500 Hall. During an interview, on 4/15/24 at 3:41 p.m., the Maintenance Support indicated the facility changed all the exhaust fans in Room 517 and there was still an odor. Room 518 had a strong urine odor, and the facility thought it was because a resident used a urinal and would spill urine on the carpet. At the time of the exit conference, the facility did not provide an environmental policy. A current policy, titled "Resident Rights," dated as reviewed on 4/18/21 and received from the Executive Director (ED) on 1/4/23 at 1:00 p.m., indicated "...The resident has a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and supports for daily living...." 3.1-19(f)(5)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00431985 and IN00431697. Complaint IN00431985- No deficiencies related to the allegations are cited. Complaint IN00431697-No deficiencies related to	R 0000	The submission of this plan of correction does not indicate an admission by St. Elizabeth Healthcare Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of St. Elizabeth	

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	the allegations are cited. Survey dates: April 15, 16, 17, 18 and 19, 2024. Facility number: 000187 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 26, 2024.		Healthcare Campus. The facility recognizes its obligation to legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the counters, stove, grill, a spatula, and the floors were clean in 1 of 1 assisted living kitchenette observed for a clean and sanitary kitchen. Finding includes: During an observation of the Assisted Living Kitchenette, on 4/16/24 at 10:00 am, the stove and counters had food particles on them. The grill grates had large amounts of charred, black ashes on it. The griddle area had a large spatula with dried food substances on it. A shelf located at the bottom of the stove had some dark material on it and the grill cleaning utensils had dark charred material. The floor under the sink had brown stains with a small amount of standing water	R 0273	All residents have the potential to be affected by the alleged deficient. The kitchen counters, stove, grill, spatula, and floors were cleaned in the kitchen as of April 15, 2024. All residents have the potential to be affected. Dietary staff to be educated on ensuring food preparation and serving areas are maintained. The following audit of ensuring food preparation and serving areas are maintained will be conducted by the ED or designee for 3 days a week x4 weeks, 2 days a week	05/14/2024

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	present. Under the dishwashing machine, there were large particles of dried, darkened food. During an interview, on 4/16/24 at 11:30 a.m., the Dietary Manager indicated the pipe under the sink was leaking, causing the brown stains and the water under the sink but she was not aware of a repair plan. The employees had cleaning schedules to follow. A current policy, titled "Aide Cleaning List -Daily," received from the Clinical Support Nurse, on 4/16/24 at 3:30 p.m., indicated "...clean and wipe down entire steamtable area after every meal service...clean and wipe down after every meal service...." A current policy, titled "Cooks Cleaning List -Daily," received from the Clinical Support Nurse, on 4/16/24 at 3:30 p.m., indicated "...sweep and mop kitchen...wipe down and clean stovetop area...."		x4 weeks, then 1 day a week x4. For a minimum of 6 months then randomly thereafter for further recommendations. The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved.	