STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(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 IN00400507 and IN00402331. Complaint IN00400507 - No deficiencies related to the allegations are cited. Complaint IN00402331 - No deficiencies related to the allegations are cited. Survey dates: March 8, 9, 10, 13, and 14, 2023 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census Bed Type: SNF/NF: 60 SNF: 7 Total: 67 Census Payor Type: Medicare: 2 Medicaid: 53 Other: 12 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 21, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Holly Bricker | Executive Director | 04/06/2023

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and	F 0550	**550 resident rights**	04/10/2023

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	interview, the facility failed to respect the dignity of a resident with a Foley catheter by ensuring the urine side of the bag was not in sight of those who passed her room. This deficient practice affected 1 of 4 residents who had a Foley catheter. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 3/10/23 at 1:35 p.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of bladder, unspecified, paranoid schizophrenia, generalized anxiety disorder, moderate intellectual disabilities, and post traumatic stress disorder. The Annual MDS (Minimum Data Set) assessment, dated 12/15/22, indicated the resident had moderate cognitive impairment but good recall; had neuromuscular dysfunction of the bladder with an indwelling Foley catheter; and occasionally felt bad about herself. The care plan, dated 3/13/19 and last revised 12/30/22, indicated the resident required an indwelling Foley catheter due to neuromuscular dysfunction of the bladder with urinary retention. The goal was for the catheter to be managed appropriately. The approaches included, but were not limited to, provide assistance for catheter care and store the collection bag inside a protective dignity pouch. During observations of the resident between 3/8/23 and 3/10/23, the following concerns were identified: On 3/8/23 at 10:00 a.m., the resident's Foley catheter bag was hanging off the side of the bed with the urine side facing outwards which could		Based on observation, record review and interview, the facility failed to respect the dignity of a resident with a Foley catheter by ensuring the urine side of the bag was not in sight of those who passed her room. This deficient practice affected 1 of 4 residents who had a Foley catheter. (Resident 2) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Resident #2's dignity bag has been corrected. Resident #2 has not had any ill effects from the alleged deficient practice.** 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 other residents with foley catheters have the potential to be affected by the alleged deficient practice.** · **All other residents with foley catheters were assessed for catheter dignity bags to ensure urine was not visible.** · **Nursing staff were in serviced on providing dignity for residents with foley catheters by ensuring the urine side of the bag is not visible.** 3. what measures will be put	

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	be seen from the hallway. The resident was asleep in bed. On 3/9/23 at 8:45 a.m., the resident's Foley catheter bag was hanging off the side of the bed with the urine side facing outwards which could be seen from the hallway. The resident was asleep in bed. On 3/9/23 at 11:25 a.m., the resident's Foley catheter bag was hanging off the side of the bed with the urine side facing outwards which could be seen from the hallway. The resident was awake in bed watching TV. On 3/9/23 at 3:30 p.m., the resident's Foley catheter bag was hanging off the side of the bed with the urine side facing outwards which could be seen from the hallway. The resident was asleep in bed. On 3/10/23 at 8:20 a.m., the resident's Foley catheter bag was hanging off the side of the bed with the urine side facing outwards which could be seen from the hallway. The resident was asleep in bed. On 3/10/23 at 8:20 a.m., the resident was asleep in bed. The catheter bag was hanging off the bed frame with the urine side facing outward. During an interview on 3/10/23 at 1:22 p.m., the resident indicated that it bothered her if people could see the urine in her catheter bag. During an interview with CNA (Certified Nurse Aide) 8 on 3/13/23 at 1:50 p.m., she indicated the catheter bags were supposed to be in a cover or turned towards the bed so the urine side could not be seen.		into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **Nursing staff were in-serviced on providing dignity for residents with foley catheters by ensuring the urine side of the bag is not visible.** · **Nurse manager/designee will complete daily rounds on all shifts to ensure residents with foley catheters have dignity bags and urine is not visible.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **Catheter QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed? **April 10, 2023** **Attachments A, B, C, D**	

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	On 3/10/23 at 1:45 p.m., the DON (Director of Nursing) presented a copy of the facility's current policy titled Resident Rights dated effective November 2016. Review of this policy included, but was not limited to, "Policy:...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care..." 3.1-3(t)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided			

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	upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician when a resident's blood pressure was elevated and when staff withheld medication for 1 of 2 residents reviewed for notification of changes. (Resident 26) Finding included: The clinical record was reviewed for Resident 26 on 3/10/23 at 10:00 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, essential (primary) hypertension, and ventricular tachycardia. The Significant Change MDS (Minimum Data Set)	F 0580	**580 notify of changes** Based on record review and interview, the facility failed to notify the physician when a resident's blood pressure was elevated and when staff withheld medication for 1 of 2 residents reviewed for notification of changes. (Resident 26) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Resident 26's Physician has been made aware of the alleged deficient practice. No**	04/10/2023

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	assessment, dated 12/12/22, indicated the resident was cognitively intact. The care plan, dated 9/16/22 and revised on 3/10/23, indicated the resident was at risk for ineffective tissue perfusion related to hypertension and end stage renal disease on hemodialysis. The interventions included, but were not limited to, monitor vital signs, observe and document variations in her blood pressure and notify the physician. The clinical record lacked documentation the physician was notified when the resident's blood pressure was elevated and when the nurse held the resident blood pressure medication for a low blood pressure. The nurse's note, dated 12/4/22 at 6:06 a.m., indicated the residents blood pressure was 250/103 at 5:00 a.m. The follow up blood pressure was 247/85 at 5:45 a.m. The staff continued to monitor. The nurse's note, dated 1/2/23 at 4:47 a.m., indicated the resident's blood pressure was 114/57. The nurse rechecked the resident's blood pressure and it was 107/75. The nurse and the resident agreed to hold the resident's blood pressure medication. During an interview on 3/13/23 at 10:40 a.m., LPN (Licensed Practical Nurse) 6 indicated she would notify the physician for any abnormal blood pressure. A normal blood pressure would be 120/80 but some residents would run a little higher than that. If the resident was a dialysis patient, she would call the physician if the blood pressure was elevated. She would not hold the medication without calling the physician first.		**new orders were received.** 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 have the potential to be affected by the alleged deficient practice.** · **DNS/designee completed a 100% audit to ensure changes of condition have MD/NP notification.** · **All nurses were in serviced on the changes of condition policy.** 1.what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **All nurses were in-serviced on the change of condition policy for residents.** · **An every shift audit will be completed on resident change of condition and MD notification.** 1.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **The Change of Condition QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the**	

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	During an interview on 3/13/23 at 3:00 p.m., LPN 9 indicated when a resident had an elevated blood pressure she would immediately call the NP (Nurse Practitioner) or the physician, and get a medication for the resident as a stat (urgent) order. She would treat the resident and after about 30 minutes if the blood pressure was still high or higher, she would send the resident to the emergency room. She would not hold medication without calling the physician. During an interview on 3/14/23 at 9:48 a.m., the DON (Director of Nursing) indicated the physician needs to be called before holding any medication. If a resident's blood pressure was elevated the nurse should have called the doctor. The Resident Change of Condition Policy, dated November 2018, as provided on 3/13/23 at 1:35 p.m., by the DON included, but was not limited to, "... It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place." 3.1-5(a)(2)		**Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments E, F, G, H**	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while			

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	the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an investigation was initiated and completed related to a resident's complaint of mistreatment for 1 of 17 residents reviewed for abuse. Findings include: The clinical record was reviewed for Resident 26 on 3/10/23 at 10:00 a.m. The resident's diagnoses included, but were not limited to, muscle weakness abnormalities of gait and mobility, reduced mobility, a nondisplaced intertrochanteric fracture of right femur, and the presence of a right artificial hip joint. The Significant Change MDS (Minimum Data Set) assessment, dated 12/12/22, indicated the resident was cognitively intact. The clinical record lacked documentation indicating an investigation was initiated and completed by the facility. During an interview on 3/9/23 at 8:55 a.m., the resident indicated in the month of February she went shopping with a group of residents and the staff from the activity department. When she came out of the mall the activity assistant was pushing her in her wheelchair. The activity assistant gave	F 0610	**610 Investigate/Prevent/Correct Alleged Violation** Based on record review and interview, the facility failed to ensure an investigation was initiated and completed related to a resident's complaint of mistreatment for 1 of 17 residents reviewed for abuse. 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **An investigation was initiated and completed related to the allegation of resident mistreatment.** · **The staff member identified was immediately educated on the abuse reporting policy.** 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 have the potential to be affected by the alleged deficient practice.** · **A 100% audit through**	04/10/2023

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	her a shove through the double doors and let go of her wheelchair to help another resident. The resident was unable to stop her wheelchair and she rolled out into the parking lot. She indicated if a car was coming, she would have been hit by the car. She informed the facility as soon as she returned, and the Admissions Director said he would take care of it. She was upset over the incident. During an interview on 3/10/23 at 10:50 p.m., the Director of Marketing and Admissions indicated the resident did come to him and mentioned the incident. An unknown CNA (Certified Nursing Aide) indicated the resident was trying to break away from the group and she had to go after her. He indicated he did not do an investigation, inform the Administrator, or fill out an event form. He didn't feel like it was an issue. During an interview on 3/10/23 at 1:00 p.m., the Activity Assistant indicated when the group was exiting the mall, she guided the resident through the double doors. She turned around to assist another resident through the doors and Resident 26 rolled out into the road. The resident was not pushed. She informed her supervisor of the incident. During an interview on 3/10/23 at 1:10 p.m., the Activity Director indicated when the incident occurred, she was on the bus helping another resident. She didn't see everything that happened, but she did see the Activity Assistant open the door and she pushed the resident through the doors. She told the resident to sit and wait when she went to assist another resident. Resident 26 rolled out into the parking lot. The resident was educated on waiting for staff. She did not report the incident to the Administrator.		**resident interviews was completed to determine that there were no resident complaints that were insufficiently investigated.** · **IDT was in-serviced on investigation of resident complaints.** · **All staff were in-serviced on the abuse prohibition reporting policy.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **IDT was in-serviced on investigation of resident complaints.** · **All staff were in-serviced on the abuse prohibition reporting policy.** · **Resident interviews will be completed daily by resident CARE Companions/designee to ensure all complaints were investigated sufficiently.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; and · **Abuse Investigation QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not**	

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	During an interview on 3/10/23 at 1:25 p.m., the Executive Director indicated she was not aware of the incident. Staff did not report it. She would start an investigation and talk to the resident. The Abuse Prohibition, Reporting, and Investigation Policy, dated 1/23, provided on 3/8/23 at 10:00 a.m., by the DON (Director of Nursing), included, but was not limited to, "... 8. It is the responsibility of every employee of American Senior Communities to report abuse situations, but also suspicion of abuse and unusual observations and circumstances to his/her immediate supervisor and to the Executive Director ..." 3.1-28(d)		**achieved, an action plan will be developed to ensure compliance.** - by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments I, J, K, L, M, N**	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review and interview, the facility failed to ensure a resident who had a referral for an evaluation by an ophthalmologist received the proper treatment to maintain vision. This deficient practice affected 1	F 0685	**F685 Treatment/Devices to Maintain Heating/Vision** Based on observation, record review, and interview, the facility	04/10/2023

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	of 3 residents reviewed for vision services. (Resident 31) Findings include: The clinical record for Resident 31 was reviewed on 3/9/23 at 9:50 a.m. The diagnoses included, but were not limited to, multiple sclerosis (MS) and type 2 Diabetes Mellitus. The Significant Change MDS (Minimum Data Set) assessment, dated 1/18/23, indicated the resident was cognitively intact and her vision was adequate without glasses. The Monthly Physician's order, dated 7/13/22, indicated the resident may be seen by the Optometrist. A care plan, dated 2/23/22 and was last revised on 2/20/23, indicated the resident was at risk for impaired vision due to age related vision changes and diabetes. A goal included the resident would not experience negative consequences of vision loss as evidenced by participating in social activities. The interventions included, but were not limited to, observe for changes in vision or complaints of eye pain, document and notify the physician. The nurse's note, dated 1/5/23 at 12:48 p.m., indicated an appointment was made with an Ophthalmologist for 2/24/23 at 10:45 a.m. The resident would need an escort to accompany her to the appointment. Transportation arrangements were made, but the company indicated insurance would not pay for the resident to go by stretcher. The resident was going to be able to go in her powerchair, but needed to be transferred into one of their chairs for the examination. Management		failed to ensure a resident who had a referral for an evaluation by an ophthalmologist received the proper treatment to maintain vision. This deficient practice affected 1 of 3 residents reviewed for vision services. (Resident 31) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. · **Resident #31 will have an appointment made to outside ophthalmology services to receive proper treatment to maintain vision.** · **Resident #31 has an appointment to see ophthalmology on 5/17/23 at 8:45am.** 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 have the potential to be affected by the alleged deficient practice.** · **100% audit of all residents in facility to ensure there are no immediate vision needs.** · **All staff in-serviced on initial and follow up procedure for referrals to inside and outside vision providers.** 3. what measures will be put into place and what systemic	

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	advised and indicated that this would be taken care of by appointment time. During an interview with the resident on 3/9/23 at 9:30 a.m., she indicated she could not distinguish between blue and green, or see as well as she used to. She liked to color and had to look carefully when she picked the colored pencils or crayons for her drawings. During an interview with the Social Worker on 3/13/23 at 9:45 a.m., she indicated either nursing or herself would make the follow up appointments when the eye doctor made a referral to an Ophthalmologist. She would have to check to see if the resident went to the 2/24/23 appointment with the ophthalmologist. During a second interview with the Social Worker on 3/13/23 at 10:40 a.m., she indicated that she spoke with the nurse who made the Ophthalmologist appointment and that the resident did not go to the 2/24/23 appointment. She did not go since she was not ready physically to go, as she was not as mobile with her walker. Management indicated they would ensure arrangements would be made by the time of the appointment, physical therapy needed to work further on her ambulation with a walker before she could go. A new appointment had been now scheduled for May. The resident's clinical record lacked documentation of the resident making or not making the appointment, or that the resident was not physically capable of attending the appointment with assistance. 3.1-39(a)(1) 3.1-39(a)(2)		changes will be made to ensure that the deficient practice does not recur; · **All staff in-serviced on initial and follow up procedure for referrals to inside and outside vision providers.** · **Facility Activity Report to be reviewed by IDT daily to ensure any vision concerns noted are addressed timely.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **SSD/designee to complete the Hearing and Vision QAPI tool weekly x 4 weeks, monthly x 6 months and quarterly x 2 quarters with results reported to the QAPI committee overseen by the Executive Director. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments O, P, Q, R,**	

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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 record review, interview and observation, the facility failed to ensure residents' Weekly Skin Assessments were completed and accurate, interventions were implemented, and treatment and monitoring was completed to identify and prevent the development or worsening of a pressure ulcer resulting in an unstageable pressure ulcer worsening to a Stage IV pressure ulcer for 3 of 6 residents reviewed for pressure ulcers. (Residents 62, 47 and 56) . Findings include: 1. The clinical record for Resident 62 was reviewed on 3/8/23 at 11:55 a.m. The diagnoses included, but were not limited to, difficulty in walking, unsteadiness on his feet, and a displaced intertrochanteric fracture of right femur. The weekly skin assessment, dated 1/10/23, indicated the resident had no pressure wounds observed.	F 0686	**686 treatment/Svcs to Prevent/Heal Pressure Ulcer** Based on record review and observation, interview and the facility failed to ensure residents' Weekly Skin Assessments were completed and accurate, interventions were implemented, and treatment and monitoring was completed to identify and prevent the development or worsening of a pressure ulcer resulting in an unstageable pressure ulcer worsening to a Stage IV pressure ulcer for 3 of 6 residents reviewed for pressure ulcers. (Residents 62, 47 and 56) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	04/10/2023

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	The weekly skin assessment, dated 1/16/23, indicated the resident had no pressure wounds observed. The current care plan, dated 1/20/23, indicated the resident had impaired skin integrity of a pressure ulcer to right heel. The resident was at risk for skin breakdown or further skin breakdown. The interventions included, but were not limited to, encourage the resident to wear heel lift boot to RLE (right lower extremity) while up in a wheelchair, encourage the resident to float his bilateral heels on a heel riser while abed, turn and reposition every 2 hours, assess wound weekly documenting measurements and description, assess for pain, and treat as ordered. Notify the physician of unrelieved or worsening pain, a pressure reducing and redistribution cushion in the chair, and Promat Plus Mattress with bolsters. The Physical Therapist (PT) note, dated 1/20/23, indicated the resident complained of right foot pain. PT 17 assessed the area and skin. Upon assessment she observed a black necrotic area on the right heel and reported it to the nursing staff for further follow-up. The current physician's order, dated 1/24/23, indicated to apply skin prep to the right heel as preventative, encourage the resident to float the bilateral heels on a heel riser while abed, encourage the resident to turn and reposition every 2 hours and PRN (as needed), with a start date 1/6/23. The wound care NP (Nurse Practitioner) to evaluate and treat, with a start date of 1/26/23. A heel lift boot to the right foot while up in a chair, if the resident was noncompliant with the heel riser encourage the resident was to use a wedge to elevate the right heel while abed,		· **Resident #62 no longer resides in the facility. Residents 47 and 56 are receiving weekly skin assessments that are timely and accurate. Residents 47 and 56 are receiving all interventions to prevent development or worsening of pressure ulcers including interventions addressing noncompliance of pressure ulcer interventions.** · **LPN 4 & 20 were immediately educated on resident 47 noncompliance interventions for pressure ulcer prevention.** · **CNAS 21 & 22 were immediately educated on resident 47 interventions for pressure ulcers.** · **Wound treatments for residents 47 and 62 are being completed and documented in the medical record.** 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 with pressure ulcers or at risk for pressure ulcers have the potential to be affected by the alleged deficient practice.** · **A 100% audit was completed by DNS/designee to identify residents at risk for development of pressure**	

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	with a start date of 2/16/23. The clinical record lacked documentation indicating the resident's pressure wound was identified before it was observed to be unstageable (full thickness tissue loss obscured by slough or eschar in wound bed). The weekly skin assessment, dated 1/24/23, indicated the resident's bilateral lower extremities were observed to have edema and an open area to the right heel. The wound care note, dated 1/26/23, indicated the resident's wound status was open. The wound was currently classified as an unstageable or unclassified wound with etiology of pressure ulcer located on the right calcaneus. The wound measures 4.5 cm (centimeters) long by 4.5 cm wide. There was no drainage observed. There was no granulation within the wound bed. There was a large (67 to 100%) amount of necrotic (dead) tissue within the wound bed including eschar. The peri wound skin appearance had no abnormalities observed for color. The peri wound skin appearance exhibited: callus, scarring, dry and scaly. Peri wound temperature was observed as no abnormality. The peri wound had tenderness on palpation. The nurse's note, dated 1/29/23 at 3:25 a.m., indicated the resident's right heel continued with necrotic skin related to a pressure injury. The resident had complained of increased pain and that it was unbearable, and he wanted to cry. The nurse had continued with non-pharmacological and pharmacological interventions with no relief expressed from the resident. The physician was notified related to the infection.		**ulcers. Interventions were reviewed by the IDT to ensure they were in place and appropriate.** **· A 100% audit was completed by DNS/designee to determine all residents with current pressure ulcers. Interventions were reviewed by the IDT to ensure they were in place and appropriate.** **· A 100% audit was completed by DNS/designee on wound treatments documentation to ensure no omissions or refusals of care and interventions were present for refusal of care.** **· 100% audit was completed by DNS/designee of all weekly skin assessment to determine accuracy and timeliness.** **· A full house skin sweep was completed to identify any discrepancies in documented skin conditions compared to most recent weekly skin assessment.** **· All nursing staff will be in-serviced by DNS/designee regarding timeliness and accuracy of skin assessments, preventative interventions for residents with pressure ulcers or at risk for pressure ulcers.** **· IDT will be educated by RDCS on developing and implementing interventions related to residents'**	

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	The Significant Change MDS (Minimum Data Set) assessment, dated 2/2/23, indicated the resident was cognitively intact. The resident had one unstageable pressure ulcer due to coverage of the wound bed by slough or eschar. The nurse's note, dated 2/9/23 at 10:15 p.m., indicated the wound NP assessed the resident and ordered a CMP (Comprehensive Metabolic Panel), CBC (Complete Blood Count), ESR (Erythrocyte Sedimentation Rate), CRP (C-Reactive Protein), and an x-ray of the right heel. The nurse's note, dated 2/11/23 at 4:41 p.m., indicated the physician wrote an order to schedule an appointment with the hospital wound care. The nurse's note, dated 2/14/23 at 5:26 p.m., indicated the laboratory and x-ray results were reviewed by the wound NP with an order to schedule an MRI (magnetic resonance imaging) of the resident's right heel to rule out osteomyelitis. The hospital MRI report, dated 2/23/23, indicated the resident had moderate marrow edema in the posterior calcaneus tuberosity without evidence of significant marrow replacement. This was nonspecific and may represent reactive marrow changes. Osteomyelitis was considered less likely at that time, but not completely excluded. The Wound Care NP note, dated 3/2/23, indicated the resident's wound status was open. The wound had been in treatment for 5 weeks. The wound was currently classified as a unstageable or unclassified wound with etiology of pressure ulcer located on the right calcaneus. The wound measured 3.4 cm (centimeters) long by 3.4 cm wide. There was no drainage observed and no		**noncompliance with treatment.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **All nursing staff will be in-serviced by DNS/designee regarding timeliness and accuracy of skin assessments, preventative interventions for residents with pressure ulcers or at risk for pressure ulcers.** · **IDT will be educated by RDCS on developing and implementing interventions related to residents' noncompliance with treatment.** · **Daily audits of weekly skin assessments will be completed by DNS/designee to ensure accuracy and timeliness.** · **Every shift audit will be completed by DNS/designee to ensure interventions for pressure ulcer prevention are in placed per plan of care.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **A Skin Management QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one**	

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	granulation within the wound bed. There was a large (67 to 100%) amount of necrotic tissue within the wound bed including eschar. The peri wound skin appearance had no abnormalities observed for color. The peri wound skin appearance exhibited callus, scarring, and was dry and scaly. The temperature was observed as no abnormalities. The peri wound had tenderness on palpation. The treatment included cleanse the wound with normal saline. pat dry, paint the wound base with betadine and cover with a bordered gauze daily and PRN (as needed) for soilage or dislodgement. During an interview on 3/10/23 at 8:35 a.m., Physical Therapist 17 indicated the resident came to them for therapy due to a right hip fracture. She found the resident's pressure wound to his right heel and it was necrotic. She informed the nursing staff. Resident 61 was blaming the physical therapy department for his pressure wound. She educated the resident on using his feet. He had no restrictions at that time. She would never tell a resident to use the footboard for strengthening exercises. Push and pull exercise using the foot board would not cause a pressure wound. Friction from the bed had caused the pressure wound. During an interview on 3/10/23 at 9:20 a.m., the DON (Director of Nursing) indicated the resident was admitted for rehab due to the surgical repair of a right hip fracture. They used skin prep and educated the resident on turning and repositioning at least every 2 hours, heel risers, and a wedge. She indicated RN 18 found the resident's pressure wound on 1/24/23 and filled out a skin event. It was an unstageable wound. He was followed by a wound management company. He had an MRI and it was negative for osteomyelitis. The resident was blaming physical		**year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments I, S, T, U, V, W, X, Y, Z, AA, BB**	

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	therapy for his pressure wound. His wound was stable and had no decline. During an observation on 3/10/23 at 10:10 a.m., the Wound Care Nurse explained to Resident 62, that she was going to provide wound care. He indicated he was in pain and requested Tylenol. She indicated the pressure wound was facility acquired. She was not sure who found the pressure wound. She cleansed the wound with wound cleanser and there was no drainage or odor. The pressure wound was unstageable, and the wound was approximately the size of a silver dollar. The wound was covered with 100% eschar tissue. The treatment included betadine and cover with a dressing. During an interview on 3/10/23 10:10 a.m., the resident indicated he would slide his heel up and down the bed sheet and mattress to get traction so he could exercise his right leg. The physical therapist told him to move his leg for strength. The therapist found the wound and told the nurse. During an interview on 3/10/23 at 11:25 a.m., RN 18 indicated she would fill in sometimes and do the weekly skin assessments. On 1/24/23 she observed a pressure wound on the resident's right heel. The wound had large black eschar and was 3.4 cm x 3.4 cm. No drainage was observed. The pressure wound should have been found on the weekly skin assessment before it got to that stage. It should have been found when the heel was red then skin preventions should have been implemented. The resident was supposed to have skin prep every shift to his heels. 2. The clinical record for Resident 47 was reviewed on 3/9/22 at 10:00 a.m. The diagnoses included, but were not limited to, Parkinson's disease,			

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	neurocognitive disorder with Lewy bodies (problems with thinking, movement, behavior, and mood), unspecified intellectual disabilities, moderate protein-calorie malnutrition, ESBL (extended beta-lactamase) resistance, osteomyelitis, and pressure ulcer of sacral region Stage IV(full skin loss extends below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments). The care plan, dated 3/31/21 and last revised 3/7/23, indicated the resident had impaired skin integrity including a pressure area to her coccyx. She was at risk for further skin breakdown due to sensory perception being slightly limited; skin was very moist; she was chairfast; had very limited mobility; her nutrition was probably inadequate; and friction and shear was a problem. She preferred to lay flat on her back most of the day, she would occasionally turn slightly for very short periods of time, despite education. She frequently refused to turn, and often refused to have dressings changed as scheduled. When she was up in her chair, the resident often refused to follow the recommendation of being up in 1 hour intervals and would refuse to lay back down. The interventions included, but were not limited to, gel cushion in chair, treatment as ordered, no brief, limit time up in wheelchair to 1 hours intervals to promote wound healing (initiated on 3/9/22), Wound NP to evaluate and treat, pressure relief boots at all times (initiated on 5/13/21), skin prep to bilateral heels for prevention, wound location to the coccyx, assess for pain and treat as ordered, notify the physician of unrelieved or worsening pain, assess the wound weekly, document measurements and description, house barrier cream at bedside to use as needed, incontinent care as needed with perineal wash and moisture barrier, lab work as ordered, low air loss			

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	mattress to bed, adjust per resident preference, notify the physician of changes in the wound such as worsening or signs of infection, observe for signs of infection, turn and reposition every 2 hours. The Wound Management Detail report indicated upon admission, on 3/28/21, the resident had an unstageable pressure ulcer which was identified on 3/28/21. The wound measured 9 cm (centimeters) in length, 6 cm in width, and was 2 cm in depth. There was light serosanguineous drainage, and the wound was 100% slough (necrotic tissue). On 8/11/21, the resident's wound progressed to a Stage IV and measured 5.4 cm in length cm in length, 3.5 cm in width, and had a depth of 2 cm. There was 1 cm of undermining at 12 o'clock and the wound was 100% granulation tissue. The nurse's note, dated 3/12/22 at 12:23 a.m., indicated the resident refused to have her dressing changed. She was normally compliant but refused. She was willing to turn on her side for offloading. The Wound Management Detail report indicated, on 3/31/22, the wound was improving and measured 3 cm in length, 3.5 cm in width, and was 100% granulation tissue. The wound was stable. The April 2022 TAR (Treatment Administration Record) indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing between 7:00 a.m. and 7:00 p.m. was not administered due to the resident's refusal on 4/6/22 at 5:45 p.m., 4/17/22 at 5:31 p.m., and 4/18/22 at 5:32.			

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	The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. On 4/28/22, the resident's wound measured 4.5 cm in length, 2.5 cm in width, and was 1.8 cm in depth with 100% granulation. The May 2022 TAR indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing, between 7:00 a.m. and 7:00 p.m., was not administered due to the resident's refusal on 5/2/22 at 5:15 p.m., 5/4/22 at 6:21 p.m., and 5/16/22 at 5:03 p.m. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance except for education on 5/4/22. The nurse's note, dated 5/4/22 at 6:26 p.m., indicated the resident continued antibiotics for osteomyelitis. She was up in her chair and refusing to lie back down. She was educated on issues related to skin breakdown. She also refused to have her dressing changed secondary to refusing to lay back down. The resident was educated on issues related to missing treatments but still refused. The nurse's note, dated 5/19/22 at 9:21 a.m., indicated a wound culture was obtained by the wound care NP. The nurse's note, dated 5/23/22 1:10 a.m., indicated the resident's culture showed a heavy growth of pseudomonas aeruginosa.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The nurse's note, dated 5/23/22 at 3:57 p.m., indicated the Wound Care NP gave orders for the resident to have Ciprofloxacin in 5% (percent) dextrose 400 mg (milligrams) IV (intravenously) daily for 7 days. On 5/26/22, the resident's wound was 3.5 cm in length, 2.5 cm in width, and 1 cm in depth and was 100% granulation tissue. The nurse's note, dated 5/31/22 at 5:36 p.m., indicated the resident had been up in her chair and was refusing to lay down. The only intervention documented was education. The June 2022 TAR indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing between 7:00 a.m. and 7:00 p.m. was not administered due to refusal on 6/25/22 at 6:48 p.m. and on 6/26/22 at 5:44 p.m. There was no documentation of the treatment being completed on either day or night shift on 6/23/22. The resident's order to limit time in the wheelchair to 1-hour intervals to promote wound healing was refused on day shift on 6/3/22. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. The nurse's note, dated 6/2/22 at 1:36 p.m., indicated the resident received orders to extend her antibiotics through 6/9/22. On 6/30/22, the resident's wound was 3.5 cm in length, 2 cm in width, and 1 cm in depth and was 100% granulation tissue.			

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The July 2022 TAR indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing twice daily was not administered on the 7:00 a.m. and 7:00 p.m. shift due to refusal on 7/24/22 at 5:19 p.m., and was not administered on the 7:00 p.m. to 7:00 a.m. shift due to refusal on 7/5/22 at 5:39 a.m. and 7/7/22 at 4:58 a.m. On the 7:00 p.m. to 7:00 a.m. shift on 7/18/22 at 5:14 a.m. The nurse documented the treatment as not administered with a reason being "nurse did not have time."

The resident's order to limit time in the wheelchair to 1 hour intervals to promote wound healing was refused on night shift on 7/23/22.

The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance.

The nurse's note, dated 7/25/22 at 12:34 a.m., indicated the resident refused her dressing change three times, related to pain.

On 7/28/22, the resident's wound was 3.4 cm in length, 2 cm in width, and 1 cm in depth and was 75% granulation tissue and had 25% slough.

The Significant change MDS (Minimum Data Set) assessment, dated 7/29/22, indicated the resident was severely cognitively impaired, had no rejection of care behaviors, was totally dependent of two or more staff for bed mobility, and had a Stage IV pressure ulcer which was present on admission.

The August 2022 TAR indicated the resident's treatment order to cleanse the wound with

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	Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing twice daily was not administered on the 7:00 a.m. and 7:00 p.m. shift due to refusal on 8/7/22 at 6:00 p.m., 8/20/22 at 3:28 p.m., and 8/24/22 at 10:58 a.m., and was not administered on the 7:00 p.m. to 7:00 a.m. shift due to refusal on 8/6/22 at 7:21 a.m. The treatment was not documented as completed on the 7:00 a.m. to 7:00 p.m. shift on 8/21/22 and the 7:00 p.m. to 7:00 a.m. shift on 8/11/22, 8/21/22, and 8/18/22. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. On 8/25/22, the resident's wound measured 3 cm in length, 2 cm in width, and 1 cm in depth and was 75% granulation with 25% slough. There was a foul odor and moderate drainage. The nurse's note, dated 8/25/22 at 9:35 a.m., indicated the resident received new orders for a wound culture and cefdinir 300 mg every 12 hours for seven days related to odor to her wound. The NP's note, dated 8/29/22 at 12:19 p.m., indicated the wound culture showed the resident had growth of pseudomonas aeuroginosa and proteus mirabilis ESBL (extended spectrum beta lactamase). Her antibiotic was changed to Cipro for seven days. The nurse's note, dated 8/29/22 at 2:30 p.m., indicated the resident received new orders for Cipro 500 mg every 12 hours for 7 days. The September 2022 TAR indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry			

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	dressing and cover with a dry dressing twice daily was not administered on the 7:00 a.m. and 7:00 p.m. shift due to refusal on 9/12/22 at 4:57 p.m., and was not administered on the 7:00 p.m. to 7:00 a.m. shift due to refusal on 9/2/22 at 8:30 a.m., 9/5/22 at 5:12 a.m., and 9/25/22 at 2:18 a.m. The treatment was not documented as completed on 7:00 p.m. to 7:00 a.m. shift on 9/13/22 and 9/15/22. The resident's order to limit time in the wheelchair to 1 hour intervals to promote wound healing was refused on day shift on 9/19/22 and 9/25/22. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. On 9/1/22, the resident's wound was 3 cm in length by 2 cm in width, 1 cm in depth, and had 75% granulation with 25% slough. There was no odor. On 9/29/22, the resident's wound was 2.6 cm in length, 1.5 cm in width, 1 cm in depth, and was 100% granulation. The October TAR indicated the resident's treatment order to cleanse the wound with Dakin's, pat dry, apply a Dakin's wet to dry dressing and cover with a dry dressing twice daily was not administered on the 7:00 a.m. and 7:00 p.m. shift due to refusal on 10/2/22 at 5:39 p.m., 10/17/22 at 4:39 p.m., 10/18/22 at 9:20 a.m., 10/29/22 at 6:29 p.m., and 10/30/22 at 3:20 p.m., and was not administered on the 7:00 p.m. to 7:00 a.m. shift due to refusal on 10/16/22 at 1:34 a.m., 10/22/22 at 10:39 p.m., 10/29/22 at 10:26 p.m., and 10/30/22 at 2:22 a.m. The treatment was not documented as completed on 7:00 p.m. to 7:00 a.m. shift on 10/4/22, 10/11/22, 10/18/22, and 10/25/22.			

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	The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. The nurse's note, dated 10/17/22 at 8:57 a.m., indicated the resident was started on meropenem 500 mg every 12 hours IV for ESBL in her wound. The nurse's note, dated 10/31/22 at 2:23 a.m., indicated the resident's treatment had come off and she refused to allow another to be applied. The November TAR indicated the resident's treatment order to cleanse the wound with normal saline, pat dry, apply collagen and cover with a dry dressing once daily from 7:00 a.m. to 7:00 p.m. The resident's order to limit time in the wheelchair to 1 hour intervals to promote wound healing was refused on day shift on 11/11/22, 11/14/22, 11/18/22, and 11/19/22. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. On 11/3/22, the resident's wound was 2.5 cm in length, 1.5 cm in width, 0.8 cm in depth, with light purulent drainage and a slight odor. The wound was 100% granulation tissue. The December TAR indicated the order to cleanse the coccyx with normal saline, pat dry, apply collagen, followed by betadine gauze and a dry dressing daily from 7:00 a.m. to 7:00 p.m., was documented as not administered due to the resident's refusal or her being up in her chair on 12/5/22 at 1:44 p.m., 12/15/22 at 4:51 p.m., and 12/25/22 at 9:06 a.m.			

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	The resident's order to limit time in the wheelchair to 1 hours intervals to promote wound healing was refused on day shift on 12/5/22 at 1:44 p.m. The clinical record lacked documentation of interventions attempted or implemented to address the resident's non-compliance. On 12/1/22, the resident's wound was 2 cm in length, 1 cm in width, 0.5 cm in depth, with no exudate, no odor, and 100% granulation tissue. On 1/5/23, the resident's wound was 2 cm in length, 1 cm in width, 0.5 cm in depth, with no exudate or odor and 100% granulation tissue. The January 2023 TAR indicated the order to cleanse the coccyx with normal saline, pat dry, apply collagen, followed by betadine gauze and a dry dressing daily from 7:00 a.m. to 7:00 p.m., was documented as not administered due to the resident being unavailable and up in her chair on 1/16/23 at 6:05 p.m. and 1/21/23 at 4:17 p.m. The resident's order to limit time in the wheelchair to 1 hour intervals to promote wound healing was refused on day shift on 12/5/22 at 1:44 p.m. On 2/2/23, the resident's wound was 1.8 cm in length, 1 cm in width, 0.4 cm in depth, there was no odor, light exudate, and 100% granulation tissue. The nurse's note, dated 2/11/23 at 5:43 p.m., indicated the resident was refusing to lie down once up in her wheelchair and was noncompliant with turning and repositioning. The nurse's note, dated 2/21/23 at 6:41 p.m.,			

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	indicated the resident had refused her dressing changes for the past two nights. She was educated on the importance of dressing changes to prevent infections and promote wound healing. The resident verbalized understanding. No further interventions were documented. On 3/9/23, the resident's wound was 1.2 cm in length, 0.6 cm in width, 0.4 cm in depth, with light drainage, no odor, and 100% granulation tissue. The resident's care plan and clinical record lacked documentation of any interventions to address the resident's refusal of care or non-compliance, or alternative interventions for when the resident refused treatments, to lie down, or reposition. During an interview on 3/9/23 at 8:58 a.m., Resident 47's family member indicated the resident had the pressure ulcer since before she got to the facility. When she first came in you could see her backbone and now it was down to almost nothing. During an observation on 3/9/23 at 9:03 a.m., PTA (Physical Therapy Assistant) 7 entered the resident's room to conduct a saline mist treatment. The resident's heels were resting directly on the bed mattress. She did not have any pressure relieving treatments in place. PTA 7 removed the resident's dressing. There was a nickel sized open area to the resident's coccyx which was approximately 80% granulation and 20% slough (yellow, necrotic tissue). There was no odor and observed and minimal serosanguineous drainage was on the dressing. During an observation on 3/13/23 at 3:11 p.m., Resident 47 was sitting in her wheelchair by the nurse's station.			

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	During an interview on 3/13/23 at 3:13 p.m., CNA 19 indicated he was caring for Resident 47 that day. He was aware of her pressure injury, but it was his first time on the hall in a little while and he was not up to date on her interventions. He knew they turned her every 2 hours, and when she was in her chair, they made sure she was repositioned often and that she was off her bottom. He had cared for her in the past. He had been aware of her refusing care and repositioning quite often. When she refused, he notified the nurse. The nurse would talk to her and try to get her to cooperate with them and then they would often be able to reposition her. During an interview on 3/13/23 at 3:16 p.m., LPN 20 indicated she was the nurse on the hall and CNA 19 was her only aide. She did not know why the resident did not like to get back in the bed. She cried, and they would try to explain it to her. They had pillows and try to offload each side every 2 hours and lay her down as soon as possible. She had tried to encourage her to lay down that same day, but it did not go over too well, she cried. She would take her back to her room and would use pillows to switch the sides, and the resident would allow her to do that. She thought it was because the resident had not wanted to lay down. The resident was adamant if she was not going to do it, she was not going to do it. She did not have any pillows in place. The LPN had helped get the resident up just before lunch at 11:30 a.m., and it was time to put the pillows back in place. She wasn't sure if the resident had those interventions on her care plan. During an observation on 3/14/2 at 8:52 a.m., CNA 21 and CNA 22 assisted Resident 47 from the bed into her chair via a Hoyer lift transfer. The resident did not have any pressure relieving boots in			

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	place, and the CNAs did not make any attempts to apply boots. During an interview on 3/14/23 at 9:03 a.m., CNA 22 indicated the resident did have pressure relieving boots, but she did not wear them anymore. CNA 21 indicated the resident did not wear the boots anymore. She had not worn them in a couple of weeks, maybe a couple of months. She didn't have them on in the mornings when they got her up. During an interview on 3/14/23 at 9:32 a.m., LPN 4 indicated the resident had the wound for a long time. She was not aware of the resident refusing any treatments unless she was up in her chair already. She believed she had done it a while back, but she tried to make sure, and do the dressing before she got up as she did not like to lay back down. She was to be laid down after an hour, but she refused, she didn't want to lay down. She wanted to be up during the day. She didn't know what they were doing additionally. She would allow staff to reposition her in the chair. Repositioning her in the chair would be an appropriate intervention. She did not know if the care plan had any interventions to address the resident's refusal of care. She did not see any specific interventions to address what to do when she refused care. She would say the resident was not able to be educated, as she was not cognitively intact. Her wound had improved. They had not discontinued the heel boots, she just put them on the resident. She didn't know why some staff didn't put them on, she did kick them off a lot, but she didn't know why they wouldn't apply them. There had been no determination to discontinue them. During an interview on 3/14/23 at 9:47 a.m., the			

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	DON indicated usually when the resident refused care they would step away and reapproach her, then notify the family. She liked being up in her chair and being social. When a resident refused, they would try to get to the root cause of why they were refusing. They would see if it was because she was in pain or if she wanted to stay up, or if she was not wanting the treatment done because she wanted to get up. The intervention of limiting time in her wheelchair would not be an appropriate intervention because she liked to get up. She would agree the resident needed alternative interventions. The boots on her heels were still an intervention. 3. The clinical record for Resident 56 was reviewed on 3/9/23 at 2:37 p.m. The diagnoses included, but were not limited to, diabetes mellitus, moderate protein-calorie malnutrition, abnormalities of gait and mobility, and osteomyelitis of the right ankle and foot. The Quarterly MDS assessment, dated 1/31/23, indicated the resident was moderately cognitively impaired. The resident required extensive assistance of one staff for ADLs (Activities of Daily Living). The care plan, dated 4/21/22 and last revised on 2/6/23, indicated the resident was at risk for skin breakdown or further skin breakdown due to the pressure area to the right heel. The interventions indicated (initiated 5/20/22) to use a heel riser when in bed, (initiated 4/21/22) to assess and document the skin condition weekly and as needed. Encourage the resident to turn and reposition at least every 2 hours. The Wound Management note, dated 4/21/22 at 3:40 p.m., indicated the resident was admitted with a Stage II (partial-thickness skin loss involving			

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	the epidermis and dermis) pressure ulcer to the right heel. The wound measured 4 cm long by 3.5 cm wide. There was light bloody exudate and 100% granulation tissue. The Wound Management note, dated 5/5/22 at 10:09 a.m., indicated the wound was unstageable to the right heel. It measured 3.4 cm long by 1.8 cm wide. There was 100% eschar tissue. The wound had declined. The nurse's note, dated 9/15/22 at 12:57 p.m., indicated the wound nurse practitioner was in to see the resident with a new order for a wound culture of the right heel. The Wound Management note, dated 9/15/22 at 3:08 p.m., the wound was a Stage IV to the right heel. It measured 2.4 cm long by 1.5 cm wide by 0.3 cm deep. There was 50% granulation tissue and 50% slough. Necrotic tissue was present. The wound culture results, obtained on 9/16/22, indicated the wound to the right foot had a heavy growth of Escherichia coli ESBL, MRSA (Methicillin Resistant staphylococcus aureus), and diptheroid bacillus. The Wound Management note, dated 12/15/22 at 6:22 p.m., indicated the Stage IV wound to the right heel measured 0.8 cm long by 0.4 cm wide, by 0.3 cm deep. There was light serous exudate and 100% granulation tissue. The Wound Management note, dated 1/26/23 at 4:16 p.m., indicated the Stage IV wound to the right heel measured 0.5 cm long by 0.4 cm wide by 0.2 cm deep The Wound Management note, dated 3/2/23 at			

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	5:00 p.m., indicated the Stage IV wound to the right heel measured 0.5 cm long by 0.5 cm wide by 0.2 cm deep with light serosanguineous exudate. The April 2022 TAR (Treatment Administration Record) lacked documentation, on 4/29/23, of the completion on the 7:00 a.m. to 7:00 p.m. shift of the following interventions: the removal of the heel lift boots to the bilateral lower extremities for skin check, the positioning device of 2 half side rails while the resident was in bed, the turning and repositioning every 2 hours and prn, and Zinc oxide ointment 20% (percent) applied topically to the coccyx. The IDT (Interdisciplinary team) note, dated 4/21/22 at 4:06 p.m., indicated the resident was admitted from the hospital on 4/20/22 with a Stage II wound to the right and left heel. The interventions were in place prior to the wound development to assess and document skin weekly and as needed, encourage the resident to turn and reposition at least every 2 hours; a pressure reducing/redistribution mattress on bed and in chair. The new interventions initiated were heel lift boots to the bilateral feet. The current treatment order was to cleanse the left and right heel with normal saline, pat dry, apply venalax, cover with ABD (army battle dressing) pad, and wrap in kerlix every day. The physician's order, dated 5/9/22, indicated to apply a Promat Plus Mattress.The physician's order, dated 5/20/22, indicated to apply a heel riser while in bed. The May 2022 TAR lacked documentation, on 5/24/23, of the completion on the 7:00 a.m. to 7:00 p.m. shift of the following interventions: heel riser while in bed, the positioning devices of half			

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	side rails while in bed to enhance bed mobility and turning and repositioning every 2 hours and prn.The nursing note, dated 5/27/22 at 1:12 a.m., indicated the resident required encouragement on keeping his bilateral lower extremity elevated. The clinical record lacked correct documentation of the pressure ulcer to the right heel on the Weekly Skin Assessments on 6/12/22, 7/3/22, 7/10/22, 7/24/22, 8/7/22, 11/11/22, 12/1/22, 12/16/22, 12/22/22, and 2/17/23.The nurse's note, dated 6/22/22 at 11:46 a.m., indicated the resident was scheduled for an MRI on 6/29/22 at 11:30 a.m. to rule out osteomyelitis of the right heel.The June 2022 TAR lacked documentation of the completion on the 7:00 a.m. to 7:00 p.m. shift on the following dates: Betadine 10% to be administered topically to the right heel, then apply an ABD pad and wrap with kerlix missed on 6/2/22, 2/15/22, 6/25/22, 6/26/22, 6/27/22 and 2/29/22.The July 2022 TAR lacked documentation of the completion on the 7:00 a.m. to 7:00 p.m. shift for the following physician orders: Bacitracin 500 units per gram topically 50/50 and zinc oxide to the buttock and Betadine 10% to be administered topically to the right heel, then apply an ABD and wrap with kerlix, heel riser while in bed, positioning devices of half side rails while in bed to enhance bed			

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	mobility, turning and repositioning every 2 hours, and the application of Zinc oxide ointment 20% applied topically to the buttock was missed on 7/9/22. The complete Weekly Skin Assessments once a day on Saturdays was missed on 7/16/22.The August 2022 TAR lacked documentation of the completion on the 7:00 a.m. to 7:00 p.m. shift of the following physician's order: Betadine 10% to be administered topically to the right heel, then apply an ABD and wrap with kerlix was missed on 8/19/22 and 8/20/22.The nurse's note, dated 8/25/22 at 7:00 p.m., indicated the resident returned to the facility from a local hospital. The wound to the right foot/heel was dressed with no signs or symptoms of infection and no foul odor.The nurse's note, dated 9/15/22 at 3:47 p.m., indicated the wound nurse practitioner was in this day with new orders to change the treatment to cleanse the right heel with Dakins solution and pat dry. Apply Vaseline gauze over the bony prominence area, apply betadine wet to dry and cover with Opti foam and wrap with kerlix, x-ray the right foot/heel, schedule an MRI to rule out osteomyelitis, obtain a wound culture. An MRI was scheduled for September 19th at 8:00 a.m. The hospital MRI of the resident's Stage IV open wound to the right heel, dated 9/19/22, indicated the wound			

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	measured 2.4 cm long by 1.3 cm wide with changes extending to the bone. There was T1 and T2 marrow changes along the posterior aspect of the calcaneus with likely small focus of the cortical destruction compatible with osteomyelitis.The nurse's note, dated 9/19/22 at 12:53 p.m., indicated new orders were for the resident to receive Gentamicin 128 mg (milligrams) IV (intravenously) every 8 hours for 10 days. The nurse's note, dated 9/22/22 at 6:41 p.m., indicated a new order to hold the Gentamycin IV dose tonight, start Gentamicin IV 128 mg on 9/23/22 every 12 hours, draw lab work for creatinine, gentamycin trough and peak on Monday.The nurse's note, dated 9/23/22 at 2:40 p.m., indicated the MRI results were received and the wound nurse practitioner had new orders to change the stop date on the IV Gentamycin until 10/6/22, Obtain a gentamycin and creatinine level on 9/26/22. The nurse's note, dated 9/25/22 at 10:37 a.m., indicated the resident remained on IV antibiotics therapy without any adverse reactions. The wound care to the right heel related to the osteomyelitis. The nurse's note, dated 9/26/22 at 11:44 p.m., indicated the resident was continued on the IV antibiotic related to the ESBL and MRSA.The physician's note, dated 10/07/22 at 9:23 a.m., indicated the resident			

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	was seen today for return admission from hospitalization due to the wound infection. The resident was continued on Gentamycin IV through 11/4/22.The physician's order, dated 10/18/22, indicated to complete the Weekly Skin Assessment daily on Thursdays. The physician's order, dated 10/19/22, indicated partial weight-bearing of the right lower extremity foot, weight-bearing only. The physician's order, dated 2/6/23, indicated weight bearing as tolerated with slippers.The physician's order, dated 2/6/23, indicated to apply the off-loading boot to the resident's right foot at all times.The physician's order, dated 2/6/23, indicated to apply Santyl ointment, 250 unit/gram, topically. Cleanse the area to the right heel with normal saline, apply nickel thick Santyl and cover with a 4 by 4 and wrap with kerlix. During an interview on 3/10/23 10:49 a.m., the DON indicated he came in with a Stage 2 to the left right heel and bottom. The bottom was healed. He had a decline to the unstageable which was expected with the osteoarthritis. An MRI and x-ray indicated osteomyelitis and he received antibiotics. He was set up with the physician. It got better over time, and he had a sore with a bone spur that needed to be sheared off to close it. The bone was a prominence sticking out. The wound measured 0.5 cm long by 0.5 cm wide. It			

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	should heal. He was here a week and it declined so the infection occurred. He was not compliant with the pressure relieving boot when he came in, but with the heel lift and he does well now. The clinical record lacked documentation of a care plan for non-compliance with floating heels or wearing a lift boot. During an observation on 3/13/23 at 9:01 a.m., LPN 11 was providing care of Resident 56 performed hand hygiene and applied gloves. She had already set up the supplies for wound care. The resident's right foot had no dressing on it. He indicated it fell off during the night. The LPN indicated the resident was going to see a surgeon due to the bone showing under the wound and to help heal the wound. She cleaned the wound with normal saline on a gauze. She removed her gloves and applied clean gloves. She then applied Santyl gel to the wound and applied a 4 by 4 gauze. She wrapped kerlix around the heel to hold the gauze in place. The heel lift was observed under the resident's calves. She removed her gloves and performed hand hygiene. The resident was observed to have an air mattress in place. During an interview on 3/13/23 at 9:14 a.m., LPN 11 indicated the wound had gotten smaller. He was not currently on antibiotics for the osteomyelitis which showed on the MRI on 10/20/22. A wound culture had been performed on			

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	9/23/22. A CNA found the dressing had fallen off the resident's heel that morning during care at 6:30 a.m.The Skin Management Program policy, dated May 2022, was provided by the DON on 3/10/23 at 2:20 p.m. The policy included, but was not limited to, "... 3. Interventions to prevent wound from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following... Redistribute pressure (such as repositioning, protecting and/or offloading heels... 4. Residents identified at risk for pressure ulcer/injury and those with pressure ulcer/injury will have an individualized care plan developed with specific risk factors and contributing factors including preventative measures... The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported... 7. IDT will review residents with alterations in skin integrity weekly..."3.1-40(a)(1)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, record review and interview, the facility failed to ensure appropriate intervention to prevent a fall for 1 of 3 residents reviewed for falls, which resulted in the resident having broken bones, bruising, and skin tears. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 3/9/23 at 2:18 p.m. The diagnoses included, but were not limited to, a fall slipping, tripping, and stumbling; muscle weakness; stiffness of the left ankle; pain in the right knee; stiffness of the right hip and right ankle; idiopathic peripheral autonomic neuropathy; contracture of the left and right ankle; mechanical complication of the internal fixation device of the right femur for a displaced supracondylar fracture; abnormal posture; and the need for assistance with personal care. The physician's order, dated 2/8/22, indicated the resident was to have two quarter side rails to enhance bed mobility related to weakness. The order was discontinued on 3/2/23. The care plan, dated 11/08/18 and last revised on 2/17/23, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to the resident having impaired mobility and decreased strength. The interventions, dated 11/8/18, indicated staff were to assist the resident with bathing as needed per resident preference; assist with bed mobility with two quarter side rails; assist with dressing, grooming, and hygiene as needed; assist with toileting or incontinent care; and assistance of two staff with the use of a	F 0689	**689 Free of Accident Hazards/Supervision/Devices** Based on observation, record review and interview, the facility failed to ensure appropriate intervention to prevent a fall for 1 of 3 residents reviewed for falls, which resulted in the resident having broken bones, bruising, and skin tears. 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Resident 35 is receiving appropriate interventions to prevent falls.** 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 that require assistance with bed mobility have the potential to be affected by the alleged deficient practice.** · **A 100% audit was completed by DNS/designee to determine appropriate assistance required for bed mobility. Resident care plans, orders, and resident profiles were updated to reflect the findings of this audit.** · **All nursing staff will be in serviced by DNS/designee regarding assistance level**	04/10/2023

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	Hoyer for transfers. The Quarterly MDS (Minimum Data Set) assessment, dated 7/22/22, indicated the resident was cognitively intact. The resident required the extensive assistance of two staff members for bed mobility, transfer, personal hygiene, and toileting. The physician's order, dated 8/12/22, indicated the resident was to have a low air loss mattress. The order was discontinued on 3/6/23. The Quarterly MDS assessment, dated 2/1/23, indicated the resident was cognitively intact. The resident required two plus staff assistance with bed mobility, transfer, and toileting. The nurse's note, dated 3/4/23 at 11:00 a.m., indicated CNA 12 alerted the nurse that the resident had fallen on the floor during incontinence care. The resident was found semi-prone on her right side between the wall and the bed. Resident's head was resting on the front left corner of her bed side table. A skin tear was observed to the right dorsal side of the hand. The resident was assisted by the nurse, a CNA (Certified Nurse Aide), and two additional nurses via Hoyer lift back into her bed. The resident complained of pain to her left ankle and left knee. Multiple skin tears were observed in addition to the left hand, including a laceration to the right side of the face, under the eyebrow, the dorsal side of left great toe, and right shin. The resident indicated she did not want to be sent to the hospital. The on-call NP (Nurse Practitioner) ordered x -rays of the areas indicated. The resident's family voiced concerns regarding the lack of a full-sized bed. The nurse's note, dated 3/4/23 at 6:18 p.m.,		**required for bed mobility based on the audit, and where the information is located on the plan of care.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **All nursing staff will be in serviced by DNS/designee regarding assistance level required for bed mobility based on the audit, and where the information is located on the plan of care.** · **Every shift audits will be completed daily by DNS/designee to ensure residents are receiving bed mobility assistance per their plan of care.** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; and · **A modified version of Accommodation of Needs QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will**	

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	indicated there was new swelling and bruising to the resident's medial side of the knee. The resident states extreme pain. The NP gave new orders for an x-ray of the right lower leg. The nurse's note, dated 3/5/23 at 10:01 a.m., indicated the resident continued to complain of severe pain in the BLE (bilateral lower extremity). The x-ray report concluded a possible subtle proximal tibial plateau fracture and an acute fracture of the proximal tibial metaphysis with mild impaction, but minimal displacement, other than a small anteriorly displaced fracture. The nurse's note, dated 3/5/23 at 12:16 p.m., indicated the resident was agreeable to being transferred to a local hospital. The hospital notes, dated 3/5/23 at 6:31 p.m., indicated the resident was being attended to by staff yesterday morning when she rolled out of bed striking her hip and bilateral knees. She had striked her head. She indicated a mild headache yesterday and was complaining of bilateral hip pain, bilateral knee pain and bilateral ankle pain. X-rays were obtained at the rehabilitation facility which indicated multiple fractures. The resident's history indicated two right hip fractures, right femur surgery, neck surgery and back surgery. The resident weighed 250 pounds and was 72 inches tall. The resident had diffused tenderness to the knee, a proximal left tibia, and the ankles were diffusely tender with chronic plantar flexion deformities. The x-ray results indicated a hairline fracture of the distal left tibia medial cortex just above the metaphysis. There was moderate swelling of the left ankle and moderate diffuse osteoporosis. The right knee x-ray revealed an acute fracture of the right proximal tibial metaphysis with minimal displacement of the		**be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments CC, DD, EE, FF**	

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	tibia-fibula. The left tibia-fibula x-ray revealed a subtle proximal tibial plateau fracture. The resident was non-ambulatory, and the fractures were non operative. The plan indicated to place a right lower extremity knee immobilizer and left equalizer boot and to be worn at all times but may be removed for hygiene and sleep unless the device was in place for fracture. The IDT (Interdisciplinary team) Fall review note, dated 3/6/23 at 12:58 p.m., indicated a new intervention was put in place to address the root cause of the fall, for assistance of two staff at all times with bed mobility and incontinence care, to discontinue the low air loss mattress and to initiate the Promat Plus mattress. During an observation on 3/8/23 at 9:23 a.m., the resident had bruising to the right chin and a cut to the right eyebrow. During an interview on 3/9/23 at 2:47 p.m. a family member indicated the resident fell and this was her third fall. During the other two falls she slid out of bed with her head and torso first. A staff member was changing her "with just one staff" and she rolled out of bed. She may have been trying to hold onto the rail and she somehow fell out of the bed with this latest fall. She had bilateral tibial fractures, and she had a fibular fracture on one leg. When she fell the first time, the family asked about bed rails and was told by the Social Worker that they couldn't have bed rails. After staff mentioned that she could go from a small enabler rail to a longer side rail "she just about lost it". The resident was in horrible pain. She had several bruises and a laceration above her eye. Her bones were not in good shape. The facility only reacted to things after the fact. They didn't put best practices in place from the beginning. You can't			

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	get two CNAs to come to the room. The resident use to be transported in a Hoyer lift and sometimes she would be stuck in bed for hours, because they couldn't get two people to come and get here up. Now she's on a lot of pain medication. The family didn't trust the staff to care that she's safe. I know we will have a big reaction if something happens, I can't foresee everything that might happen. The surgeon said her bones are like lace. The pain she had gone through with this fall should never have happened. The nurse's note, dated 3/10/23 at 3:55 a.m., indicated fall precautions remained in place and the resident continued to have facial bruising and a steri strip to the right temple. She had swelling to bilateral feet. During an observation on 3/10/23 at 12:55 p.m., the resident's right cheek and jaw were slightly swollen. During an interview on 3/10/23 at 12:58 p.m., CNA 12 indicated the resident could move her legs up and down and could open them a bit. She could raise her upper torso up and down and reach her face with her arms. She controlled her bed most of the time. When she rolled, she would get started and would rock and eventually roll over. She was not concidered a total assist, but a partial assist. She put her light on when said she was wet. She changed the resident daily and the bed was stripped at the same time. The resident was turning toward the wall and had ahold of the side rail. She rocked herself and went over. She just had a hold of her gown, and she went over. She didn't put her leg over. She would just wiggle over. She rolled a little too far. Her torso was twisted. Her leg and bottom went over first. She hit the bedside table against the wall first. She had			

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	always been considered a one person assist until the recent fall. The resident would let the CNA know what she wanted to do or not do. She was laying straight on the mattress and turned onto her left side. She got her sheets together and got the rolled-up sheets under the resident. She was already on her side. She was laying on the middle of the mattress and rolled too far and just kept going. During an interview on 3/10/23 at 1:05 p.m., the Therapy Director indicated the resident had previously been able to roll with maximum assistance (75% plus assistance). She could grab the quarter side rails. She just now got the new bed in and therapy still needed to check the bed. She was not currently in therapy, but when she came back from the hospital, an assessment was planned to be completed. Prior to the fall she could not move her legs in bed and required assistance. She had received therapy and received range of motion. The resident had always required the assistance of two for pulling her up in bed. For nursing care, she required position devices, and maximum assistance of two dated 2/8/22. She could not fling her legs over to roll on her side. She required assistance and had a minimal amount of her own assistance. She could grab her rails to assist with rolling, but she could not move her legs. At therapy discharge, the resident could lean to her left and reposition herself independently to midline. She had a low air loss mattress. It could have led to her falling out of bed, due to the decompression when getting close to the edge. It should be on the firm setting for bed mobility. During an interview on 3/18/23 at 10:50 a.m., the MDS Coordinator indicated the MDS assessments was a collaboration of the nurses, charting, hospital records, the resident, and the			

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	family. The Functional Status section was based on the gathered information from huddles, and the decline of the resident. It would be addressed during meetings. The MDS had changed since she took over the MDS assessments. The DON (Director of Nursing) conducted the assessments prior to her coming in December 2022. During an interview on 3/13/23 at 11:14 a.m., the resident indicated CNA 12 was providing incontinence care, and gave her a push to roll over. The CNA had been getting ready to change her and was getting the wet brief out from under her. Her legs eventually went over, out of the bed. She had been hanging onto the rail to get her balance. The CNA was short and couldn't grab her in time to prevent her from rolling out of bed. They sometimes called for 2 CNAs to change her because she couldn't roll well. She now had pain from the fall. Her left forearm had a large circular bruise, approximately 2 1/2 inches and her right forearm had a small circular eraser sized bruise. They made braces for her legs. The Fall Management policy, last revised on August 2022, was provided by the DON on 3/13/23 at 1:36 p.m. The policy included, but was not limited to, "... Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and			

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	155697	A. BUILDING 00 B. WING	03/14/2023

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	bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with a history of UTIs was provided proper management of the urinary catheter drainage system by maintaining the drainage system off the floor for 1 of 3 residents reviewed for urinary tract infections. (Resident 47)	F 0690	**690 Bowel/Bladder Incontinence, Catheter, UTI** Based on observation, record review, and interview, the facility failed to ensure a resident with a history of UTIs was provided proper management of the urinary catheter drainage system by	04/10/2023

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	Findings include: The clinical record for Resident 47 was reviewed on 3/9/22 at 10:00 a.m. The diagnoses included, but were not limited to, UTI (urinary tract infection), extended beta-lactamase (ESBL) resistance, acute kidney failure, and pressure ulcer of sacral region Stage 4. The care plan, initiated on 4/12/21 and last revised on 3/7/23, indicated the resident had an indwelling urinary catheter due to pressure injury, incontinence, and neurogenic bladder. The interventions included, but were not limited to, do not allow the tubing or any part of the drainage system to touch the floor, and report signs of UTIs (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine). The NP's (Nurse Practitioner's) note, dated 6/27/22 at 9:08 p.m., indicated the resident had a urine culture which was positive for ESBL E. (escherichia) Coli. New orders were given for Bactrim DS (double strength) daily for ten days. The urinalysis, dated 6/28/22, indicated the resident's urine was positive for ESBL E. Coli greater than 100,000 CFU/mL (colony-forming units per milliliter) and proteus mirabilis 20-25,000 CFU/mL. The urinalysis, dated 7/15/22, indicated the resident's urine was positive for ESBL E. Coli greater than 100,000 CFU/mL. The NP's note, dated 7/18/22 at 9:25 a.m., indicated the resident's urine culture was positive for ESBL		maintaining the drainage system off the floor for 1 of 3 residents reviewed for urinary tract infections. (Resident 47) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Resident 47 urinary catheter drainage system has been corrected and is off the floor. Resident 47 has not had any ill effects from the alleged deficient practice.** 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 other residents with foley catheters have the potential to be affected by the alleged deficient practice.** · **An audit of all other residents with foley catheters completed by DNS/designee to ensure catheter drainage system is not touching the floor.** · **Nursing staff were in-serviced on keeping catheter drainage system from touching the floor.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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	E. Coli. and she was started on imipenem 500 mg every 6 hours for seven days. The nurse's note, dated 9/18/22 at 8:54 p.m., indicated the resident had yellowish-green tinged urine with heavy sediment. The NP was notified. The nurse's note, dated 9/19/22 at 5:33 p.m., indicated the NP ordered to obtain a urinalysis with culture and sensitivity. The NP's note, dated 9/27/22 at 5:15 p.m., indicated the resident was started on imipenem 500 mg every 6 hours for seven days related to an ESBL UTI. The nurse's note, dated 12/1/22 at 1:03 p.m., indicated the resident had a large amount of sediment her urinary drainage bag. The NP was notified. The nurse's note, dated 12/1/22 at 6:49 p.m., indicated new orders were received for a urinalysis. The urinalysis report, dated 12/5/22, indicated the resident's urine was positive for ESBL E. Coli greater than 100,000 CFU/mL. The NP's note, dated 12/8/22 at 9:00 a.m., indicated the resident had a UTI and was started on Macrobid 100 mg (milligrams) twice daily for 7 days. The Quarterly MDS (Minimum Data Set) assessment, dated 12/9/22, indicated the resident was severely cognitively impaired and had an indwelling urinary catheter. The nurse's note, dated 1/31/23 at 5:39 p.m.,		· **Nursing staff were in-serviced on keeping catheter drainage system from touching the floor.** · **Nurse manager/designee will complete daily rounds on all shifts to ensure residents with foley catheters do not have catheter drainage system touching the floor.** 1.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **Catheter QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** **Attachments GG, HH, II, D**	

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	indicated the resident complained of burning with her catheter. The NP was notified. The urinalysis report, dated 2/5/23, indicated the resident had klebsiella with a growth of greater than 100,000 CFU/mL. The nurse's note, dated 2/6/23 at 1:49 p.m., indicated the resident was started on augmentin 500/125 mg every 12 hours for ten days related to her urinalysis. The nurse's note, dated 2/20/23 at 7:07 p.m., indicated a new order for a urinalysis was obtained and the specimen was awaiting pickup. The urinalysis report, dated 2/26/23, indicated the resident had growth of greater than 100,000 CFU/mL of two colony types of E. Coli ESBL. The nurse's note, dated 2/27/23 at 12:36 p.m., indicated the NP had been in and gave new orders for a midline placement and IV (intravenous) meropenem to be administered every 8 hours for seven days related to ESBL. During an observation, on 3/10/23 at 11:25 a.m., Resident 47 was sitting in her reclining wheelchair in the main dining room. Her catheter bag was hooked to the bottom of her wheelchair. The bag was resting directly touching the floor. Pale yellow urine was observed in the tubing. The bag was approximately one-quarter full. During an observation on 3/10/23 at 1:21 p.m., Resident 47 was sitting in her wheelchair in the common area to the left of the nurse's station. Her catheter bag was hooked to the bottom of her wheelchair. The bag was resting directly touching the floor. Pale yellow urine was observed in the			

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	tubing. During an observation on 3/10/23 at 2:30 p.m., Resident 47 was sitting in her wheelchair in the common area to the right of the nurses station. Her catheter bag was hooked to the bottom of her wheelchair. The bag was resting directly touching the floor. Pale yellow urine was observed in the tubing. Two CNAs were standing directly next to the resident talking to her and each other and did not make any attempts to correct the tubing. During an observation on 3/14/2 at 8:52 a.m., CNA 21 and CNA 22 provided catheter care for Resident 47 and assisted her from the bed into her chair via a Hoyer lift transfer. CNA 22 grabbed the catheter tubing with her left hand and the bag hook with her right and lowered the bag to the ground to let the urine drain into the tubing. The bag was observed to directly touch the floor. During an interview on 3/14/23 at 9:03 a.m., CNA 22 indicated she didn't think she had let the catheter bag touch the floor. She knew it was not supposed to touch the floor. During an interview on 3/14/23 at 9:47 a.m., the DON indicated the resident's catheter bag should not be allowed to touch the floor. During an interview on 3/14/23 at 10:55 a.m., the DON indicated the Indwelling Urinary Catheter Care, Emptying Drainage Bag, & Catheter Removal Nursing Policy & Procedure, last reviewed on 12/2012, was the only policy she could locate for catheter maintenance. The policy did not address proper maintenance of the urinary drainage system off the floor. 3.1-41(a)			

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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, record review, and interview, the facility failed to ensure the oxygen concentrator filters were applied and maintained for 6 of 18 residents reviewed for respiratory care. (Residents 33, 35, 56, 170, 171, and 49). Findings include: 1. The clinical record for Resident 33 was reviewed on 3/9/23 at 12:55 p.m. The diagnoses included, but were not limited to, copd (chronic obstructive pulmonary disease) with acute exacerbation, malignant neoplasm of upper lobe, left bronchus or lung, emphysema, and anxiety disorder. The physician's order, dated 10/4/22, indicated staff were to change the resident's oxygen tubing and humidity, and clean the concentrator and filter once a day on Sunday. The care plan, dated 10/5/22 and last revised on 1/21/23, indicated the resident was at risk for impaired gas exchange related to the COPD with shortness of breath while lying flat, decreased mobility, opioid use, emphysema, and lung cancer. The interventions, dated 10/5/22, indicated staff were to administer oxygen as ordered at 4 L (liters)	F 0695	**695 Respiratory/Tracheostomy Care and Suctioning** Based on observation, record review, and interview, the facility failed to ensure the oxygen concentrator filters were applied and maintained for 6 of 18 residents reviewed for respiratory care. (Residents 33, 35, 56, 170, 171, and 49) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Residents 33,35,56,171, and 49 did not have any ill effects related to this alleged deficient practice. Residents identified immediately had oxygen tubing and filters checked, cleaned, and/or changed out to new tubing or filter.** 2. how other residents having the potential to be affected by the same deficient practice will be	04/10/2023

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	via NC (nasal cannula), and to monitor the resident's oxygen saturation rates as needed or ordered. The nurse's note, dated 12/6/22 at 3:42 a.m., indicated the resident had been coughing up yellow thick mucus, and running a low-grade temperature of 99.2 degrees F (Fahrenheit). The Significant Change MDS (Minimum Data Set) assessment, dated 1/17/23, indicated the resident was cognitively intact. She required supervision or was independent for mobility. The nurse's note, dated 1/25/23 at 4:43 a.m., indicated the resident had increasing SOB (shortness of breath). The NP (Nurse Practitioner) was notified and a new order was received for a STAT (urgent) 2-view chest x-ray. During an observation on 3/8/23 at 9:20 a.m., the filter was observed to be missing from the oxygen concentrator. During an observation on 3/9/23 at 8:56 a.m., the oxygen was set at 4 liters. There was no filter on the oxygen concentrator. During an observation on 3/10/23 at 11:25 a.m., the oxygen concentrator had no filter in place. The resident indicated the tubing was changed on Sundays. During an observation on 3/13/23 at 9:49 a.m., the oxygen concentrator had no filter in place. The tubing had a change date of 3/13/23. During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON (Director of Nursing), Resident 33's oxygen		identified and what corrective action(s) will be taken; · **All other residents that receive oxygen therapy have the potential to be affected by this alleged deficient practice.** · **Audit completed on all residents with oxygen orders by IDT nurses to ensure oxygen tubing is dated within a week and filters are clean**. · **Licensed staff will be in-serviced by the DNS/Designee to ensure that residents have preventative measures for respiratory care, including delivery of oxygen in a sanitary manner**. 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **Licensed staff will be in-serviced by the DNS/Designee to ensure that residents have preventative measures for respiratory care, including delivery of oxygen in a sanitary manner**. · **Observational rounds will be completed daily by DNS/designee to ensure weekly change of oxygen tubing, humidification, and cleaning of filters is completed.** 4. how the corrective action(s) will be monitored to ensure the	

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	filter was missing, and the tubing had been changed on Monday 3/13/23. During an interview on 3/13/23 at 9:55 a.m., the DON indicated the staff would blow out and rinse the filters every 2 weeks. The manufacturer would also check the machines weekly. If the filters were missing, they would not be filtering as they should. 2. The clinical record for Resident 35 was reviewed on 3/9/23 at 2:18 p.m. The diagnoses included but were not limited to chronic obstructive pulmonary disease with acute exacerbation and anxiety disorder. The Quarterly MDS assessment, dated 7/22/22, indicated the resident was cognitively intact. The resident required extensive assistance of two staff members for bed mobility, transfer, personal hygiene, and toileting. During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON, Resident 35's oxygen concentrator filter had scattered clumped particles of white dust. 3. The clinical record for Resident 56 was reviewed on 3/9/23 at 2:37 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, atrial fibrillation, and acute pulmonary edema. The care plan, dated 4/21/22, indicated the resident was at risk for impaired gas exchange related to decreased mobility, opioid use, pulmonary edema, heart failure, and acute respiratory failure. The interventions, dated 4/21/22, indicated to administer oxygen as ordered, monitor oxygen saturation rates as		deficient practice will not recur, what quality assurance program will be put into place; · **Oxygen Therapy QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10,2023** Attachments JJ, KK, LL, MM	

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	needed or ordered. The physician's order, dated 10/19/22, indicated staff were to change the resident's oxygen tubing and humidity, and clean the concentrator and filter once a day on Sunday. The Quarterly MDS assessment, dated 1/31/23, indicated the resident was moderately cognitively impaired. He required extensive assistance of one staff member for ADLs (Activities of Daily Living). During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON, Resident 56's oxygen filter had scattered particles of clumps of white dust. The tubing had been changed on Monday 3/13/23. 4. The clinical record for Resident 170 was reviewed on 3/13/23 at 11:03 a.m. The diagnosis included, but was not limited to, atrial fibrillation. The clinical record lacked documentation of a care plan related to the resident's oxygen use. The physician's order, dated 2/7/22, indicated staff were to change the resident's oxygen tubing and humidity, and clean the concentrator and filter once a day on Sunday. The Admission MDS assessment, dated 2/13/23, indicated the resident was cognitively intact. She required extensive assistance of 1 to 2 staff members for ADLs. During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON, Resident 170's oxygen filter was missing and the tubing had been changed on Monday			

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	3/13/23. 5. The clinical record for Resident 171 was reviewed on 3/13/23 at 1:25 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, respiratory failure whether with hypoxia or hypercapnia, and emphysema. The care plan, dated 12/3/19, indicated the resident was at risk for impaired gas exchange related to shortness of breath while laying flat due to emphysema with oxygen use. The resident returned to the facility after hospitalization, with a new order for a bipap. The resident refused to use the bipap despite education. The interventions, dated 12/3/19, indicated to monitor oxygen saturation rates as needed or ordered, and O2 at 3 liters per minute via nasal cannula. The physician's order, dated 1/16/23, indicated staff were to change the resident's oxygen tubing and humidity, and clean the concentrator and filter once a day on Sunday. The Quarterly MDS assessment, dated 3/10/23, indicated the resident was moderately cognitively impaired. She required extensive assistance of 1 to 2 staff members for ADLs. During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON, Resident 171's oxygen filter was missing on the left side of the oxygen concentrator and the filter to the right side of the oxygen concentrator was completely covered with white dust and the dust was hanging from the filter. 6. The clinical record for Resident 49 was reviewed on 3/10/23 at 1:57 p.m. The diagnoses included,			

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	but were not limited to, chronic obstructive pulmonary disease and atherosclerotic heart disease. The Quarterly MDS assessment, dated 2/11/23, indicated the resident was cognitively intact. The care plan, dated 8/9/21 and last revised on 2/14/23, indicated the resident was at risk for impaired gas exchange related to COPD with shortness of breath while lying flat, CHF (congestive heart failure), acute respiratory failure, dependency on supplemental oxygen, and morbid obesity. The interventions, dated 8/9/21 indicated to administer oxygen as ordered at 3 liters per nasal cannula, and to monitor oxygen saturation rates as needed or ordered. During a tour of the facility for oxygen use on 3/13/23 between 9:50 a.m. and 10:05 a.m., with the DON, Resident 49's oxygen filter was missing and the oxygen tubing had been changed on Monday 3/13/23. The current Oxygen Concentrator policy, provided by the RDCO (Regional Director of Clinical Operations) on 3/17/23 at 10:35 a.m., included, but was not limited to, " ... Precautions and Hazards 1)DO NOT operate the oxygen concentrator without the filter or with a dirty filter ... 4) Place unit AWAY from curtains, walls, or other obstacles that block the flow of air to the unit. 5) Check the inlet filter pad and ensure that it is in place and clean ... Daily Maintenance ... 3) Clean the air inlet filter PRN [as needed] and weekly ..." 3.1-47(a)(6)			

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	155697	A. BUILDING 00 B. WING	03/14/2023

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review, and interview, the facility failed to ensure accurate documentation in the Controlled Substances Record sheet of the administered narcotics and an	F 0755	**755 Pharmacy Srvcs/Procedures/Pharmacist/Records** Based on observation, record	04/10/2023

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	expired medication for 8 of 36 residents' medication storage reviewed. (Residents 55, 28, 33, 4, 10, 47, 43, and 39) Findings include: 1. During an observation of the 60 Hall medication cart on 3/14/23 at 9:45 a.m., with LPN (Licensed Practical Nurse) 6, the following discrepancy was observed: -Resident 55's Controlled Substances Record sheet indicated the Tramadol 50 mg (milligrams) half tablet (25 mg) had a count of 29 tablets remaining. The Tramadol medication card only contained 28 tablets. The last documented administration was on 3/13/23 at 8:00 a.m. The clinical record for Resident 55 was reviewed on 3/14/23 at 11:15 a.m. The diagnoses included, but were not limited to, osteoarthritis, gastrostomy, and hydrocephalus. The physician's order, dated 10/31/22, indicated the resident was prescribed Tramadol 25 mg by gastric tube once daily for mild to moderate pain. The March 2023 MAR (Medication Administration Record) indicated the Tramadol had been administered on 3/14/23 between 7:00 a.m. and 11:00 a.m. During an interview on 3/14/23 at 8:00 a.m., LPN 6 indicated she had administered the medication and forgot to sign the medication out. During an interview on 3/14/23 at 9:54 a.m., LPN 6 indicated she should have signed off the narcotic as soon as she gave it.		review, and interview, the facility failed to ensure accurate documentation in the Controlled Substances Record sheet of the administered narcotics and an expired medication for 8 of 36 residents' medication storage reviewed. (Residents 55, 28, 33, 4, 10, 47, 43, and 39) 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Residents # 39, 43, 47,10, 4, 33, and 55 Controlled Substances Record Sheet was signed to reflect doses administered on the date of alleged deficient practice.** · **LPN 3, LPN 4, LPN 5, and LPN 6 were educated on the policy and procedure of medication administration.** · **Resident 28's expired medication was destroyed and reordered.** 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 other residents that receive medications have the potential to be affected by the alleged deficient practice.** · **Audit of all med carts completed to ensure there were no expired medications**	

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	2. During an observation of the 60 Hall medication cart on 3/14/23 at 9:50 a.m., with LPN 5, the following discrepancies were observed: a. Resident 28's nitroglycerin give 0.4 mg sublingually every 5 minutes up to 3 doses for chest pain, had an expiration date on the bottle of 12/2022. The medication had not been administered. The clinical record for Resident 28 was reviewed on 3/14/23 at 11:02 a.m. The diagnoses included, but were not limited to anxiety and acute post-traumatic stress disorder. The physician's order, dated 2/13/20, indicated the resident was prescribed nitroglycerin 0.4 mg sublingually every 5 minutes up to 3 doses for chest pain. The March 2023 MAR indicated no nitroglycerin had been administered. b. Resident 33's Controlled Substances Record sheet indicated the clonazepam 0.5 mg had a count 25 tablets left. The clonazepam medication card indicated a count of 25 tablets left. The last documented administration was on 3/13/23 at 8:00 p.m. Resident 33's Controlled Substances Record sheet indicated the morphine sulfate extended release 15 mg give twice a day had a count of 3. The morphine medication card had a count of 2 tablets left. The last documented administration was on 3/13/23 at 8:00 p.m. The clinical record for Resident 33 was reviewed on 3/14/23 at 11:12 a.m. The diagnoses included, but was not limited to, malignant neoplasm of the		· **Licensed staff were educated on medication administration policy and medication storage policy.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · **Licensed staff were educated on medication administration policy and medication storage.** · **Observational rounds will be completed daily by DNS/designee to ensure medications are administered and documented per facility policy. Rounds will also include medication cart audit for expired meds. Licensed staff were educated on medication administration policy and medication storage policy. POLICIES ARE LOCATED IN PHARMACY MANUAL, CORP DOCS** 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **Medication storage QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen**	

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	upper lobe of the left bronchus or lung and the breast, and generalized anxiety disorder. The physician's order, dated 10/4/22, indicated the resident was to receive morphine extended release 15 mg every 12 hours for chronic pain. The physician's order, dated 10/4/22, indicated the resident was to receive clonazepam 0.5 mg twice daily for generalized anxiety disorder. The March 2023 MAR indicated the morphine had been administered on 3/14/23 at 9:00 a.m. The clonazepam had been administered on 3/14/23 between 7:00 a.m. and 11:00 a.m. c. Resident 4's Controlled Substances Record sheet indicated the hydrocodone-acetaminophen 7.5-325 mg, give 1 tablet 4 times daily had a count of 13. The hydrocodone-acetaminophen medication card indicated a count of 12 left. The last documented administration was on 3/13/23 at 8:00 p.m. Resident 4's Controlled Substances Record sheet indicated the clonazepam 0.5 mg, give 3 half tablets (0.75 mg) 3 times daily had a count of 3. The clonazepam medication card indicated a count of 0 left. The last documented administration was on 3/13/23 at 8:00 p.m. The clinical record for Resident 4 was reviewed on 3/14/22 at 11:18 a.m. The diagnoses included, but were not limited to, anxiety disorder, bilateral primary osteoarthritis of the first carpometacarpal joints, and right artificial hip joint. The physician's order, dated 11/9/21, indicated the resident was prescribed clonazepam 0.75 mg 3 times daily for anxiety disorder.		**by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10,2023** **Attachments I, NN, OO, PP, QQ**	

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	The physician's order, dated 6/30/21, indicated the resident was prescribed hydrocodone-acetaminophen 7.5-325 mg 4 times daily for chronic pain. The March 2023 MAR indicated the hydrocodone-acetaminophen and clonazepam had been administered on 3/14/23 at 8:00 a.m. During an interview on 3/14/23 at 9:55 a.m., LPN 5 indicated she had administered the medication and forgot to sign them out. She should have signed the narcotics out right then and there. 3. During an observation of the 20 Hall medication cart on 3/14/23 at 9:57 a.m., with LPN 4, the following discrepancies were observed: a. Resident 10's Controlled Substances Record sheet indicated the Lyrica 100 mg give 1 capsule daily, had a count of 1. The Lyrica medication card indicated a count of 0 left. The last documented administration was on 3/13/23 at 8:00 a.m. Resident 10's Controlled Substances Record sheet indicated the Lyrica 100 mg give 1 capsule daily, had a count of 30. The Lyrica medication card indicated a count of 29 left. The last documented administration was on 3/9/23 with no time documented. Resident 10's Controlled Substances Record sheet indicated the Alprazolam 0.25 mg give twice daily, had a count of 29. The Alprazolam medication card indicated a count of 28 left. The last documented administration was on 3/13/23 at 8:00 p.m.			

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	The clinical record for Resident 10 was reviewed on 3/14/23 at 11:02 a.m. The diagnoses included, but was not limited to generalized anxiety disorder, idiopathic neuropathy, and chronic ischemic heart disease. The physician's order, dated 2/24/21, indicated the resident was prescribed Alprazolam 0.25 mg twice daily for generalized anxiety. The March 2023 MAR, indicated the Alprazolam was administered on 3/14/23 between 7:00 a.m. and 11:00 a.m. The physician's order, dated 2/24/21, indicated the resident was prescribed Lyrica 100 mg one daily for chronic pain. The March 2023 MAR indicated the Lyrica was last administered on 3/14/23 between 7:00 a.m. and 11:00 a.m. The physician's order, dated 2/24/21, indicated the resident was prescribed Lyrica 25 mg one daily for chronic pain. The March 2023 MAR indicated the Lyrica 25 mg was administered on 3/14/22 between 7:00 a.m. and 11:00 a.m. b. Resident 47's Controlled Substances Record sheet indicated the hydrocodone-acetaminophen 5-325 mg, give every 4 hours, had a count of 20. The hydrocodone-acetaminophen medication card had a count of 19 left. The last documented administration was on 3/14/23 at 4:00 a.m. The clinical record for Resident 47 was reviewed on 3/14/23 at 11:20 a.m. The diagnosis included, but was not limited to, a Stage 3 pressure ulcer to			

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	the sacral region. The physician's orders, dated 6/8/22, indicated the resident was prescribed hydrocodone-acetaminophen 5-325 mg every 4 hours for the Stage 3 pressure ulcer to the sacral region. The March 2023 MAR indicated the hydrocodone-acetaminophen 5-325 mg had been administered on 3/14/23 at 8:00 a.m. c. Resident 43's Controlled Substances Record sheet indicated the Tramadol 50 mg tablet, give 2 times daily, had a count of 28. The Tramadol medication card indicated a count of 27 left. The last documented administration was on 3/13/23 at 8:00 p.m. The clinical record for Resident 43 was reviewed on 3/14/23 at 11:31 a.m. The diagnosis included, but was not limited to, chronic pain syndrome. The physician's order, dated 2/14/22, indicated the resident was prescribed Tramadol 50 mg twice daily for mild pain. The March 2023 MAR indicated the Tramadol 50 mg had been administered on 3/14/23 between 7:00 a.m. and 11:00 a.m. During an interview on 3/14/23 at 10:24 a.m., LPN 4 indicated she should have signed them off when they were given. 4. During an observation of the Front Hall medication cart on 3/14/23 at 10:03 a.m. with LPN 3, the following discrepancy was observed: a. Resident 39's Controlled Substances Record			

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	sheet indicated the oxycodone-acetaminophen 7.5-325 mg, give two times daily, had a count of 30. The oxycodone-acetaminophen medication card indicated a count of 29 left. The last documented administration was on 2/14/23 with no documented time. The clinical record for Resident 39 was reviewed on 3/14/23 at 11:38 a.m. The diagnosis included, but were not limited to, peritonitis, and chronic inflammatory demyelinating polyneuritis. The physician's order, dated 11/30/20, indicated the resident was prescribed oxycodone-acetaminophen 7.5-325 mg twice daily for chronic pain. The March 2023 MAR indicated the oxycodone-acetaminophen had been administered on 3/14/23 at 7:00 a.m. During an interview on 3/14/23 at 10:13 a.m., LPN 3 indicated she should have sign them out. Resident 39 had just hovered over her. The General Dose Preparation and Medication Administration policy, last revised on 1/1/13, was provided by the RDCO (Regional Director of Operations) included, but was not limited to, " ... 4.1.2 Check the expiration date on the medication ... 5.5 Document the administration of controlled substances in accordance with applicable law ... 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given ... " 3.1-25(b)(3)			

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair during 3 of 3 kitchen observations. This deficient practice had the potential to affect 66 of 67 residents who received meals in the facility. Findings include: During the initial tour of the kitchen, on 3/8/23 at 9:17 a.m., the following concerns were observed: -There was various food debris, one straw, a sugar packet, an ink pen, and built up brown grime	F 0812	**812 Food Procurement/Store/Prepare/Serve-Sanitary** Based on observation, record review, and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair during 3 of3 kitchen observations. This deficient practice had the potential to affects 66 of 67 residents who received meals in the facility. 1. what corrective action(s) will	04/10/2023

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	on the floor under the two compartment sink counter. -There was a heavy accumulation of black dust on the expanders of two window unit air conditioners above the prep counter. There was duct tape and foam which was poorly secured around the border of the air conditioners and a heavy draft of cold air could be felt coming in. - There was heavy gray dust and brown streaks of grease running down the wall beside the outlet next to the prep counter. - Inside the dry storage there were crumpled creamer packets by and under the ice machine. There was a silver tumbler and a styrofoam cup with a small amount of brown liquid in it, on the table by the ice machine. There was a heavy accumulation of white substance on the floor under the ice machine pipe, and a heavy build up substance on the pipe with moisture observed on the pipe. There were several empty salt, sweetener, and pepper packets behind the ice machine, as well as an opened soda can lying on its side. There was one hair net, several creamers, and sweetener packets under the dry storage shelves. There were several condiment cups and 1 black apron under the shelves as well as a heavy build up of brown debris. Several of the wire racks were observed to have a moderate amount of dust coating them. - In the chemical storage room the light fixture was broken and hanging by wires from the ceiling, there was a pipe running to wall with the cover hanging off of it where the internal structure of the building was exposed, the floor was covered in black grime, the sink fixture was rusted with the enamel coating peeling, and a musty odor was		be accomplished for those residents found to have been affected by the deficient practice. · **No residents were harmed by the alleged deficient practice** · **Daily/weekly/monthly cleaning lists specified for each culinary position posted and initiated on 3/15/23 to be signed off by each as cleaning tasks are completed.** · **CM/designee to complete AM checklist daily to ensure cleaning lists completed/proper storage of foods/supplies and present to ED each day.** · **Concerns to be placed on Daily follow up on Daily Kitchen CQI to be addressed same day.** · **LPN #25 educated on sanitation and proper wearing of hair net.** 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 have the potential to be affected by the alleged deficient practice.** · **Daily/weekly/monthly cleaning lists specified for each culinary position posted and initiated on 3/15/23 to be signed off by each as cleaning tasks are completed.**	

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	observed in room. - In the walk in fridge there were three butter packets and brown grime built up along the walls under shelves. - The flat top grill was completely caked in black grime which could be seen flaking off in areas. Only approximately 20% of the grill top was clean. - The oven vent hood had a moderate accumulation of dust. - In the walk-in freezer there was a heavy accumulation of ice on the pipe in the back corner. The foam protector was shredded and falling off the pipe. There were littered paper shred and broken plastic food containers under the shelf. There was a box of cinnamon swirl bread touching the ceiling and dangling over the edge of the shelf. -There was grease streaking down the side of the convection oven. - In the dish washing area the back splash had been removed and a heavy accumulation of black peeling buildup was observed where it used to be. The ceiling had multiple areas of peeling paint dangling over the dish washing areas. There were several very large chunks of paint dangling from the ceiling over the dish washing area. There was a heavy accumulation of white substance and food debris under the dishwasher. - There was a heavy buildup of dust on the wall behind the toaster. During a follow-up visit to the kitchen, on 3/8/23 at 11:31 a.m., all of the previously observed		**· CM/designee to complete AM checklist daily to ensure cleaning lists completed/proper storage of foods/supplies and present to ED each day.** **· Concerns to be placed on Daily follow up on Daily Kitchen CQI to be addressed same day.** **· Maintenance concerns to be placed on Maintenance Request for prompt follow up.** **· Corporate RD will complete Short Sanitation minimum monthly and provide plan of correction, in-services needed (completed by CM) and maintenance concerns to be addressed.** **· Culinary staff in-serviced on cleaning policy and procedures (daily/weekly/monthly cleaning check lists).** **· All staff in-serviced on proper use of hair nets/sanitation when entering the kitchen** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **· Culinary staff in-serviced on cleaning policy and procedures (daily/weekly/monthly cleaning check lists).**	

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CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(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
	concerns remained the same. The Maintenance Director entered the kitchen and began rolling silverware. He did not have a beard net covering his beard which was approximately 3 inches long and full. During a follow-up tour of the Kitchen with the Corporate Dietary Manager on 3/10/23 at 1:50 p.m., the following concerns were observed: -There was various food debris, one straw, a sugar packet, an ink pen, and a build up of brown grime on the floor under the two compartment sink counter. -There was a heavy accumulation of black dust on the expanders of two window unit air conditioners above the prep counter. There was duct tape and foam which was poorly secured around the border of the air conditioners and a heavy draft of cold air could be felt coming in. - There was heavy gray dust and brown streaks of grease running down the wall beside the outlet next to the prep counter. - Inside the dry storage there were crumpled creamer packets by and under the ice machine. There was one opened energy drink, one styrofoam cup containing a small amount of clear liquid, one styrofoam cup containing a small amount of dark brown liquid, one half empty bottle of water, and one silver on the table by the ice machine. There was a heavy accumulation of white substance on floor under the ice machine pipe, and a heavy build up substance on the pipe with moisture observed on the pipe. There were several empty salt, sweetener, and pepper packets behind the ice machine, as well as an opened soda can lying on its side. There was one hair net,		· **All staff in-serviced on proper use of hair nets/sanitation when entering the kitchen** · **CM/designee to complete AM checklist daily and present to ED to ensure kitchen maintains regulatory standards.** 1.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **Short sanitation to be completed weekly x 4 weeks, and then monthly with results reported to the QAPI committee overseen by the ED. If threshold not met an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed **April 10, 2023** Attachments I, RR, SS, TT, UU, VV, WW, XX	

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	several creamers, and sweetener packets under the dry storage shelves. There were several condiment cups and 1 black apron under the shelves as well as a heavy build up of brown debris and a black pasta spoon. Several of the wire racks were observed to have a moderate amount of dust coating them. There was an orange splatter running down the wall beside the ice machine. - There was 2 boxes of vented lids, one box of foam containers, and a box of knives and spoons between 2 to 8 inches from the ceiling. - In the chemical storage room the light fixture was broken and hanging by wires from the ceiling, there was a pipe running to wall with the cover hanging off of it where the internal structure of the building was exposed, the floor was covered in black grime, the sink fixture was rusted with the enamel coating peeling, and a musty odor was observed in room. - In the walk in fridge there were three butter packets and brown grime built up along the walls under shelves. - The flat top grill remained with approximately 20% of the stove top covered in black grime which was flaking in some areas. - The oven vent hood had a moderate accumulation of dust. - In the walk in freezer there was a heavy accumulation of ice on the pipe in the back corner. The foam protector was shredded and falling off the pipe. There were littered paper shred and broken plastic food containers under the shelf. There was a box of cinnamon swirl bread touching			

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	the ceiling and dangling over the edge of the shelf. -There was grease streaking down the side of the convection oven. - In the dish washing area the back splash remained removed with a heavy accumulation of black peeling buildup where it used to be, the ceiling had multiple areas of peeling paint dangling over the dish washing areas. There were several very large chunks of paint dangling from the ceiling over the dish washing area. There was a heavy accumulation of white substance and food debris under the dishwasher. - There was a heavy buildup of dust on the wall behind the toaster. During an interview on 3/10/23 at 1:54 p.m., the Corporate Dietary Manager indicated she was filling in from another building and was training the facility's newly hired Dietary Manager. She indicated the pipe by the ice machine was disgusting. She could see the dust on the racks in the dry storage room. She knew it needed worked on and fixed upon her first impression. The racks should be swept under daily and cleaned at least weekly. Boxes should not be touching the ceiling. The concerns in the chemical room were a maintenance issue. There should never be drinks near the ice machine, the staff had a break room and it was a short walk away. There should be someone cleaning the vent hood. She had started working on the stove and it was looking better. During an observation on 3/10/23 at 1:57 p.m., a long-haired, blonde staff member entered kitchen, grabbed a cup of coffee and left. As she exited the door the Corporate DM indicated to the staff			

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	member to please use a hair net if entering. She indicated she did not know who the staff member was. During an interview on 3/10/23 at 2:21 p.m., LPN (Licensed Practical Nurse) 25 indicated she had entered the kitchen earlier to get coffee for a resident. She had not been aware she was supposed to wear a hair net as she usually did not go in the kitchen. During an interview on 3/13/23 at 2:28 p.m., Dietary Aide 26 indicated sweeping under shelves and counters was to be done daily. She was not sure how long the kitchen issues had been going on, but she did know the stove had been blackened for some time. It was to be cleaned after every meal. She was uncertain how long, but it would not have accumulated the way it had if it had been cleaned appropriately. The backsplash area in the dishwashing room had been that way for at least a couple of months. During an interview on 3/13/23 at 2:30 p.m., Dietary Aide 27 indicated floors were to be cleaned daily. Things had been chaotic without a dietary manager. They did not have anyone to oversee cleaning and tasks. During an interview on 3/14/23 at 2:35 p.m., the Dietary Cook indicated the hole in the wall in the chemical room had been there when she started working at the facility a week and a half prior. She had not noticed the light in the ceiling. The stove was completely black when she first came back. It would not have built up like that in a day or two. It was to be cleaned every day. Sweeping was supposed to be completed every day, before the evening cook went home. She was not sure if anyone was ensuring it was being done. She			

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	would sweep under the shelves in the freezer at least once a week. During an interview on 3/14/23 at 2:39 p.m., the Dietary Manager indicated they did have cleaning schedules, but they had just gotten them. They did not have any completed cleaning check offs they could provide for the last three months. He had been here for just shy of three months. There had not really been anyone ensuring the cleaning tasks were being completed. He wasn't sure how long the issues had been there. The stove top had been in that shape since he had started. They had been without a dietary manager about 3 months before he started,, and he started three months ago but was still in training and the culinary manager position he had only had for two weeks. So realistically there were without a culinary manager for about 6 months. The Cleaning Schedules, provided on 3/13/23 at 3:00 p.m., by the Executive Director, indicated the following tasks: -The AM Dishwasher Aide was to clean the soiled dish table in the dish room, including the legs, garbage disposal and the pipes, and sweep and mop the dish room area daily. -The PM Dietary Aide/Dish was to clean the aide prep table and the exterior of the ice machine daily. - Weekly, the walk in cooler and freezer floor were to be swept, the milk cooler was to be cleaned, the janitor closet was to be cleaned, and the dry storage was to be cleaned and organized. - Monthly, the filters in the hood exhaust, the walls and baseboards throughout the kitchen			

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	were to be cleaned. The floors were to be power scrubbed. The Cleaning Schedules policy, last reviewed 12/22, provided on 3/13/23 at 3:00 p.m., by the Executive Director, included but was not limited to, " ... Policy ... The culinary staff will maintain the sanitation of the culinary department through compliance with a written, comprehensive cleaning schedule. Procedure 1. The Culinary Manager will schedule all cleaning and sanitation tasks for the department. 2. The cleaning schedule will be posted for all cleaning tasks, and employees will initial tasks as completed. 3. The Culinary Manager is responsible to ensure all cleaning tasks are completed timely and thoroughly." 3.1-21(i)(3)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with			

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	COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers,			

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	who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to ensure the residents were COVID-19 tested in accordance with their policy for 1 of 3 residents reviewed for COVID testing. (Resident 31). Findings include: The clinical record for Resident 31 was reviewed on 3/13/23 at 9:56 a.m. The diagnoses included, but were not limited to, mild intermittent asthma, personal history of COVID-19, and MS (multiple sclerosis). The Significant Change MDS (Minimum Data Set) assessment, dated 1/18/23, indicated the resident was cognitively intact. On 7/13/22, the resident received the following physician orders: Symbicort (budesonide-formoterol) HFA aerosol inhaler 160-4.5 mcg (micrograms)/actuation - give: 2 puffs inhalation for shortness of breath twice daily, and for COVID-19 testing as needed via POC (rapid viral test) Antigen or PCR (polymerase chain reaction) test per facility policy and CDC (Center for Disease Control) Guidance - as needed. On 7/14/22, the resident received another physician's order for albuterol sulfate HFA aerosol inhaler 90 mcg/actuation - give 180 mcg	F 0886	**886 COVID-19 Testing-Residents & Staff** Based on record review and interview, the facility failed to ensure the residents were COVID-19 tested in accordance with their policy for 1 of 3 residents reviewed for COVID testing. (Resident 31). 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · **Resident 31 currently shows no signs or symptoms of COVID. COVID testing is not required.** 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 have the potential to be affected by the alleged deficient practice.** · **Audit of all residents in the facility were reviewed by IDT to determine any symptoms of COVID and need for COVID testing.**	04/10/2023

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	inhalation for shortness of breath every 6 hours. A care plan, dated 2/23/22 with a review date of 2/20/23, indicated the resident was at risk for impaired gas exchange related to MS and asthma. The interventions included, but were limited to, administer medication as ordered; assess vital signs and lung sounds as needed; and monitor oxygen saturation rates as needed or ordered. A nurse's note, dated 1/16/23 at 1:27 p.m., indicated the resident complained of sinus issues. The Nurse Practitioner (NP) saw the resident and gave a new order for ZPak (an antibiotic). A nurse's note, dated 1/16/23 at 2:02 p.m., indicated the resident was started on an antibiotic for sinus issues with the first dose being given at that time. The Respiratory Surveillance Line List for January 2023, indicated the resident was listed as having congestion, but documentation was lacking of the resident having been COVID tested before being given an antibiotic . During an interview, on 3/13/23 at 10:12 a.m., LPN (Licensed Practical Nurse) 6 indicated she would monitor for signs and symptoms of COVID like fever, congestion, cough, chills, nausea and vomiting, and any change in mental status. She would isolate the resident and do a Covid test. She would call the physician, DON (Director of Nursing) and the IP (Infection Preventionist). On 3/8/23 at 9:00 a.m., the Administrator presented a copy of the facility's current policy titled Infection Prevention and Control Guidelines During the COVID-19 Pandemic dated effective 11/7/22. The review of the policy included, but		· **All nurses were in-serviced on symptoms of COVID and testing requirements per policy.** 3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? · **All nurses were in-serviced on symptoms of COVID and testing requirements per facility policy.** · **Daily audit by IP/designee to review facility activity report for noted signs and symptoms of COVID.** 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? · **COVID QAPI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.** by what date the systemic changes for each deficiency will be completed? **April 10, 2023** **Attachments YY, ZZ, AAA, BBB**	

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	was not limited to, "... Procedure:... 2. Core Principles of COVID-19 Infection Prevention:...h. Resident and staff testing conducted per policy...6. SARS-CoV-2 Viral Testing: a. anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19..."			