STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with Complaint IN00417903. Complaint IN00417903 - Federal/state deficiencies related to the allegations are cited at F689, F744, F880, F921, and F9999. Survey dates: September 18, 19, 20, 21, 22 & 25, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 2 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 4, 2023.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10-25-23 to the state findings of the Annual & Complaint Surveys conducted on 09-25-23.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Van Hoy	Administrator	10/23/2023

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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	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, interview, and record review, the facility failed to ensure resident dignity was respected for 2 of 2 residents during 3	F 0550	F - 550 *1.) The corrective action taken for those residents found to have*	10/25/2023

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	random observations. (Resident P, Resident 48) Findings include: 1. On 9/20/23 at 8:38 A.M., Hospitality Aide (HA) 10 indicated Resident P was already up because "she's a feeder". At that time, Resident P was observed in the common area with other residents within hearing distance. On 9/21/23 at 9:53 A.M., the Social Services Director (SSD) indicated Resident P did not have teeth and that "she is a feed". At that time, she was in her office, and residents could be heard just outside in the dining area. 2. On On 9/22/23 at 9:35 A.M., Licensed Practical Nurse (LPN) 25 was observed walking toward Resident 48 in the common area while speaking with him. LPN 25 indicated to Resident 48 "I just can't stop what I'm doing to help you all the time", then walked away from the resident. On 9/22/23 at 2:35 P.M., the Director of Nursing (DON) indicated staff should not refer to residents as "feeders". On 9/22/23 at 2:39 P.M., the DON provided a current non-dated Dignity policy that indicated "Residents are treated with dignity and respect at all times ... not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs ...". 3.1-3(a)		*been affected by the deficient practice is that* the resident identified as resident P is no longer being identified by staff as a feeder and is being treated with dignity and respect. The staff member identified as HA 10 has been re-educated on the facility's dignity policy and instructed to not identify any resident by a label/title. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 48 is now being treated with dignity and respect. The staff member identified as LPN 25 has been re-educated on the facility's dignity policy and has been instructed to interact with all residents in a kind and compassionate manner. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A house wide audit of all residents and staff members has been conducted. All staff members are now interacting with all residents in a dignified and respectful manner and are addressing each resident in an appropriate manner. *The measures that have been put into place to ensure that the deficient practice does not recur is*	

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			that a mandatory in-service has been provided for all staff members on the facility's dignity policy. All staff members have been re-educated on the manner to appropriately address and interact with each resident in a respectful and dignified manner. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the staff's approach in addressing and interacting with all residents in a respectful and dignified manner. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
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			

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	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 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).			

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	Based on observation, interview, and record review, the facility failed to notify appropriate parties after a significant change in resident status for 1 of 1 residents reviewed for insulin and 1 of 3 residents reviewed for nutrition. (Resident T, Resident P) Findings include: 1. On 9/18/23 at 10:52 A.M., Resident T indicated her blood sugars had been running high lately. On 9/19/23 at 11:40 A.M., Resident T's clinical record was reviewed. Diagnosis included, but was not limited to, Diabetes Mellitus. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 7/15/23, indicated no cognitive impairment. Resident T was totally dependent of two staff for bed mobility, transfers, toileting, and bathing. Insulin had been administered 7 of 7 days of the look back period. Current physician orders included, but were not limited to: Insulin Aspart FlexPen 100 UNIT/ML (milliliter) Solution pen-injector, Inject as per sliding scale: if 201 - 250 = 6 u (units); 251 - 300 = 9 u; 301 - 350 = 12 u; 351 - 400 = 15 u; 401+ = 18 u and call M.D. (medical doctor), if not reduced, subcutaneously before meals and at bedtime, dated 3/30/23. accu checks achs [sic] (before meals and at bedtime) and prn (as needed), dated 1/18/23. Insulin Aspart Solution Pen-injector 100 UNIT/ML Inject 5 units subcutaneously before meals, dated 10/8/22. A current diabetic care plan, dated 11/3/21,	F 0580	F – 580 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the blood sugar readings for the resident identified as resident T have been reviewed. There is now documentation to support that the physician is being notified in accordance with the current physician's orders when the resident's blood sugars are elevated for further instructions by the physician. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the weight record of the resident identified as resident P has now been reviewed. There is now documentation to support that the physician and the resident's representative have been notified of the resident's weight loss and will continue to be updated on any additional significant weight change. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All clinical record documentation for the past thirty days has been completed. All changes in a resident's condition/status have been reported to the resident's physician and their	10/25/2023

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	included but were not limited to, the following interventions: Diabetes medication as ordered by doctor and fasting serum blood sugar as ordered by doctor, dated 11/3/21. Resident T's Diabetic Administration Record (DAR) for 7/2023 through 9/2023 indicated the following dates the blood sugar was over 400: 7/10/23 at 4:30 P.M. (424) 7/22/23 at 11:30 A.M. (461) 8/28/23 at 4:30 P.M. (432) 9/3/23 at 11:30 A.M. (404) 9/5/23 at 6:30 A.M. (445) 9/5/23 at 4:30 P.M. (425) 9/6/23 at 4:30 P.M. (460) 9/9/23 at 8:00 P.M. (421) 9/12/23 at 4:30 P.M. (452) 9/12/23 at 8:00 P.M. (452) 9/14/23 at 11:30 A.M. (413) 9/14/23 at 4:30 P.M. (490) 9/19/23 at 4:30 P.M. (401) The clinical record lacked documentation of notification to the MD as ordered for blood sugars over 400. On 9/20/23 at 1:01 P.M., the Director of Nursing (DON) indicated any notifications should have been documented in a progress note. On 9/22/23 at 1:23 P.M., the DON indicated she could not locate any documentation of notification to the MD related to Resident T's blood sugars over 400. 2. On 9/19/23 at 8:48 A.M., Resident P's Power of Attorney (POA) indicated she was unaware if the resident had any weight loss since she has been in the facility. She indicated if she had, the facility		representative. These notifications have been documented in the respective resident's clinical records. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and the social services director on the facility's policy related to notification of change in resident's condition/status. The staff members have been re-educated on their responsibility to document these notifications in the clinical record in accordance with facility policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor documented notifications of changes in the resident's condition/status. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	had not notified her. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Admission date was 10/11/22. Diagnoses included, but were not limited to, dementia and non-traumatic brain dysfunction. The most recent quarterly MDS Assessment, dated 7/13/23, indicated extensive assistance of two staff with bed mobility, transfers, toileting, and eating, and weight loss. Current physician orders included, but were not limited to, the following: regular diet, pureed texture, nectar thick consistency, magic cup all 3 meals, dated 6/1/23. Weights included the following since admission with warnings: 10/11/22 129.4 lbs (pounds) 11/10/22 127 lbs 12/12/22 129.4 lbs 1/24/23 124.4 lbs 3/14/23 120.2 lbs 4/16/23 111 lbs (1 month 7.7% loss, 3 month 10.8% loss, 6 month 14.22% loss) 5/2/23 109.8 lbs (6 month 13.5% loss) 6/7/23 112.6 lbs 7/6/23 109.4 lbs 7/17/23 103.6 lbs 8/15/23 106 lbs (11.8% loss since 3/14/23) Resident P's clinical record lacked documentation of notification to POA or physician related to weight losses. On 9/20/23 at 2:43 P.M., the Director of Nursing (DON) indicated the Dietician came to the facility once a week on Tuesdays. While there, they go			

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	over any resident concerns including weight loss. On 9/20/23 at 2:54 P.M., Licensed Practical Nurse (LPN 2) indicated the aides obtained resident weights, then give to the DON to enter into the clinical record. Once in the record, if the nurse notices a loss, they would be expected to notify the MD and POA. On 9/22/23 at 1:23 P.M., the DON indicated she could not locate any documentation that the POA or MD had been notified of Resident P's weight loss. At that time, she indicated the notification should have been done. On 9/22/23 at 1:33 P.M., the Administrator provided a current non-dated Change in a Resident's Condition or Status policy that indicated "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)". 3.1-5(a)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview, observation, and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 2 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for insulin. (Resident 7, Resident P, Resident F)	F 0641	F – 641 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS was immediately submitted for the resident identified as resident 7 as soon as the error was brought to	10/25/2023

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	Findings include: 1. On 9/20/23 at 11:10 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, hypertension, edema, and permanent atrial fibrillation. The most recent quarterly MDS Assessment, dated 7/3/23, indicated Resident 7 had moderate cognitive impairment and did not receive an anticoagulant or diuretic during the 7 day look back period (6/26/23 - 7/3/23). Current physician orders included, but were not limited to: Rivaroxaban (an anticoagulant medication) Oral Tablet 20 MG (milligrams) - Give 1 tablet by mouth one time a day related to permanent atrial fibrillation, dated 2/5/23 Spironolactone (a diuretic medication) Tablet 25 MG - Give 1 tablet by mouth one time a day for edema related to congestive heart failure, dated 9/24/22 Discontinued physician orders included, but were not limited to: Metolazone (a diuretic medication) Oral Tablet 2.5 MG - Give 1 tablet by mouth one time a day for edema related to congestive heart failure, hypertension, edema, dated 9/24/22 and discontinued on 9/19/23. The June 2023 MAR (medication administration record) indicated Resident 7 received rivaroxaban daily in June with the exception of 6/5 and metolazone daily in June with the exception of 6/5 and 6/26.		the MDS coordinator's attention. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS was immediately submitted for the resident identified as resident P as soon as the error was brought to the MDS coordinator's attention. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS was immediately submitted for the resident identified as resident F as soon as the error was brought to the MDS coordinator's attention. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of each resident's most recent MDS to ensure that all entries in the MDS were accurate. No additional errors were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the MDS coordinator and all members of the interdisciplinary team on the facility's policy related to the accuracy of the MDS. Each member of the team was reminded of the importance of ensuring that all information entered into the MDS must be accurate based on the resident's current condition	

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	The July 2023 MAR indicated Resident 7 received rivaroxaban daily in July with the exception of 7/4 and metolazone daily in July. On 9/22/23 at 9:42 A.M., the MDS Coordinator indicated that rivaroxaban should have been coded as an anticoagulant received and metolazone should have been coded as a diuretic received on the 7/3/23 quarterly MDS Assessment and was overlooked. 2. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety. The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting. The MDS indicated anti-anxiety medications were administered 4 of 7 days in the look back period from 7/7/23 through 7/13/23. Current physician orders included, but were not limited to: Clonazepam (an anti-anxiety medication) Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for Restlessness, dated 8/6/23. Discontinued orders included, but were not limited to: Lorazepam (an anti-anxiety medication) Oral Tablet 2 MG Give 1 tablet by mouth three times a day, dated 7/11/23 and discontinued 7/12/23. Resident P's Medication Administration Record (MAR) for 7/2023 indicated the following administration of anti-anxiety medications from 7/7/23 through 7/13/23: Clonazepam 0.5mg given 7/9/23, 7/19/23, 7/12/23,		and plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy of the MDS. The tool will monitor the information in the MDS to ensure that that the documentation in the clinical record matches the information on the MDS. This tool will be completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	7/13/23. Lorazepam 2mg given 7/11/23. On 9/25/23 at 9:47 A.M., the MDS Coordinator indicated 4 days of anti-anxiety medication was entered in error for Resident P, and should have been entered as 5 days. 3. On 9/20/23 at 8:35 A.M., Licensed Practical Nurse (LPN) 2 indicated Resident F had behaviors of wandering especially at night. On 9/21/23 at 8:41 A.M., Resident F was observed wandering in another resident's room. On 9/22/23 at 9:42 A.M., Hospitality Aide (HA) 6 indicated Resident F wandered a lot in and out of resident rooms, in the hallway, and around the nurses station. She indicated the resident required redirection when observed wandering. On 9/22/23 at 11:26 A.M., the Director of Nursing (DON) indicated a motion sensor had been installed above Resident F's door to alert staff when she was exiting the room due to her wandering. On 9/22/23 at 10:00 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and non-traumatic brain dysfunction. The most recent quarterly MDS Assessment, dated 7/29/23, indicated a severe cognitive impairment. Resident F required limited assistance of one staff with bed mobility, transfers, and eating. The MDS indicated no wandering behaviors.			

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	155801	A. BUILDING 00 B. WING	09/25/2023

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	A current wandering care plan dated 1/11/22 indicated the following interventions: I will not leave facility unattended through the review date My safety will be maintained through the review date I will demonstrate happiness with daily routine through the review date Monitor for fatigue and weight loss Pad alarm to bed On 9/25/23 at 9:59 A.M., LPN 23 indicated Resident F had always wandered, and wandered daily. She indicated wandering would not have been documented in the clinical record because it was a normal behavior for the resident. She indicated if the behavior worsened or changed, it would be documented in the behavior binder, then reviewed by the Social Services Director (SSD). On 9/25/23 at 10:47 A.M., the MDS Coordinator indicated behavior (such as wandering) is obtained for the MDS Assessment from the resident's progress notes. If it was not there, it was put into the MDS as not done. She indicated she did not get MDS information for behaviors from the behavior binder or any other place in the clinical record. On 9/22/23 at 9:42 A.M., the MDS Coordinator indicated that the facility follows the RAI (Resident Assessment Instrument) user's manual.			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.			

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	(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure care plans were revised for 3 of 3 residents (Resident 16, Resident 27, Resident 38) and lacked documentation of care plan conferences being completed for 11 of 13 residents reviewed for care plan conferences (Resident 1, Resident 14, Resident 16, Resident 20, Resident 46, Resident 7, Resident 22, Resident M, Resident S, Resident F, Resident P) Findings include: 1. On 9/22/23 at 8:15 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, COPD and bipolar disease.	F 0657	F - 657 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 27 has had their care plan updated to address the resident's suicidal ideation. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 38 has had their care plan updated and the side effects for the use of an antipsychotic has been removed.	10/25/2023

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	The most current quarterly MDS (Minimum Data Set) Assessment, dated 7/12/23, indicated Resident 27 was cognitively intact and needed supervision with the assistance of 1 for mobility, transfers, and eating. Progress notes indicated Resident 27 was hospitalized for suicidal ideation on 9/12/23 and returned on 9/13/23. Current care plans included, but were not limited to: "The resident has a mood problem r/t (related to) disease process anxiety that included the intervention monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide... dated 10/5/21." During an interview on 9/25/23 at 8:47 A.M., the DON (Director of Nursing) indicated the resident had an acute problem and may not be care planned for problems because they were medical interventions. At that time, she indicated the care plan should be updated for suicidal ideation. 2. On 9/21/23 at 8:43 A.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, generalized anxiety disorder and persisting dementia. The most current quarterly MDS Assessment, dated 7/4/23, indicated Resident 38 was cognitively intact and needed supervision and the assistance of 1 for dressing, transferring, and eating. The MDS indicated there was a 7 day look back for antidepressant. Current physician orders indicated, but were not limited to: Desvenlafaxine ER Oral Tablet Extended Release		*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 16 has had their care plan updated and now addresses the use of an anticoagulant. There is also documentation to support that a care plan conference has now been held for the resident and/or their representative to review the current care plan. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 1 now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 14 now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 20 now has documentation to support that a care plan conference has been	

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	24 Hour 100 MG (Desvenlafaxine), Give 1 tablet by mouth one time a day for depression dated 7/6/23. Ziprasidone HCl Oral Capsule 20 MG (Ziprasidone HCl), Give 20 mg by mouth one time a day for agitation for 2 Weeks. This was discontinued on 6/13/2023. Care plans included but were not limited to: I am at risk for adverse side effects due to receiving psychotropic medication (antidepressant and antipsychotic) not dated. The care plan was not updated to reflect the discontinuation of antipsychotic side effects. During an interview on 9/21/23 at 9:36 A.M., the regional clinical support indicated if there are changes in orders the care plan goals should be updated immediately. 3. On 9/20/23 at 8:56 A.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction and history of transient ischemic attack. The most current quarterly MDS Assessment, dated 9/7/23, indicated that Resident 16 was cognitively intact and needed extensive assistance with the assist of 1 for mobility, transfer, and toilet. The 7 day look back indicated the use of an anticoagulant. Physician orders included, but were not limited to: Eliquis Tablet 2.5 MG (Apixaban), Give 2.5 mg by mouth two times a day related to unspecified atrial fibrillation dated 2/28/20. Anticoagulation medication - monitor for		conducted for the resident and/or their representative to review the current care plan. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 46 now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *8.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 7 now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *9.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 22 now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *10.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident M now has documentation to support that a	

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	discolored urine, black tarry stool, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, SOB (Shortness of Breath) nose bleed. Document: "Y" if monitored and none of the above observed. Document "N" if monitored and any of the above was observed and complete progress note with findings every shift dated 12/7/21. The care plans lacked a care plan for anticoagulant use. During an interview on 9/18/23 at 10:48 A.M., Resident 16 indicated she does not know about blood thinners. Progress notes lacked a care plan conference since 3/15/2023. 4. On 9/20/23 at 11:56 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and essential hypertension. The most current quarterly MDS Assessment, dated 6/19/23, indicated Resident 1 was cognitively intact and needed supervision with the assist of 1 for mobility, transfers, and toileting. Progress noted lacked documentation of a care conference since 3/15/23. During an interview on 9/19/23 at 9:05 A.M., Resident 1 indicated they did not know about or participate in care conferences. 5. On 9/20/23 at 9:30 A.M., Resident 14's clinical record was reviewed. Resident 14's diagnoses included, but were not limited to, Chronic		care plan conference has been conducted for the resident and/or their representative to review the current care plan. *11.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident S now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *12.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *13.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P now has documentation to support that a care plan conference has been conducted for the resident and/or their representative to review the current care plan. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice.	

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	Obstructive Pulmonary Disease (COPD) and atrial fibrillation. The most current quarterly MDS Assessment, dated 9/27/23, indicated that Resident 14 was cognitively intact, required extensive assistance of 1 for transfers and bed mobility. Progress notes lacked documentation of a care conference since 3/9/23. On 9/18/23 at 10:07 A.M., Resident 14 indicated they do not know about care conferences. 6. On 9/21/23 at 12:32 P.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, essential tremor and major depressive disorder. The most current quarterly MDS Assessment dated 8/22/23 indicated Resident 20 was cognitively intact and needed supervision with assist of 1 for mobility transfer and eating. Progress notes lacked a care conference since 3/3/23. During an interview on 9/18/23 at 10:48 A.M., Resident 20 indicated she did not know when she last had a care plan conference. 7. On 9/19/23 at 1:18 P.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, (COPD) and occlusion stenosis of carotid artery. The most current quarterly MDS Assessment, dated 7/10/23, indicated Resident 46 was cognitively intact, required supervision with the		A house wide audit of all resident care plans has been conducted to ensure that the care plans have been revised to meet the resident's current needs. In addition, an audit of care plan conferences has been conducted to ensure that there is documentation to support that each resident and/or their representative has been invited to participate in a care plan conference for the resident within the past ninety days. Care plans will continue to be scheduled at least every ninety days or more often if warranted and the results of those care plan meetings documented in the clinical record. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility's care planning policy. Each member was re-educated on their responsibility to ensure that each resident's care plan was revised and updated when warranted to reflect the resident's current needs. The members were also re-educated on their responsibility to ensure that each resident and/or their representative were to be invited to participate in the care plan conferences and that the results of these conferences are to be documented in the	

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	assistance of 1 for transfers and mobility, and was on oxygen. Progress notes lacked documentation of a care plan conference. During an interview on 9/18/23 at 10:29 A.M., Resident 46 indicated they did not know about care plan conferences. 8. On 9/20/23 at 11:10 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 9/23/22. Diagnoses included, but were not limited to, congestive heart failure, spinal stenosis, and generalized anxiety disorder. The most recent quarterly MDS Assessment, dated 7/3/23, indicated Resident 7 had moderate cognitive impairment and required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting. A care Plan Conference was completed on 1/6/23. The clinical record lacked documentation of any other care plan conference. 9. On 9/20/23 at 9:07 A.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 11/1/22. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Obstructive Sleep Apnea, and depression. The most recent quarterly MDS Assessment, dated 8/10/23, indicated Resident 22 was cognitively intact and required supervision from staff for all Activities of Daily Living (ADLs). A care plan conference was completed on 3/15/23. The clinical record lacked documentation of any other care plan conference.		clinical record. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation in the clinical record related to the accuracy of the resident's care plan and to ensure there is documentation to support that each resident and/or their representative have been invited to participate in a care plan conference at least every ninety days or more often if warranted. This tool will be completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	10. On 9/19/23 at 1:13 P.M., Resident M's clinical record was reviewed. Resident M was admitted on 11/4/22. Diagnoses included, but were not limited to, Alzheimer's Disease, Diabetes Mellitus, and depression. The most recent quarterly MDS Assessment, dated 5/14/23, indicated Resident M had severe cognitive impairment and required extensive assistance of 2 or more staff for bed mobility and transfers and total assistance of 2 or more staff for toileting and bathing. A care plan conference was completed on 3/8/23. The clinical record lacked documentation of any other care plan conference.11. On 9/18/23 at 9:51 A.M., Resident S indicated she had not been invited or attended a care plan conference. On 9/19/23 at 1:56 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, Lupus, epilepsy, and depression. The most recent quarterly MDS Assessment, dated 6/27/23, indicated Resident S was cognitively intact, and required limited assistance of one staff with bed mobility, transfers, eating, and toileting. Resident S's clinical record indicated a care plan conference summary on 6/6/22 and 3/8/23. Resident S's clinical record lacked any other documentation that a care plan conference had taken place since 3/8/23. 12. On 9/22/23 at 10:00 A.M., Resident F's clinical record was reviewed. Diagnoses included, but			

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	were not limited to, dementia, anxiety, and non-traumatic brain dysfunction. The most recent quarterly MDS Assessment, dated 7/29/23, indicated a severe cognitive impairment. Resident F required limited assistance of one staff with bed mobility, transfers, and eating. The MDS indicated no wandering behaviors. Resident F's clinical record indicated a care plan conference summary on 6/6/22 and 3/8/23. Resident F's clinical record lacked any other documentation that a care plan conference had taken place since 3/8/23. 13. On 9/19/23 at 8:44 A.M., Resident P's Power of Attorney (POA) indicated she had not been invited or attended a care plan conference. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety. The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting. Resident P's clinical record lacked documentation of a care plan conference taking place since admission on 10/11/22. On 9/21/23 at 9:42 A.M., the Social Services Director (SSD) indicated she had been at the facility for three months and just started documenting care plan conferences in the resident's clinical record. She indicated care plan			

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	conferences were supposed to be completed quarterly. At that time, she indicated if a care plan conference had not been documented in the resident's record, it was assumed it had not been done. During an interview on 9/20/23 at 11:37 A.M., the DON indicated care plan conferences were done quarterly, the MDS coordinator kept up with the care plan revision, the nurse staff did them upon admission, and MDS coordinator took over after that. The care plan should be updated with significant changes and as needed. On 9/21/23 at 11:13 A.M., the Administrator presented a current Care Plans, Comprehensive Person policy, undated, and indicated "a comprehensive, person-centered care plan includes measurable objectives and timetables to meet resident ...needs is developed and implemented for each resident... care plan is consistent with the resident rights to participate in the development of his or her care plan... the resident is informed to participate in his or her treatment ... and provided advance notice of care planning conferences... The interdisciplinary team reviews and updates the care plan...significant change...when desired outcomes are not met...at least quarterly in conjunction with the required quarterly MDS Assessment". 3.1-35(a) 3.1-35(d)(2)(B) 3.1-35(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 1 residents reviewed for insulin. A resident did not receive insulin as ordered, and the physician was not notified of blood sugars over 400 as ordered. (Resident T) Finding includes: On 9/18/23 at 10:52 A.M., Resident T indicated her blood sugars had been running high lately, and she was unsure why. She indicated at that time the facility did not offer a diabetic diet, and expected diabetic residents to know what they could and couldn't eat. She indicated she received the same food as all other residents, and had not received education related to what she should and should not eat to regulate her blood sugar. On 9/19/23 at 11:40 A.M., Resident T's clinical record was reviewed. Diagnosis included, but was not limited to, Diabetes Mellitus. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 7/15/23, indicated no cognitive impairment. Resident T was totally dependent of two staff for bed mobility, transfers, toileting, and bathing. Insulin had been administered 7 of 7 days of the look back period. Current physician orders included, but were not	F 0684	F - 684 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident T has now been re-educated on the best food choices in an effort to aide in the management of their diabetes. The resident is now receiving their insulin in accordance with the physician's orders and professional standards of practice. The resident's physician is also being notified when the resident's blood sugars are over 400 in accordance with the physician's orders. Lab work will be obtained as ordered by the physician. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A house wide audit of all resident MARs/TARs has been conducted. The MARs/TARs reflect that all residents are receiving treatments and care in accordance with professional standards of practice and their	10/25/2023

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	limited to: Insulin Aspart FlexPen 100 UNIT/ML (milliliter) Solution pen-injector, Inject as per sliding scale: if 201 - 250 = 6 u (units); 251 - 300 = 9 u; 301 - 350 = 12 u; 351 - 400 = 15 u; 401+ = 18 u and call M.D. (medical doctor), if not reduced, subcutaneously before meals and at bedtime, dated 3/30/23. accu checks achs [sic] (before meals and at bedtime) and prn (as needed), dated 1/18/23. Insulin Aspart Solution Pen-injector 100 UNIT/ML Inject 5 units subcutaneously before meals, dated 10/8/22. Basaglar KwikPen Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Glargine) Inject 30 units subcutaneously at bedtime, dated 3/29/23. May admit to hospice, dated 1/30/23. A current diabetic care plan, dated 11/3/21, included but were not limited to, the following interventions: Diabetes medication as ordered by doctor and fasting serum blood sugar as ordered by doctor, dated 11/3/21. Resident T's Diabetic Administration Record (DAR) for 7/2023 through 9/2023 indicated the following dates the blood sugar was over 400: 7/10/23 at 4:30 P.M. (424) 7/22/23 at 11:30 A.M. (461) 8/28/23 at 4:30 P.M. (432) 9/3/23 at 11:30 A.M. (404) 9/5/23 at 6:30 A.M. (445) 9/5/23 at 4:30 P.M. (425) 9/6/23 at 4:30 P.M. (460) 9/9/23 at 8:00 P.M. (421)		individualized physician's orders. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's required professional standard of practices. The staff members were re-educated on their responsibility to ensure that each resident is to receive the care and services as outlined by their specific physician's orders and that the staff members are responsible for documenting the care and services provided in the clinical record. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality assurance tool has been developed and implemented to monitor the documentation to support that each resident is receiving treatments and care in accordance with professional standards of practice as outlined by their specific physician's orders. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	9/12/23 at 4:30 P.M. (452) 9/12/23 at 8:00 P.M. (452) 9/14/23 at 11:30 A.M. (413) 9/14/23 at 4:30 P.M. (490) 9/19/23 at 4:30 P.M. (401) The clinical record lacked documentation of notification to the MD as ordered for blood sugars over 400. The DAR from 7/2023 through 9/2023 indicated the following dates insulin had not been administered as ordered: Insulin Aspart FlexPen not received: 7/1/23 at 8:00 P.M. (blood sugar also not done) 7/2/23 at 8:00 P.M. (blood sugar also not done) 7/7/23 at 8:00 P.M. (blood sugar also not done) 7/9/23 at 8:00 P.M. (blood sugar also not done) 7/13/23 at 8:00 P.M. (blood sugar also not done) 7/14/23 at 8:00 P.M. (blood sugar also not done) 7/17/23 at 8:00 P.M. (blood sugar also not done) 7/20/23 at 8:00 P.M. (blood sugar also not done) 7/21/23 at 8:00 P.M. (blood sugar also not done) 7/29/23 at 8:00 P.M. (blood sugar also not done) 8/6/23 at 8:00 P.M. (blood sugar also not done) 8/7/23 at 4:00 P.M. 8/7/23 at 4:30 P.M. (blood sugar also not done) 8/12/23 at 8:00 P.M. (blood sugar also not done) 8/30/23 at 4:00 P.M. 8/30/23 at 4:30 P.M. (blood sugar also not done) 9/17/23 at 4:00 P.M. 9/17/23 at 4:30 P.M. (blood sugar also not done) The DAR from 7/2023 through 9/2023 indicated the following dates insulin had not been administered as ordered: Basaglar KwikPen 30 units at bedtime: 7/1/23 7/2/23 7/7/23			

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	7/9/23 7/13/23 7/14/23 7/17/23 7/20/23 7/21/23 7/29/23 8/6/23 8/12/23 Resident T's clinical record indicated a Hemoglobin A1c had been collected 8/14/22. The clinical record lacked another collection of Hemoglobin A1c. On 9/20/23 at 1:01 P.M., the Director of Nursing (DON) indicated any notifications should have been documented in a progress note. On 9/22/23 at 12:07 P.M., the Dietary Manager indicated the facility did not currently have therapeutic diets including diabetic diets, but they would be getting them soon to implement. On 9/22/23 at 1:23 P.M., the DON indicated she could not locate any documentation of notification to the MD related to Resident T's blood sugars over 400. On 9/22/23 at 2:12 P.M., the DON indicated since Resident T was on hospice, she could eat whatever she wanted as comfort foods. She further indicated all labs were discontinued when hospice started in January, and prior to that, only one diabetic lab was performed. 3.1-37(a)			
F 0689 SS=G	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	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 to prevent accidents. Based on observation, interview, and record review, the facility failed to revise care plans and follow interventions to reduce the risk of falls for 2 of 4 residents reviewed for accidents. This deficient practice resulted in a fall with fractures requiring hospitalization and a fall with a closed head injury requiring hospitalization. (Resident M, Resident P). Findings include: 1. On 9/19/23 at 1:13 P.M., Resident M's clinical record was reviewed. Resident was admitted on 11/4/22. Diagnoses included, but were not limited to, Alzheimer's Disease, Major Depressive Disorder, and Diabetes Mellitus. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 5/14/23, indicated Resident M had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility and transfers and a total assistance of 2 or more staff for toileting and bathing, and had no falls since the prior MDS assessment on 4/5/23. Current physician orders included, but was not limited to: Low bed at all times while in bed and not receiving care, dated 8/31/23.	F 0689	F - 689 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident M has now been reassessed related to their specific fall prevention interventions. The care plan has been revised to reflect the current fall safety interventions and all nursing staff has been in-serviced on the resident's current safety interventions and their responsibility to ensure that those safety interventions are in place at all times. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has now been reassessed related to their specific fall prevention interventions. The care plan has been revised to reflect the current fall safety interventions and all nursing staff has been in-serviced on the resident's current safety interventions and their	10/25/2023

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	Toe touch weight bearing on the left side, dated 8/25/23. Maintain Post total hip precautions for L (left) hip arthroplasty, dated 5/25/23. A current falls care plan, revised 7/17/23, indicated Resident M was at risk for falls due to a history of a wedge compression fracture and included the interventions: Staff to ensure resident using walker at all times while ambulating, dated 11/11/22. Relocate closer to Nurse's station when out of isolation, dated 4/4/23. Assistive device front wheeled rolling walker, dated 11/21/22. Encourage and educate resident on using the call light when needing assistance. Clip call light to shirt for visual reminder when in chair or bed in room, dated 11/21/22. Low bed, dated 8/30/23. Non skid footwear at all times, dated 11/21/22. Non skid strips left side of bed, dated 7/18/23. Therapy as ordered, dated 11/21/22. Transfer assist with 1 staff assist, gait belt and walker at all times, dated 11/21/22. The clinical record indicated Resident M had fallen 5 times since admission. On 11/10/22 at 4:15 A.M., Resident M sustained an unwitnessed fall while attempting to ambulate to the bathroom. The intervention "staff to ensure resident using walker at all times while ambulating" was added to the care plan. On 11/21/22 the following interventions were added: assistive device front wheeled rolling walker, Encourage and educate resident on using the call light when needing assistance. Clip call light to shirt for visual reminder when in chair or bed in room, non-skid footwear at all times, Therapy as		responsibility to ensure that those safety interventions are in place at all times. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A house wide audit has been completed for all residents related to their potential safety risk factors. Each resident's fall risk care plan has been reviewed and revised to reflect the resident's specific fall interventions. All nursing staff has been in-serviced on each resident's current safety interventions and their responsibility to ensure that those safety interventions are in place at all times. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's fall prevention program policy. The staff was re-educated on the use of safety interventions specific to each resident's needs in an effort to prevent falls and/or prevent injury from a fall. The staff was reminded of their responsibility to ensure that the resident's care plans are updated following each fall and that each staff member is responsible for ensuring that the resident's safety interventions are	

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	ordered, and transfer assist with one staff member, gait belt and walker at all times. On 4/3/23 at 1:00 P.M., Resident M sustained an unwitnessed fall. At that time, the resident was in isolation for COVID-19. The resident was unable to recall what happened and was sent to the ER (emergency room) for treatment and evaluation. The intervention "relocate closer to nurse's station when out of isolation" was added to the care plan on 4/4/23. A progress note, dated 5/16/23, indicated that Resident M had been complaining of left hip pain especially when in therapy and was ordered to get a left hip x-ray. A progress note, dated 5/17/23, indicated the x-ray showed an old femoral neck fracture with moderate displacement and bone resorption without callus formation. The resident was sent to the hospital. A progress note, dated 5/18/23, indicated the resident was scheduled for hip surgery. Resident M was readmitted to the facility on 5/21/23. On 6/28/23 at 4:15 P.M., Resident M sustained a witnessed fall while attempting to stand up unassisted from the bed. The fall was witnessed by maintenance staff. The resident hit his head on his bedside table and complained of left hip pain. The resident was sent to the ER. The intervention "non skid strips left side of bed" was added to the care plan on 7/18/23. A progress note, dated 6/28/23 at 6:04 P.M., indicated the resident would be admitted to the		in place in accordance with their plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's safety intervention plan. The tool will monitor to ensure that the resident's safety interventions are in place and that the care plan has been updated following each fall with new appropriate safety interventions added following each fall. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	hospital with a fracture to his left femur and would require surgery. Resident M was readmitted to the facility on 7/3/23. On 8/22/23 at 8:30 P.M., Resident M sustained a witnessed fall. Staff observed the resident sliding from the bed onto the floor landing on his buttocks, but was unable to reach the resident in time to stop the fall. The care plan was not updated with an intervention. The clinical record lacked documentation of an IDT (interdisciplinary team) meeting. Fall Documentation, dated 8/23/23, indicated the resident needed a low to the floor bed. On 8/25/23 at 2:45 A.M., Resident M sustained an unwitnessed fall while attempting to get out of bed. Resident was observed sitting on the floor with both legs out in front of him. At that time, he complained of left hip pain, the left leg appeared to be longer than the right leg and was rotated inward, and resident was unable to move his left leg. The resident was sent to the ER. The intervention "low bed" was added to the care plan. The clinical record lacked documentation of an IDT meeting. The low bed was added to the care plan on 8/30/23. A progress note, dated 8/25/23, indicated Resident M had a left hip fracture that would be repaired nonsurgically. Orders were given to get repeat films in 2 weeks, monitor pain relief at the facility, and to be toe touch weight bearing on the left side. On 9/18/23 at 10:05 A.M., Resident M was observed lying in bed. The bed was raised. There			

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	was a sign next to the bed that indicated "Put my bed back in lowest position before you leave! Thank you!". There were no skid strips next to the bed. On 9/20/23 at 8:35 A.M., the resident was observed sitting in his recliner in his room. There were no skid strips next to the bed, no walker in the room, and the call light was wrapped around the bed side rail. On 9/20/23 at 10:52 A.M., OT (occupational therapist) 27 and PT (physical therapist) 19 indicated that Resident M came off of toe touch weight bearing orders last week and was now full weight bearing for transfers. They indicated that the resident used a walker previously, but had not used a walker for a while now. On 9/20/23 at 3:22 P.M., Resident M was observed lying in bed. The bed was raised. At that time, the DON (Director of Nursing) indicated the bed was not in its lowest position and it should be. On 9/21/23 at 9:18 A.M., QMA (Qualified Medication Aide) 2 indicated fall interventions for Resident M were a low bed, assistance of 2 staff for transfers using a gait belt, and skid strips next to the bed. At that time, QMA 2 indicated the skid strips were not there. On 9/21/23 at 9:23 A.M., CNA (Certified Nurses Aide) 7 indicated she was not sure what fall interventions were in place for Resident M. On 9/21/23 at 2:52 P.M., Resident M was observed lying in bed. The bed was raised. At that time, the DON indicated the bed was not in the lowest position and should be. She indicated that all staff were gathered earlier that morning and inserviced			

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	about Resident M's bed being in the lowest position.2. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and non-traumatic brain dysfunction. Admission date was 10/11/22. The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting, and was totally dependent of two staff for bathing. Resident P had experienced one fall with injury since the previous assessment. A falls risk assessment, dated 10/12/22 indicated a moderate fall risk on admission. Current physician orders included, but were not limited to, the following: pommel cushion for positioning, dated 3/21/23. A current risk for falls care plan, dated 10/12/22, included, but were not limited to, the following interventions: Fall mat placed at bedside, dated 6/14/23. If resident is in a stationary chair, keep wheelchair out from resident reach/vision to prevent resident from attempting to transfer without assistance, dated 11/4/22. Non skid footwear at all times, dated 10/12/22. Fall incident reports since admission included the following falls: Fall 1 11/4/22 at 12:10 P.M. Fall was witnessed. Resident stood up from a chair, pushed her wheelchair over, and sat on the floor. She did not hit her head. The new intervention at that time was to move wheelchair out of reach, and the care plan			

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	was updated. Fall 2 12/4/22 at 12:15 P.M. Fall was not witnessed by staff. Resident stood from wheelchair attempting to get into bed and fell per roommate, resulting in a facial laceration. First aid applied, and resident was sent to the Emergency Room (ER). At the ER, a CT of cervical spine without contrast and CT of the head without contrast were both negative for injury. The following day, 12/5/22, the Interdisciplinary Team (IDT) reviewed the fall and agreed that an appropriate intervention following the fall was a pad alarm at all time. The falls care plan was not updated with a new intervention. Fall 3 12/29/22 at 7:30 A.M. Fall was not witnessed. Resident fell while ambulating in her room, and hit back of head. Resident was sent to the ER, where she fell again. Resident received three staples to a laceration on the back of head, and a CT was negative. Upon return from the ER, and alert note dated 12/29/23 indicated a new intervention for a self release alarm belt. The falls care plan was updated. Staples were removed 1/13/23. Fall 4 1/16/23 at 11:35 P.M. Fall was not witnessed. Resident was found with neck cocked to the left side against the wall with blood on the wall. The resident was pale and with loss of consciousness, as she was staring with eyes deviated up not blinking or moving. When assessed, pupils were slightly unequal. The roommate indicated the resident had gotten up to walk and tried to grab the wheelchair and fell. Resident regained consciousness after about a minute, and was sent to the ER, where she received three staples to the back of the head (in a different area than the			

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	previous fall). Prior to the fall, an alert note dated 1/15/23 indicated "resident got up out of bed and ambulated in the hall, she is placed in her wheelchair, she is making repeated attempts to ambulate on her own, her gait is too unsteady for this, she is toileted given tylenol and put back to bed, no further attempts to ambulate on her own, bed alarm in place". The falls care plan was not updated with a new intervention. Staples were removed on 1/27/23. Fall 5 6/13/23 at 3:30 P.M. Fall was not witnessed. Resident was found on the floor with a large hematoma on the left side of the forehead and dilated pupils. Resident was alert to staff, and blood pressure was elevated at 206/93. Resident was sent to the ER and returned same day. An alert note dated 6/13/23 at 8:04 P.M. indicated "Resident received back from hospital with a diagnosis of closed head injury and scalp hematoma, hematoma and bruising noted on the left forehead and a dressing noted on the left elbow ..." Prior to the fall, on 6/13/23 at 1:35 P.M., an alert note indicated "resident noted to be trying to exit the foot of her bed, this resident returned to the correct position per 1, bed in low position and her mat in place." Care plan was updated on 6/14/23 for fall mat at bedside. Progress notes included, but were not limited to, the following: 10/22/22 at 12:39 P.M. "Admission ... While in ER(9/26)fell and hit head causing a hematoma on scalp ..." 1/17/23 at 2:39 P.M. "... Res [resident] is lethargic and unable to stand w/o [without] max assist of 2 ..."			

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	1/30/23 at 1:26 P.M "CNAs' reported concern to this RN about residents L [left] facial droop. Resident was laying asleep on her left side in recliner with pull tab alarm on, after receiving morning medication. When resident awoke CNAs took resident to dining room to eat. CNAs statedresident [sic] had "L flaccid arm and not making eye contact." Upon RN assessment resident sitting in w/c [wheelchair] leaning to left, but this position not abnormal for resident, neither is residents L facial droop. RN walked behind residents left side, she turned andlooked [sic]. Walked to residents' right side, she turned and looked ... RN does not see any indication to send resident to hospital at this time" 1/30/23 at 3:37 P.M. Nurse Practioner visit indicated "no new orders" 2/13/23 at 6:46 A.M. "this resident is sitting on the floor at this time". The clinical record lacked any other information related to the fall. 3/6/23 at 12:09 P.M. "Resident has slid out of w/c twice in front of nurses. Did not hit head, no injuries. [psych services] called for recommendation". The clinical record lacked any other information related to the fall. 3/6/23 at 12:45 P.M. "OK to increase Klonipin [sic] [an anti-anxiety medication] to 0.5mg TID [three times a day]" 3/14/23 at 10:42 A.M. "HOLD [medication orders] PER LPN/resident lethargic" 3/18/23 at 1:48 P.M. "HOLD this noon clonazepam [an anti-anxiety medication] per LPN d/t sleeping, lethargy"			

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	6/15/23 at 9:57 A.M. "Therapy came to RN and expressed concern that resident is lethargic. Asleep in the chair with head lying R [right] side. Resps [respirations] 17 even/ unlabored. Resident arouses to stimuli, moves all extremities. Hematoma to L eye unchanged, scabbed over ... Continue to monitor" 6/30/23 at 12:21 P.M. "resident was in bed lying on back and vomitted [sic] small amount. lungs sounded wet upper anterior and diminished throughout posteriorly. when turned to listen she coughed pretty forcefully clearing some. resident was gotten up in chair. reported that resident had vomited couple times past few days. went and listened to resident again and upper airway has cleared some. she is in no distress. abdomen is soft but bowel sounds are diminished. texted [Nurse Practitioner] all the above. awaiting further instructions" 6/30/23 at 2:02 P.M. "[Nurse Practitioner] here to see resident. resident looks better. lungs fairly clear diminished posteriorly. BS hypoactive. she is in no distress. no new orders at this time. resident in bed with head of bed elevated" 7/5/23 at 2:52 P.M. "follow stroke protocol and send to ER for CT scan of brain. Sedating meds held at lunch. Sent to ER ..." 7/6/23 at 6:02 P.M. "... Res admitted with Pneumonia. Will continue to follow up" 7/8/23 at 5:00 P.M. "resident returned from the hospital per transport and is in a wheelchair at this moment, resident transferred per 1 without difficulty, this resident has a fixed glaze at this time and her pupils do not react to light, facial			

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	features are not bilateral, adrooping [sic] noted on the left side of her mouth, an MRI in hospital showed negative for stroke [two days prior], bruising noted on her right wrist and left top of her hand, red sacrum covered with a mepilex at this time, 127/69,P80, T98, R16,02 sat is 93%, resident is in bed on her left side and the bed is in low position, call bell at bedside although resident never utilizes it, no attempts to get out of bed, she is trying to sleep" 7/8/23 at 7:32 P.M. "after 2 attempts made to feed this resident but still not waking up, will try snacks later if she wakes up, in bed in low position, no attempts made to get out on own" 7/10/23 at 10:22 A.M. "Res has been noted to pocket food at meals. Oral care after meals has Un swallowed food. Res is having difficulty swallowing since return from hospital. left side of face has droop and res tends to lean to left side. Will report to Speech therapist and have evaluated. Will monitor" 7/14/23 at 5:48 P.M. "I spoke with [POA] and stated that [resident] is declining and could benefit from a hospice evaluation, [POA] approved completely that we could implement hospice, hospice will be notified ..." 8/5/23 at 6:08 P.M. "Resident has appeared restless throughout this shift more so after 12p, fidgeting around while in w/c causing chair alarm to sound, as well as while in bed, had to be assisted from fall mat in bdrm [bedroom] back into bed multiple x's [times] after 1200" On 9/20/23 at 8:38 A.M., Resident P was observed sitting in a high back wheelchair in the common area with an alarm box hanging from the back of it			

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	and clipped to the collar of her shirt. The back of the wheelchair was observed with the left anti-tipper facing down and engaged, and the right was facing up. Resident P was observed to rock back and forth in the wheelchair. On 9/21/23 at 1:33 P.M., Resident P was observed during the survey on the floor between the bed and a mat on buttocks wearing incontinence brief and no pants. The fall mat was observed 1-2 feet from the bed. Resident P was observed grimacing and moaning. The sock on the left foot was hanging halfway off. Staff was notified and assisted the resident back into the bed. Once back in the bed, Resident P was observed to move around a lot. On 9/21/23 at 2:19 P.M., the Director of Nursing (DON) indicated Resident P had been care planned to come off of the bed onto a mat, and because of that would not be considered a fall every time she rolled out of bed. At that time, Resident P's care plan were reviewed with the DON and she indicated that intervention had not been care planned as intended. On 9/22/23 at 9:25 A.M., Resident P was observed lying in bed. Resident P's wheelchair was observed beside the foot of the bed within sight of the resident. On 9/22/23 at 11:22 A.M., the DON indicated Resident P's wheelchair should be out of reach as well as out of sight while lying in the bed. On 9/25/23 at 9:26 A.M., Resident P was observed sitting in a high back wheelchair in the common area with no socks or shoes on. On 9/21/23 at 2:10 P.M., the DON indicated that,			

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	after a fall, the IDT meets and the care plan should be updated with a relevant intervention that is different than before. On 9/21/23 at 12:49 P.M., the Administrator provided a current non-dated Falls and Fall Risk policy that indicated "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... a fall is defined as" Unintentionally coming to rest on the ground, floor or other lower level ... Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred ... If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...". This Federal tag relates to complaint IN00417903. 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure that residents	F 0695	F - 695 *1.) The corrective action taken for*	10/25/2023

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	received necessary respiratory care and services in accordance with professional standards of practice for 3 of 3 residents reviewed for Respiratory Care. Care plans and orders were not revised, and tubing and humidification bottle changes were not documented. (Resident 14, Resident 46, Resident 7) Findings include: 1. On 9/18/23 at 9:48 A.M., Resident 14's oxygen concentrator was observed to have no water in the humidification bottle and the tubing was not dated. On 9/18/23 at 10:36 A.M., Resident 46 was observed wearing a nasal cannula that was not dated. On 9/20/23 at 9:00 A.M., Resident 46 was observed wearing a nasal cannula that was not dated On 9/20/23 at 9:10 A.M., Resident 14's oxygen concentrator was observed to have no water in the humidification bottle and the tubing was not dated. On 9/20/23 at 9:30 A.M., Resident 14's clinical record was reviewed. Resident 14's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation. The most current quarterly MDS (Minimum Data Set) Assessment, dated 9/27/23, indicated that Resident 14 was cognitively intact, required extensive assistance of 1 for transfers and bed mobility, and was on oxygen.		*those residents found to have been affected by the deficient practice is that* the resident identified as resident 14 now has an oxygen cannula that is dated, the humidification bottle contains water and the resident's oxygen saturation is being documented in the clinical record in accordance with the physician's orders. The resident's respiratory equipment, (cannula, humidifier bottle) are being changed out weekly and dated when placed in service. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 46 now has their nasal cannula dated when placed into service. Their respiratory equipment is changed out weekly and dated when placed into service. The resident's oxygen saturations are now being recorded in the clinical record as ordered by the physician. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 7 now has their nasal cannula and humidifier bottle dated. The respiratory equipment is changed out every seven days per facility policy. The equipment is now being dated when placed in service. The MAR has now been updated to reflect a place to document oxygen	

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	Current physician orders included, but were not limited to: May apply O2 (oxygen) 2-4 LPM (liters per minute) via nasal cannula as needed for SOB (shortness of breath) to keep SpO2 (percent of oxygen in the blood) > (greater than) 88% every 12 hours dated 11/26/22. Monitor O2 saturation every 12 hours two times a day for O2 use, dated 11/26/22. On 9/21/23 at 12:30 P.M., the regional director provided a copy of Resident 14's TAR (treatment administration record) for September 2023, for checking oxygen saturation every shift. The following day shifts lacked documentation on 9/1 and 9/7. The following night shifts lacked documentation on 9/2, 9/6, 9/9, 9/12, 9/16, and 9/19. Current care plans included, but were not limited to: Potential for shortness of breath (SOB) while lying flat r/t (related to) COPD and smoking that included the intervention, but was not limited to, administer oxygen per MD (Medical Doctor) order, unknown date. 2. On 9/19/23 at 1:18 P.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and occlusion stenosis of carotid artery. The most current quarterly MDS Assessment, dated 7/10/23, indicated Resident 46 was cognitively intact, required supervision with the assistance of 1 for transfers and mobility, and was on oxygen.		saturations when the resident is utilizing their prn oxygen. In addition, the care plan has been updated to reflect the resident's use of prn oxygen. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents who currently have orders for oxygen therapy are potentially at risk for this deficient practice. A house wide audit has been completed on all residents that currently have orders for oxygen therapy. All residents that utilize oxygen have their respiratory equipment dated when placed in service, equipment is changed out weekly when in use, oxygen saturation levels are recorded in the clinical record per physician's orders and their care plans have been updated to reflect the use of oxygen therapy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all nursing staff on the facility oxygen administration policy. The staff members have been re-educated on their roles of ensuring that the equipment is being dated when placed in service, that the humidifier bottles contain water at all times, that oxygen saturations are being recorded in the clinical record in accordance with the	

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	Current physician orders included, but were not limited: wear 2L (liters) of O2 at all times to maintain O2 levels above 90% dated 4/21/23. On 9/21/23 at 12:30 P.M., the regional director provided a copy of Resident 46's TAR for September 2023, for checking oxygen saturation every shift. The following day shifts lacked documentation on 9/1 and 9/15. The following night shifts lacked documentation on 9/2, 9/5, 9/6, 9/9, 9/12, 9/16, 9/18 and 9/19. Current care plans included, but were not limited to: The resident has oxygen therapy r/t COPD that included the intervention but was not limited to, oxygen settings via O2 nasal cannula to maintain levels >90%. 3. On 9/18/23 at 09:45 A.M., Resident 7 was observed receiving oxygen at 3 L per minute. The oxygen tubing and the humification bottle were not labeled with the date they were last changed. On 9/20/23 at 8:40 A.M., Resident 7 was observed receiving oxygen at 3 L per minute. The oxygen tubing and the humification bottle were not labeled with the fate they were last changed. On 9/20/23 at 11:10 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD). The most recent quarterly assessment, dated 7/3/23, indicated that Resident 7 had moderate cognitive impairment and was on oxygen. Current physician orders included, but was not limited to: May apply oxygen 1-3L NC (nasal canula) to		physician's orders and that the care plans reflect the use of oxygen therapy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the facility's administration of oxygen therapy. The tool will monitor to ensure that the respiratory equipment is dated when placed in service, and that there is water in the humidifier bottles. The tool will also monitor to ensure that the equipment is changed out weekly and that oxygen saturation levels are being recorded in the clinical record as ordered by the physician. The tool will also monitor to ensure that the care plan reflects the use of oxygen therapy. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	maintain O2 (oxygen) SATS (saturations) above 90%., dated 4/3/23 The clinical record lacked orders, progress notes, or care plans related to how often tubing and humidification bottles were supposed to be changed. On 9/20/23 at 11:02 A.M., LPN (Licensed Practical Nurse) 2 indicated that [name of company] changed the tubing weekly when they were in the facility and the nurses changed the humidification bottles when they noticed they were low, but there was nowhere to document it had been done. During an interview on 9/20/23 at 11:19 A.M., the regional consultant indicated that [name of company] checked machines, made sure they worked, brought in tubing and waters, and used to come in and date them, but didn't do it last week because of COVID in the facility. She further indicated there should be a piece of tape around the tubing with the date, and it was a night shift duty. During an interview on 9:11 A.M., the regional consultant indicated if resident was on continuous oxygen, she would take sats each shift. If PRN (as needed) and she noticed that the resident was symptomatic, she would check O2 sats. If < 90, she would start O2 and report it to the nurse practitioner. Therapy would also check O2 sat. She would also report to MD (medical doctor) if the resident was symptomatic and used O2 more. She indicated the PRN and continuous O2 check should be on the MAR (Medication Administration Record) or TAR (treatment administration record). On 9/20/23 at 1:58 P.M., the DON (Director of			

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	Nursing) provided a current Oxygen Administration policy, undated, and indicated "the purpose of this procedure is to provide guidelines for safe oxygen administration... check the mask, tank, humidifying jar, etc. to be sure in good working order...Be sure there is water in the humidifying jar and that the water level is high enough...that bubbles as oxygen flows". 3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure a resident with dementia received the appropriate treatment and services to maintain their highest level of well-being for 1 of 2 residents reviewed for dementia care. (Resident F) Finding includes: On 9/20/23 at 8:35 A.M., Licensed Practical Nurse (LPN) 2 indicated Resident F had behaviors of leaving her room and getting into bed with other residents especially at night. She indicated an alarm box was placed at the top of her door with a motion sensor to alert staff when she was leaving her room at night, but it had not worked well. She indicated she was unsure what they were going to do as a new intervention. On 9/21/23 at 8:41 A.M., Resident F was observed wandering in Resident T's room.	F 0744	F - 744 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F is now receiving behavioral services from a new psychiatric service. In addition, new assessments have been completed for activity preferences, wander risk assessment and social services to address the resident's current needs. The resident will continue to be evaluated by the new behavioral health service and behaviors tracked in accordance with facility policy. A new behavioral care plan has also been developed and implemented to address the resident's current	10/25/2023

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	On 9/22/23 at 9:25 A.M., Resident F was observed lying in bed. An alarm box was observed hanging from the side rail, with a cord going under the resident. The lights on the box were not lit. At that time, LPN 25 indicated she was unable to tell if the pad alarm was on or functioning, and did not want to test it because it may wake the resident. After checking the box, LPN 25 indicated the alarm was not on. On 9/22/23 at 9:42 A.M., Hospitality Aide 6 indicated Resident F wandered a lot in and out of other resident rooms, hallways, and at the nurse's station, and had been instructed to re-direct the resident. She indicated it was sometimes difficult to re-direct, and would notify the nurse when she displayed those behaviors. On 9/22/23 at 10:00 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and non-traumatic brain dysfunction. Admission date was 12/30/21. The most recent quarterly MDS Assessment, dated 7/29/23, indicated a severe cognitive impairment. Resident F required limited assistance of one staff with bed mobility, transfers, and eating. The MDS indicated no behaviors. Resident F's clinical record lacked a current physician's order related to behaviors or behavior monitoring. A current wandering care plan, dated 1/11/22, indicated the following interventions: I will not leave facility unattended through the review date. My safety will be maintained through the review		behaviors. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents diagnosed with dementia have the potential to be affected by this deficient practice. All residents diagnosed with dementia have been reviewed to ensure that they are receiving appropriate treatment and services in an effort to maintain their highest level of well-being. In addition, a house wide audit of all employee files has been completed to identify which employees need the required dementia training. Dementia training has now been provided for all those identified employees. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policies related to dementia care and behavioral management. The staff members were re-educated on providing the necessary treatment and services for those residents with dementia. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor that the resident with dementia is receiving the appropriate treatment and services	

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	date. I will demonstrate happiness with daily routine through the review date. Monitor for fatigue and weight loss. Pad alarm to bed. A current cognitive loss related to diagnoses of dementia care plan, dated 1/4/22, indicated the following interventions: Activities to assess and provide appropriate level activities for memory improvement. Approach resident warmly and positively. Attempt to limit re-orientation of resident to once per contact. Check frequently for safety. Encourage family/responsible party to visit at frequent intervals. Engage resident in conversation and arrangement of personal effects in room to help re-orientate. Engage resident in conversation during meal time. Establish daily routine with resident. Give on instruction at a time to resident. Praise resident for appropriate verbal response. Provide consistency in scheduling direct care providers on all shifts when possible. Provide verbal reminders to resident as necessary to assist with recall of recent events. A current impaired cognitive function impaired thought processes related to dementia care plan, dated 1/4/22, indicated the following interventions: Ask yes/no questions in order to determine my needs. Communicate with myself/family/caregivers regarding residents capabilities and needs. Cue, reorient and supervise me as needed. Discuss concerns about confusion, disease process, nursing home placement with myself/family/caregivers.		to maintain the highest level of well-being. The tool will monitor to ensure an appropriate plan of care has been developed implemented to provide the necessary care and services to meet their specific needs. The tool will also monitor to ensure that all staff members have received and continue to receive the required dementia training in accordance with the regulations. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	I will take medications as ordered. Monitor/document for side effects and effectiveness. Use task segmentation to support short term memory deficits. Break tasks into one step at a time for me. A current Activities care, dated 6/9/22, indicated the following interventions: All staff to converse with resident while providing care Assist with arranging community activities. Arrange transportation. Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and age appropriate. Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities. Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Provide with activities calendar. Notify resident of any changes to the calendar of activities. Review resident's activation needs with the family/representative. Thank resident for attendance at activity function. The resident needs assistance with activities of daily life as required during the activity. The resident needs 1:1 bedside/in-room visits and			

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	activities if unable to attend out of room events. The resident needs assistance/escort to activity functions. Resident F's clinical record lacked resident-centered and resident specific care plans or interventions related to a diagnosis of dementia. Progress notes included, but were not limited to, the following: 7/4/23 at 10:25 P.M. "this resident is wandering into others rooms, she is toileted and put into a dry brief and gown and put to bed, staying in bed at this moment" 8/7/23 at 12:07 P.M. MD Visit "... Patient is found in the common area, resting on sofa. She is easily alerted when name is called. Staff expresses recent change in behaviors. She has been more irritable lately; had an episode of agitation and resistance to care during shower over the weekend. Mood lability noted as well as sexually inappropriate behaviors. Staff shared with me a couple examples of inappropriate behaviors including resident laying next to her roommate in bed with no pants on; she tried sitting on a male co-resident's lap a few times; also kissed a different male co-resident on the lips. These behaviors are very unlike her. When mood changes and behaviors were addressed with PCP, PCP initially increased tramadol ..." 8/9/23 at 8:51 A.M. "... res [resident] continues to become very busy, confused, wondering [sic], picking up things, etc. in the evening ..." 8/11/23 at 4:01 P.M. "Resident was at BINGO / ICE CREAM PARTY 8/11/23 afternoon (2:00PM - 3:15PM) Resident sat with activity Director during			

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	activity and spoke quietly to staff / self the duration of the activity. Resident was speaking about how she would like to "take some of these good looking men back to bed with her" and "if she could just get her hands on one of these men, she would sure show them a good time" This is unusual talk for resident. This staff has noticed that sexual talk has become more frequent with the resident within the past week along with increased agitation and refusal of meals. Nursing staff has been notified of residents changed behavior and is monitoring" 8/12/23 at 2:54 A.M. "res [resident] up and down frequently tonight. Wondering [sic] down hall. Redirected to room several times and has finally gone to sleep. Increased confusion and easily upset with staff. Agitation has increased even with restart of lexapro [an antidepressant medication]. Will monitor and update [psych services]" 8/13/23 at 8:47 P.M. "res [resident] wondering [sic] into other res [resident] rooms getting into their beds and belongings. Res redirected and will come out of her room and roam into others. Monitoring and redirecting. Res [resident] becomes agitated at times with redirection" 8/15/23 at 12:00 A.M. "At last follow-up visit, resident was restarted on Lexapro as behaviors seemed to be increasing since PCP [primary care provider] discontinued the Lexapro [an antidepressant]. However, nursing staff has not noted any improvement over the last couple weeks; instead, her behaviors continue to worsen. Staff states she has started to become combative at times when redirection attempts are made. Staff is requesting a short-term PRN [as needed] anxiolytic [anti-anxiety] to help manage current			

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	behaviors for now. According to recent facility progress notes, resident has been wandering into other rooms, and grabbing others belongings and getting into their beds at times. Staff has to keep a very close eye on her toavoid [sic] conflict" 8/18/23 at 5:34 P.M. "resident is pleasant and cooperative with staff, she is also wandering into others rooms and sitting on the beds, this resident is redirected ..." 8/23/23 at 1:45 A.M. "When making rounds noted that resident was not in her room or in bed. Continued rounds and immediately found resident in room 20 bed A. Noted resident had been incontinent as she had removed her brief and place on floor. Assisted female resident OOB [out of bed] andcovered [sic] her withs [sic] sheet to provide privacy and dignity . She ambulated up the hallway and to BR [bedroom] where she was tolieted [sic] and peri care provided. PJs reapplied and resident assisted to bed. Resident placed on 15 minute checks for her safety d/t [due to] wandering" 9/6/23 at 1:58 A.M. "Resident awake and ambulating past nurse's station. CNA [Certified Nurse Aide] greeted resident but she continued ambulating down the hallway so CNA walked alongside her. CNA asked resident if she needed to use the commode and motioned towards central BR [bathroom]. Resident said "No I'mjust [sic] going in the room" and ambulated towards door of an occupied room. Staff redirected her easily and assisted back to her room. Resident brief was dry and intact and she wouldn't allow staff to toilet. She climbed back in her bed and laid down. 15 minsafety [sic] checks will be implemented for the remainder of the shift ..."			

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	9/8/23 at 4:09 P.M. "this resident often wanders into others room and sleep in the bed, she is found in another room and easily redirected" 9/12/23 at 12:31 A.M. "wandering up and around nursing desk, easily redirected, resident then lay down on the sofa to rest" 9/14/23 at 2:50 A.M. "Resident up wandering hallway attempted to enter room 22B and and [sic] lay down with resident as staff intervened. Assisted resident back to bed. Bed alarm applied to bed per NM [nurse manager] to monitor resident's movements" 9/20/23 at 5:40 P.M. "calmer since change in medication. Easily redirected. Still up wondering at times. No sexual talks or actions. Will continue to monitor" Resident F's clinical record lacked a care plan conference since 3/8/23. Quarterly wandering assessments from 9/2022 through 9/2023 included the following: 2/16/23 High risk to wander 4/25/23 High risk to wander The clinical record lacked a wandering assessment since 4/25/23. Resident F's clinical record lacked behavior assessments. Resident F's clinical record lacked preferences or likes/dislikes. The most recent activities assessment was completed 6/30/22. The most recent social services assessment was			

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	completed 1/1/22 upon admission. On 9/25/23 at 10:32 A.M., Resident F was observed lying in her roommate's bed. The Activities Director indicated she was not going to wake her as she did not want to cause behaviors and wanted her to sleep. A pad alarm was not observed on the bed. The following anonymous resident interviews were obtained during the course of the survey: Confidential Resident Interview (CRI) 1 - Resident F wandered into our room during the day and evenings and got into my bed. At one point, Resident F grabbed onto my wrist and would not let go. The resident indicated the wrist had been previously broken and hurt when Resident F grabbed it. Both residents in the room indicated it sometimes took two staff members to get Resident F out of the room, and most of the time staff had to be notified that she had wandered into the room. CRI 2 - Resident F wanders at night and several times I have had to call staff to come and get her. It started about a week ago, and has happened maybe three times. CRI 3 - Resident F has been in my room. She wandered into the room and moved things around. Staff came to get her immediately. CRI 4 - Resident F wandered in my room and tried to get into my bed. Staff would come to take her back to her room. On 9/22/23 at 11:02 A.M., LPN 25 indicated Resident F had dementia and got up out of bed to take care of her "kids". They had been trying to			

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	adjust her medications because she recently started going through "some sort of transition". She indicated Resident F had not always had the behaviors she did now. She indicated the alarm at her door was a night shift intervention because of her tendency to enter other resident rooms at night. During the day, staff could easily monitor and redirect due to there being more staff. On 9/22/23 at 11:26 A.M., the Director of Nursing indicated all staff had been educated to redirect Resident F with wandering behaviors as needed. She further indicated there should have been a care plan in place with specific interventions related to wandering. On 9/25/23 at 10:46 A.M., LPN 23 (the nurse on Resident F's hall) indicated she was not really familiar with Resident F. She indicated she thought the resident liked talking about her mom and cooking, and when Resident F had behaviors, she would redirect and walk/talk with her. She was unsure of any proactive interventions for Resident F related to behaviors. On 9/25/23 at 10:50 A.M., the Activities Director indicated Resident F was passively involved in group activities, and would sit with her during activities. She indicated the resident was not interested in participating, but did enjoy being part of the group. She indicated Resident F liked socializing, and sitting with other residents and staff. Music and TV did not keep her attention very long, and usually turned them on in her room to keep her calm. There were coloring books and workbooks for the resident when she was wandering. When she is in an aggressive mood, staff should walk with her. She indicated being proactive with the resident worked better than reacting when behaviors occurred, as redirection			

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	would agitate her more. She indicated preferences for residents were not discussed at staff meetings, and only communicated verbally with report. Any likes or dislikes for the residents would be documented in their electronic medical record. On 9/25/23 at 11:08 A.M., LPN 15 indicated she thought Resident F liked to read and watch TV, as both would keep her attention. At the beginning of a shift, she would do a walk through with the off-going staff, and go over who was a bed check and who was not. Likes and dislikes would only be communicated if it was "different". She indicated she was unaware of any specific incidents of Resident F wandering into other resident's rooms. On 9/22/23 at 8:45 A.M., employee files were reviewed. Four of five employee files reviewed for staff members employed greater than a year lacked documentation of dementia-specific training. On 9/22/23 at 1:33 P.M., a current non-dated Intervention and Monitoring Behavioral Assessment policy was provided and indicated "The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care ... The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement, or attempts to include the resident and family in care planning and treatment, will be documented ... Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care			

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	plan will include, as a minimum: (1) frequency; (2) intensity; (3) duration; (4) outcomes; (5) location; (6) environment; and (7) precipitating factors or situations". This Federal tag relates to complaint IN00417903. 3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order			

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	unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 1 residents reviewed for insulin and 2 of 5 residents reviewed for unnecessary medications. Residents' as needed anti-anxiety medication was ordered for greater than 14 days (Resident 7, Resident T. Resident P). Findings include: 1. On 9/20/23 at 11:10 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but was not limited to, generalized anxiety disorder. Resident 7 was admitted on 9/23/22. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 7/3/23, indicated Resident 7 had moderately impaired cognition and an anti-anxiety medication was administered for 7 of 7 days during the look back period.	F 0758	F - 758 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the order for the Hydroxyzine for the resident identified as resident 7 was re-ordered by the physician on 09-26-23 and was ordered for only 14 days. The medication was discontinued as ordered on 10-10-23. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the prn Lorazepam order for the resident identified as resident T was discontinued on 09-22-23 and the resident no longer has any orders for prn psychotropics.	10/25/2023

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	Current physician orders included, but were not limited to, the following: Hydroxyzine HCl (an antianxiety medication) tablet 25mg (milligrams) - Give 25 mg by mouth every 6 hours as needed for itching, dated 5/29/23 with no end date documented. There was no extension of the medication ordered by the physician. The June 2023 MAR (medication administration record) indicated Resident 7 received hydroxyzine on 6/1, 6/8, 6/9, 6/11, 6/15, 6/16, 6/18. The July 2023 MAR indicated Resident 7 received hydroxyzine on 7/4, 7/5, 7/12, 7/13, 7/18, 7/20, 7/23, 7/25, and 7/27. The August 2023 MAR indicated Resident 7 received hydroxyzine on 8/1, 8/3, 8/5, 8/10, 8/15, 8/17, 8/18, 8/20, 8/21, 8/22, 8/24, 8/29, and 8/31. The September 2023 MAR indicated Resident 7 received hydroxyzine on 9/2, 9/3, 9/5, 9/6, 9/7, 9/9, 9/18, and 9/19. A medication regimen review (MRR) by the pharmacist, dated 6/14/23, indicated hydroxyzine was a psychotropic medication and required a stop date or a documented clinical rationale if given over 14 days. The clinical record lacked documentation of a clinical rational by a physician for the hydroxyzine given greater than 14 days. On 9/22/23 at 9:42 A.M., the MDS Coordinator indicated that hydroxyzine was coded as an antianxiety medication. 2. On 9/19/23 at 11:40 A.M., Resident T's clinical		*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the prn Clonazepam order for the resident identified as resident P was reviewed by the physician on 09-21-23 and ordered for an additional 14 days. The prn Clonazepam was then discontinued on 10-02-23. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to affected by this deficient practice. A house wide audit was conducted to determine if any additional residents had orders for prn psychotropic medications without a 14 day stop date. There currently are no residents with orders for prn psychotropic medications that do not have a 14 day stop date on their orders. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility's antipsychotic drug use policy. The nurses were re-educated on the regulation regarding the limited use of prn psychotropic medications. The nurses were reminded of their responsibility to ensure that the physician do not prescribe prn psychotropic	

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	155801	A. BUILDING 00 B. WING	09/25/2023

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	record was reviewed. Diagnoses included, but were not limited to, anxiety and depression. The most recent quarterly MDS Assessment, dated 7/15/23, indicated no cognitive impairment. Resident T was totally dependent on two staff with bed mobility, transfers, toileting, and bathing, and had received anti-anxiety medications 7 of 7 days during the look back period. Current physician orders included, but were not limited to, the following: Lorazepam (an anti-anxiety medication) Oral Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 2 hours as needed for restlessness/anxiety, dated 1/30/23. A current psychotropic medication care plan, dated 7/7/23, indicated but was not limited to, the following interventions: Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least quarterly. Discuss with MD, family for ongoing need for use of medication. A pharmacy review dated 7/24/23 indicated no recommendations. A pharmacy review was noted in the progress notes on 8/26/23 that indicated "cipro/lorazapam recommendations" On 9/21/23 at 10:26 A.M., the Regional Consultant indicated the pharmacy recommendation dated 8/26/23 had not been sent yet from the pharmacy. 3. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and dementia.		medications for longer than a 14-day period without the supportive reassessment of the resident's condition and documentation by the physician to support the medical justification for their continued use. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the use of prn psychotropic medications. The tool will monitor to ensure that all prn psychotropic medication orders include the 14 days stop date and if the medication is medically justified beyond that time frame that the physician has documented their assessment and the medical justification for their continued use. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting, and had received antianxiety medications 4 of 7 days during the look back period. Current physician orders included, but were not limited to, the following: Clonazepam (an anti-anxiety medication) Tablet 0.5 MG Give 1 tablet by mouth every 6 hours as needed for Restlessness, dated 8/6/23. A current anxiety care plan, dated 7/24/23, indicated, but was not limited to, the following intervention: Medications as ordered. A Medication Administration Record (MAR) for 8/2023 and 9/2023 indicated the following dates clonazepam as needed was administered: 8/12/23 8/15/23 8/17/23 8/19/23 8/20/23 8/22/23 8/23/23 8/24/23 8/28/23 8/29/23 8/31/23 9/2/23 9/3/23 9/5/23 9/7/23 9/8/23 9/9/23			

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	9/10/23 9/13/23 On 9/21/23 at 2:10 P.M., the DON (Director of Nursing) indicated that antianxiety medications should be reviewed every 14 days and the MD should document a response on the pharmacy review. She further indicated that if the medication had a stop date it would be flagged for review, but if there was not a stop date listed it would not be flagged and was overlooked. On 9/22/23 at 1:34 P.M., a current Antipsychotic Medication Use policy, undated, indicated "PRN (as needed) orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order". 3.1-48(a)(2)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;			

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	§483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on interview and record review, the facility failed to ensure dental services were provided for 2 of 2 residents reviewed for dental. Residents were not referred to a dentist for acute dental pain or to obtain replacement dentures. (Resident 22, Resident P) Findings include: 1. On 9/19/23 at 9:24 A.M., Resident 22 indicated	F 0791	F - 791 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 22 was scheduled to be examined by the dentist on 10-06-23 however the resident was in the hospital. A new dental appointment has been	10/25/2023

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	he had dental pain and was told he was on a list to see a dentist, but hadn't seen anyone yet. On 9/20/23 at 9:07 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, and Obstructive Sleep Apnea. The most recent quarterly MDS Assessment (Minimum Data Set), dated 8/10/23, indicated Resident 22 was cognitively intact and had no dental pain. A progress note, date 12/24/22, indicated the resident had a bad tooth and the gum surrounding it was red, swollen, and painful. The note indicated it had been reported to the MD (Medical Doctor) and an appointment would be scheduled with the dentist as soon as possible after the holiday weekend. Documentation of the dentist referral and visit summary was requested and not provided. On 9/20/23 at 8:42 A.M., the Social Services Director indicated that she was unable to find any dentist request forms or summaries for Resident 22. 2. On 9/19/23 at 8:42 A.M., Resident P's Power of Attorney (POA) indicated Resident P had dentures prior to being admitted to the facility. She indicated she was unsure if they were lost at the hospital prior to admission, on the way, or at the facility after she got there. She indicated the facility had not mentioned anything to her or asked about dentures or a dental visit. On 9/19/23 at 2:16 P.M., Resident P's clinical record was reviewed. Diagnoses included, but		scheduled for resident 22 for 10-23-23. The resident will continue to be monitored for any oral pain/discomfort and prn pain medication offered accordingly. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P did not have dentures upon admission and had orders for a pureed diet with nectar thick liquids. The resident is not having any oral issues at this time and has been schedule to be seen by the in-house dentist on their next visit to the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a house wide audit of all residents has been completed at the time to identify any residents with dental needs. Any residents identified with dental needs will be scheduled to be seen by either the in-house dentist or the dentist of their choice which ever the resident prefers. No residents were identified to have any immediate dental needs at this time. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff and the social service director on the facility's dental services	

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	were not limited to, dementia and anxiety. Admission date was 10/11/22. The most recent quarterly MDS Assessment, dated 7/13/23, indicated a severe cognitive impairment. Resident P required extensive assistance of two staff with bed mobility, transfers, eating, and toileting. No dental concerns were identified. Current physician orders included, but were not limited to: regular diet, pureed texture, nectar thick consistency, magic cup all 3 meals, dated 6/1/23. Current physician orders lacked an order related to dental or ancillary visits. A current care plan, dated 1/27/23, indicated edentulous. Interventions included, but were not limited to: Coordinate arrangements for dental care, transportation as needed/as ordered, dated 1/27/23. Admission notes, dated 10/22/23 indicated Resident P was admitted edentulous (without teeth). Resident P's clinical record lacked documentation of a dental visit or appointment to see a dentist. On 9/21/23 at 9:53 A.M., the Social Service Director (SSD) indicated a dentist came to the facility at least quarterly, and would send a list of who they would be seeing prior to their visit. When completed, they would send a visit summary, which was scanned into the resident's clinical record. She indicated the facility staff could add to the list of residents to be seen as needed. She indicated she would expect all new		policy. The social service director will be responsible for the scheduling of all dental appointments with priority given to those residents with any immediate dental needs or concerns. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool will be developed and implemented to monitor the effectiveness of the facility's dental service policy to ensure that residents with any dental needs are provided dental services in a timely manner. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	residents to be put on the list within their first 90 days. At that time, she indicated she was unsure if Resident P came in with dentures, and had not spoken with her POA about getting dentures or any dental visits. On 9/20/23 at 12:22 P.M., a current Dental Services policy, undated was provided and indicated "routine and 24-hour emergency dental services are provided to our residents ... All dental services provided are recorded in the resident's medical record". 3.1-24(a)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. Finding includes: On 9/20/23 at 12:15 P.M., a test tray was obtained. The following temperatures were indicated: Meat loaf -114.7 degrees F (Fahrenheit) Peas and Carrots 110.0 degrees F	F 0804	F - 804 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the residents identified as 7, 31, 11, 20 and 27 are now receiving their meal trays with food that is at the proper temperature to ensure palatability. *The corrective action taken for the other residents that have the*	10/25/2023

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	Potatoes 112.4-degrees F On 9/18/23 at 9:41 A.M., Resident 7 complained of hot foods not hot. On 9/18/23 at 10:12 A.M., Resident 31 complained of hot foods not hot. On 9/18/23 at 10:52 A.M., Resident 11 complained of breakfast being cold. On 9/18/23 at 10:49 A.M., Resident 20 complained the food was cold. On 9/18/23 at 11:26 A.M., Resident 27 indicated she did not like the food because of the temperature variation. During an interview on 9/22/23 at 10:47 A.M., the Dietary Manager indicated the temperature for food should be 135 degrees when plated. On 9/22/23 at 10:50 A.M., the Dietary Manager provided a current Food Preparation and Service policy, undated, and indicated "food service employees shall prepare and serve food in a manner that complies with safe food handling practices ... The danger zone for food temperatures is between 41 degrees and 135 degrees. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness". 3.1-21(a)(2)		*potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving their meal trays with food that is at the proper temperature to ensure palatability. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all dietary staff on the facility's policies related to food preparation with a focus on food temperatures. The staff was re-educated to ensure their knowledge level related to ensuring proper food temps on all food items and beverages served and the best practices to ensure those temperatures are maintained at the time the food is served to the residents. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor food temperatures at the time the residents are served. This tool will be completed by the Food Service Manager and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is	

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			warranted.	
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure garbage was disposed of properly for 2 of 2 dumpsters observed on the northwest side of the building. The dumpster was left open and trash bags were not closed and were on the ground around the dumpster. Finding includes: On 9/18/23 at 11:03 A.M., the dumpsters outside of the dining room entrance were observed uncovered. The dumpsters were filled to the top with black plastic trash bags filled with garbage. There were 18 black garbage bags on the ground that were visible with more garbage bags underneath. Some of the garbage bags were not closed. There were flies and bees swarming around the garbage and dumpsters. On 9/21/23 at 8:19 A.M., the dumpster outside of the dining room entrance was observed uncovered. The lids were not fully closed with a black garbage bag half in and half out of one of the dumpsters. On 9/11/23 at 11:15 A.M., the Administrator indicated all trash bags should be tied closed, all trash should be in the receptacle, and the dumpster lid should be closed. He indicated that trash should not be overflowing out of the dumpsters or on the ground. On 9/21/23 at 12:49 P.M., a current Waste Disposal policy was provided and indicated "all	F 0814	F - 814 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents and staff have the potential to be affected by this deficient practice. All garbage is now being disposed of properly. All trash bags are closed when taken to the dumpster and the dumpster lid is closed when not in use. No trash bags are left on the ground or outside of the dumpster container. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* although no specific residents were identified during the survey, all residents and staff have the potential to be affected by this deficient practice. All garbage is now being disposed of properly. All trash bags are closed when taken to the dumpster and the dumpster lid is closed when not in use. No trash bags are left on the ground or outside of the dumpster container. *The measures that have been put into place to ensure that the*	10/25/2023

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	infectious and regulated waste destined for disposal shall be placed in closable leak-proof containers or bags". 3.1-21(i)(5)		*deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's waste disposal policy. Staff was reminded that all garbage bags must be closed and placed entirely inside the dumpster and the lid closed when not in use. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the proper disposal of all waste/garbage. This tool will be completed by the Maintenance Supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.			

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	§483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format.			

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	The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to ensure the facility was sufficiently staffed for 1 of 1 quarters reviewed. Low weekend staffing was triggered by the CMS (Centers for Medicare and Medicaid Services) PB&J. (Payroll Based Journal) (April, May, June, 2023) Finding includes: On 9/18/23 at 9:00 A.M., the CMS Casper Report was reviewed. The PB&J Data Report for Quarter 3, 2023 (April 1- June 30) indicated: Excessively Low Weekend Staffing was triggered. On 9/21/23 at 1:57 P.M., the Administrator provided the nursing schedules for the third quarter weekends for April, May, June, 2023. The Administrator indicated the facility was not able to provide the exact dates that low weekend staffing triggered on the PB&J. The Administrator indicated he and the DON reviewed the weekend schedules for the third quarter and flagged the days they thought were low staffing compared to the census. The weekend staffing schedules were reviewed and the following dates were flagged for low weekend staffing: Saturday 4/15/23 Sunday 4/16/23 Saturday 4/22/23 Sunday 4/23/23	F 0851	F - 851 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified, all residents have the potential to be affected by this deficient practice. The Director of Nursing is continuing to review their staffing schedules to ensure adequate staffing levels are being maintained with a focus on the weekend staffing patterns to ensure the needs of the residents can continue to be met. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* although no specific residents were identified, all residents have the potential to be affected by this deficient practice. The Director of Nursing is continuing to review their staffing schedules to ensure adequate staffing levels are being maintained with a focus on the weekend staffing patterns to ensure the needs of the residents can continue to be met. *The measures that have been put*	10/25/2023

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	Saturday 5/20/23 On 9/22/23 at 9:16 A.M., a current Reporting Direct Care Staffing Information (Payroll-Based Journal) policy, undated, indicated "complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal system in a uniform format specified by CMS ... Reported staffing information is based on payroll records, invoices, tied back to a contract, or other verifiable information".		*into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Director of Nursing on the facility's staffing pattern to ensure adequate staff is being maintained daily to ensure that the needs of all residents can be met. The director of nursing was reminded that it is their responsibility to ensure adequate staffing is maintained each and every day including the weekends. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the nursing staffing patterns to ensure adequate staffing is maintained each day including the weekends. This tool will be completed by the Business Office Manager and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene was done for 2 of 6 observations of medication administration (Resident L, Resident B) and 1 of 1 observation of a dressing change (Resident T), and the facility failed to ensure toothbrushes were labeled and covered for 1 random observation. Finding includes: 1. On 9/18/23 at 9:14 A.M., LPN (Licensed Practical Nurse) 2 was observed to prepare and administer medications to Resident B. Resident B was standing beside the medication cart. No hand	F 0880	F - 880 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B is now receiving their medications by staff members who are demonstrating good hand hygiene during medication administration. The nurse identified as LPN 2 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration.	10/25/2023

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	hygiene was observed before or after administering the medications. 2. On 9/18/23 at 9:29 A.M., LPN 2 was observed to prepare Resident L's medications, put them in a drawer, lock the cart, leave the medication cart and walk to the medication room. LPN 2 was observed to come back to the cart, unlock it, obtain the prepared medications, go to Resident L's room and administer the medications to Resident L. No hand hygiene was done before preparing or administering the medications. On 9/21/23 at 10:54 A.M., QMA (Qualified Medication Aide) 2 indicated hand hygiene should be done before and after administering medications. 3. On 9/21/23 at 1:13 P.M., Registered Nurse (RN) 41 was observed to change a dressing for Resident T. After the dressing change was completed, RN 41 removed gloves and washed her hands with a 12 second lather. On 9/25/23 at 11:57 A.M., Certified Nurse Aide (CNA) 29 indicated hands should be washed with soap and water with a 30 second lather. 4. On 9/18/23 at 10:00 A.M., two uncovered and unlabeled toothbrushes were observed sitting on the back of the bathroom sink in Room 26 in between the faucet and wall with three combs resting on them. The bathroom was shared by two residents. At that time, neither resident in Room 26 were aware of who's toothbrushes were in the bathroom. On 9/25/23 at 11:59 A.M., the same toothbrushes were observed in the bathroom of Room 26. At that time, Qualified Medication Aide (QMA) 33 indicated both residents in Room 26 use		*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident L is now receiving their medications by staff members who are demonstrating good hand hygiene during medication administration. The nurse identified as LPN 2 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident T is now receiving their dressing changes by staff members who are demonstrating good hand hygiene during and following dressing changes. The nurse identified as RN 41 has been re-educated on the facility's hand hygiene policy and has successfully completed a return demonstration. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the two toothbrushes located in the bathroom of room 26 have been discarded and the residents in room 26 have been given new toothbrushes which are labeled with their names and are stored in plastic bags to prevent the spread of infection.	

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	toothbrushes, but it was unknown who the toothbrushes belonged to that were in the bathroom. She indicated they needed to be gotton rid of. On 9/21/23 at 12:48 P.M., a current Administering Medication policy, undated, indicated "staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable". This Federal tag relates to complaint IN00417903. 3.1-18(b) 3.1-18(l) 3.1-19(f)		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving their medications and treatments by staff members who are demonstrating proper hand hygiene in accordance with facility policy and acceptable standards of infection control practices. A house wide audit of all personal items such as toothbrushes, combs, etc. has been completed to ensure that all personal items are properly labeled and stored properly to prevent the spread of infection. All personal care items are now properly label and stored to prevent the spread of infection. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policy on hand hygiene and the personal property policy. All staff members have successfully demonstrated proper hand hygiene in accordance with facility policy and acceptable standards of infection control practices. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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			developed and implemented to monitor the facility staff's practices to ensure proper hand hygiene is being performed per facility policy and that the resident's personal care items are all labeled and stored properly to prevent the spread of infection. This tool will be completed by the Infection Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment. for 1 of 1 laundry areas and 3 of 3 resident halls. Washers had debris build up, floors had debris build up, and point of contact water temperatures were over 122 degrees F (Fahrenheit). Findings include: 1. On 9/20/23 8:22 A.M., the laundry room was observed. A washer was observed to have debris build up under the lid, a washer door was observed to have debris build up, the back of the washer had scale build up, the plastic piping	F 0921	F - 921 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified all residents and staff have the potential to be affected by this deficient practice. The laundry area and the service hallway have been deep cleaned and are now clean and free of any debris. The laundry area and service hallway have been placed on a routine cleaning schedule to ensure they	10/25/2023

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	behind the washer had debris build up, and the service hallway was observed to have debris build up along the walls. On 9/20/23 at 8:30 A.M., Laundry Aide 2 indicated she tries to clean the washers daily, and the build up on the back of the washer is from the (name of town) water. On 9/21/23 at 1:20 P.M., Housekeeper 2 indicated the floor is swept daily on the service hall, mopped if needed. 2. On 9/18/23 from 11:05 A.M. to 11:51 A.M., the following water temperatures were obtained from resident rooms and areas: Bathroom between rooms 10 and 12 was 126.6 degrees Fahrenheit. The resident in room 10 indicated the water in the bathroom continuously ran hot and you had to be careful to not burn yourself. Shower room sink on the long hall was 124.9 degrees Fahrenheit. Bathroom between rooms 9 and 11 was 126.0 degrees Fahrenheit. Bathroom in Room 26 was 130.1 degrees Fahrenheit. The resident in Room 26 indicated you had to watch and not keep the hot water on by itself so it did not get too hot. On 9/18/23 from 11:29 A.M. to 12:20 P.M., the following water temperatures were obtained from resident rooms: Room 27 bathroom was 129.9 degrees Fahrenheit. Room 19 bathroom was 125.9 degrees Fahrenheit.		remain clean, sanitary and free of debris. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the water temperatures have now been adjusted. The water temperature in the bathroom between room 10 and 12 is now temping at a safe water temperature level. The shower room sink on the long hall is now temping at a safe water temperature level. The bathroom between room 9 and 11 is now temping at a safe water temperature level. The bathrooms in rooms 26, 27, 19, 18 are now temping at a safe water temperature level. The bathrooms between rooms 1 and 3, rooms 2 and 4, rooms 5 and 7, rooms 6 and 8 are now temping as a safe water temperature level. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The laundry area and the service hallway are now clean and have been placed on a routine cleaning schedule to ensure they remain clean and free of debris. The water temperatures will continue to be checked by the maintenance supervisor and temperatures will be adjusted as warranted to ensure resident and	

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	The resident in room 19 indicated the water was pretty hot and had to mix with cold. Room 18 bathroom was 129.6 degrees Fahrenheit. Bathroom between rooms 1 and 3 was 125.0 degrees Fahrenheit. Bathroom between rooms 2 and 4 was 125.1 degrees Fahrenheit. Bathroom between rooms 5 and 7 was 126.3 degrees Fahrenheit. Bathroom between rooms 6 and 8 was 124.6 degrees Fahrenheit. On 9/18/23 at 11:30 A.M., the Maintenance Supervisor indicated the water temperatures in resident bathrooms were checked weekly, and had not been checked since last week. He indicated the temperatures sometimes ran high in dietary but he had not noticed them running high in the resident rooms. He also indicated a tankless water heater was utilized with a digital setting, and the goal for resident room water temperatures was between 115 and 117 degrees Fahrenheit. At that time, the following resident rooms and areas were checked using his thermometer: Bathroom between Rooms 10 and 12 was 123.8 degrees Fahrenheit. Shower room sink on the long hall was 123.6 degrees Fahrenheit. Bathroom between rooms 9 and 11 was 124.2 degrees Fahrenheit. Bathroom in room 26 was 131.8 degrees Fahrenheit.		staff safety. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all laundry, housekeeping and maintenance staff on the facility's policies related to water temperatures and the cleaning and disinfecting of environmental surfaces policy. The staff has also been directed to properly report any abnormal water temperatures to the maintenance department for prompt correction. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the facility environment to ensure all areas are clean, sanitary and free of debris. The monitoring includes the laundry and service hallway of the facility. The tool will also monitor water temperatures to ensure they are maintained at a safe water temperature level. This tool will be completed by the environmental supervisor and/or their designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	On 9/18/23 at 11:40 A.M., water temperature logs were obtained that indicated weekly readings from 1/2023 through 9/2023. The readings ranged from 114 to 118 degrees Fahrenheit, with the most recent taken on 9/14/23. On 9/18/23 at 12:19 P.M., Licensed Practical Nurse (LPN) 15 indicated the staff restroom water ran warm. On 9/18/23 at 12:20 P.M., Housekeeper 35 indicated the water in the housekeeping room ran warm. On 9/18/23 at 12:21 P.M., Hospitality Aide (HA) 6 indicated during showers, some of the residents would indicate the water was too hot. On 9/22/23 at 1:21 P.M., the Administrator provided a current non-dated Safety of Water Temperatures policy that indicated "Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 [degrees Fahrenheit], or the maximum allowable temperature per state regulation". On 9/21/23 at 11:13 a.m., the Administrator provided the current policy on maintenance/housekeeping with a revision date of 8/15/23. The policy included, but was not limited to, floors throughout the building are to be cleaned in accordance with the cleaning schedule. On 9/21/23 at 11:13 a.m., the Administrator provided the current policy, on cleaning and disinfecting environmental surfaces. The policy was undated. The policy included, but was not limited to, "Housekeeping surfaces (e.g.; floors,			

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	tabletops) will be cleaned on a regular basis (e.g.; daily, three times per week) and when surfaces are visible soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g.; daily, three times per week) and when surfaces are visibly soiled...". This Federal tag relates to complaint IN00417903. 3.1-19(f) 3.1-19(r)			
F 0940 SS=D Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on observation, interview, and record review, the facility failed to provide training to staff assigned to supervise residents who smoke for 1 of 1 resident reviewed for smoking. A resident violated the facility's smoking policy and the designated staff were not trained in how to handle the situation. (Resident 22) Finding includes: On 9/19/23 at 11:03 A.M., Resident 22 was observed walking out to the smoking area with cigarettes in his hand. Housekeeper 3 handed out cigarettes from individual containers to other residents who smoke, but did not hand cigarettes	F 0940	F – 940 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 22 has been re-educated on the facility smoking policy that was signed by the resident upon admission. The staff members identified as housekeeper 3 and laundry aide 2 have now been educated on the facility's smoking policy and have received instructions on how to address any resident that fails to	10/25/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to Resident 22. Resident 22 was observed smoking. There was not an individual container labeled with Resident 22's name in the box. At that time, Housekeeper 3 indicated Resident 22 kept his cigarettes in his room. On 9/20/23 at 8:59 A.M., Laundry Aide 2 was observed handing out cigarettes to residents. Resident 22 was not handed cigarettes by staff and was observed walking outside with 2 cigarettes in his hand. On 9/20/23 at 9:07 A.M., Resident 22's clinical record was reviewed. Diagnosis included, but was not limited to, Chronic Obstructive Pulmonary Disease (COPD). The most recent quarterly MDS (Minimum Data Set) Assessment, dated 8/10/23, indicated Resident 22 was cognitively intact, had no behaviors, and required supervision of staff for all Activities of Daily Living (ADLs). A smoking assessment, dated 5/5/23, indicated the resident needed the facility to store his lighter and cigarettes. A behavior progress note, dated 8/1/23, indicated the resident told staff that he kept his tobacco in his room. A current smoking care plan, dated 3/14/23, indicated that staff should notify the charge nurse immediately if it is suspected the resident has violated the facility smoking policy. A resident and facility representative signed smoking policy, dated 11/1/22, indicated "No resident will be allowed to keep their cigarettes or lighters but rather these items will be kept by staff		follow the facility's smoking policy. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A house wide audit of all employee files has been completed and all staff members have not been educated on the facility's smoking policy and how to address any resident who is non-compliant with the policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff members on the facility's smoking policy with a focus on how to address any resident who may be non-compliant in following the smoking policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that each staff member has the knowledge on the facility's smoking policy and how to address any resident who is non-compliant with the smoking policy. This tool will be completed by Social Services and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	09/25/2023

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	in a secure area and distributed at smoking times". On 9/20/23 at 9:19 A.M., the DON (Director of Nursing) indicated that Resident 22 was not supposed to have cigarettes in his room and she was unaware that he had his own cigarettes. She further indicated that if non-nursing staff saw that he had his own cigarettes, they should inform nursing staff so that they could educate the resident on facility policy. At 9/20/23 at 9:56 A.M., Laundry Aide 2 indicated Resident 22 rolled his own cigarettes and kept them in his room. She indicated she did not tell anyone about Resident 22 providing his own cigarettes because it wouldn't do any good. On 9/21/23 at 12:55 P.M., orientation materials for Housekeeper 3 and Laundry Aide 2 were provided and lacked documentation of smoking specific policy training. On 9/22/23 at 1:36 P.M., the Administrator indicated that he was unaware of any official training done for supervision of smokers and instruction was provided to those staff verbally. On 9/18/23 at 11:06 A.M., a current Smoking Policy - Residents policy, undated, indicated "All smoking materials are to be kept at the nurse's station and will be distributed at each designated smoke time". 3.1-14(k)(4) 3.1-14(k)(5)		The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	9999	10/25/2023

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	(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of staff completing a minimum of three hours of dementia-specific training annually for 4 of 5 staff employed greater than 1 year reviewed. (QMA 16, RN 31, QMA 2, CNA 11) Finding includes: On 9/22/23 at 8:45 A.M., employee files were reviewed. Employee files for QMA (Qualified Medication Aide) 16, RN (Registered Nurse) 31, QMA 2, and CNA (Certified Nurses Aide) 11 lacked documentation of dementia-specific training. QMA 16 started employment with the facility on 7/13/17. RN 31 started employment with the facility on 10/3/21. QMA 2 started employment with the facility on 5/21/15. CNA 11 started employment with the facility on 9/12/18.		*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The staff members identified as QMA 16, RN 31, QMA 2 and CNA 11 have now completed their three hours of dementia specific training for the year. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* although no residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The staff members identified as QMA 16, RN 31, QMA 2 and CNA 11 have now completed their three hours of dementia specific training for the year. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a house wide audit of all personnel files was completed to identify any employee who has not met the annual three-hour dementia specific training requirement. Dementia specific in-services have now been conducted and all staff members are current with the required annual three hours of dementia specific training.	

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	On 9/25/23 at 1:35 P.M., the Director of Nursing (DON) provided sign-in sheets for classes "End of Life Dementia Inservice", "Dementia InService", and "Dementia Progression In Service", all dated 2/24/23. She indicated those were the only dementia-specific inservices she could find and that she knew it was not everything staff needed to comply with the State Regulation. She further indicated each of the inservice classes provided were 1 hour in length. QMA 16's name was listed as an attendee on 1 of the 3 inservice sign in sheets. RN 31's name was not found on any of the sign in sheets. QMA 2's name was listed as an attendee on 1 of the 3 inservice sign in sheets. CNA 11's name was not found on any of the sign in sheets. On 9/25/23 at 2:13 P.M., the DON indicated the facility followed all state regulations for inservice and education guidelines. This Federal tag relates to complaint IN00417903.		*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor employee files to ensure that all employees hired have documentation to support that they have received the initial six hours of dementia specific training and the required three hours of dementia specific training annually thereafter. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	