STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00405733. Complaint IN00405733 - No deficiencies related to the allegations are cited. Survey dates: May 30, 31, June 1, 2, 5, and 6, 2023 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 47 Other: 14 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 15, 2023.	F 0000	The filing of this plan of correction does not constitute an admission that the deficiencies did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Angela Brewer | Executive Director | 06/28/2023

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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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure residents were addressed in a dignified manner for 3 of 3 residents reviewed for dignity (Residents 18, 30,	F 0550	1. -Residents 18, 30, and 10 were observed for signs of distress with none noted. Residents are being addressed per preference 2. All residents have the	06/30/2023

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	and 10). Findings Include: 1. During the lunch meal observation, on 5/30/23 at 12:20 p.m., Resident 18 was sitting at the lunch table and was being assisted with eating by Activity Assistant 5. Activity Assistant 5 addressed Resident 18 as "Mama." She asked Resident 18, "Mama, would you like to take a bite?" Activity Assistant 5 proceeded to assist the Resident 18 with eating and asked, "Mama, would you like to take a drink?" Resident 18's record was reviewed on 6/1/23 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, rheumatoid arthritis (a chronic inflammatory disorder affecting many joints, including those in the hands and feet), hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood. The record lacked a care plan indicating resident preferred to be called "Mama." A significant change of status Minimum Data Set (MDS) assessment, dated 3/22/23, indicated the resident had a severe cognitive deficit and required a 1 person to assist with eating. 2. During the lunch meal observation, on 5/30/23 at 12:25 p.m., Resident 30 was sitting at the lunch table and was being assisted with eating by Activity Assistant 5. Activity Assistant 5 had addressed Resident 10 as "Mama." She asked Resident 10, "Mama, are you hungry?" Activity Assistant 5 proceeded to assist the resident with eating and indicated, "Mama, I need you to open		potential to be affected. Staff educated on appropriately addressing residents. Care plans updated as appropriate for resident preferred name. 3. Staff education completed regarding addressing residents. SS/Designee will round daily to ensure residents are addressed per preference. Any new admission will be asked preferred name and this will be care planned accordinglyl 4. SS/Designee will complete Resident/Staff Interaction CQI tool weekly x4 weeks and monthly x6 months. If 95% is not achieved an action plan will be implemented.	

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	your mouth to eat the food." Resident 30's record was reviewed on 6/2/23 at 9:58 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty in swallowing), and urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra). The record lacked a care plan indicating resident preferred to be called "Mama." A quarterly Minimum Data Set (MDS) assessment, dated 3/27/23, indicated the resident had a severe cognitive impairment and was unable to complete the BIMS (brief interview for mental status) test and required a 2 person assist with bed mobility, dressing, toileting, and transfers. The resident required 1 person to assist with eating. 3. During the lunch meal observation, on 5/30/23 at 12:38 p.m., Resident 10 was observed to be sitting in a chair in the dining room with a small side table in front of her for eating. Activity Assistant 5 spoke with the resident and asked, "Mama are you done eating?" Activity Assistant immediately laughed and indicated she meant to say her name instead of "Mama." Resident 10's record was reviewed on 6/2/23 at 9:54 a.m. The profile indicated the resident's diagnoses included, but were not limited to, vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to your brain) without behavioral disturbance, hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to			

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	meet your body's needs) and need for assistance with personal care. The record lacked a care plan indicating resident preferred to be called "Mama". A quarterly Minimum Data Set (MDS) assessment, dated 4/12/23, indicated the resident had a severe cognitive deficit and required a 2 person assist with bed mobility, dressing, toileting, and transfers. The resident required 1 person to assist with eating. During an interview, on 6/2/23 at 9:35 a.m., Dementia Care Director indicated staff were to address residents by their name unless care planned otherwise. It is not the expectation of the staff to call residents by the name "Mama". On 6/2/23 at 1:48 p.m., the Executive Director provided and identified a document as a currently facility policy, titled "Resident Rights," revised dated 11/16. The policy indicated, " ...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care ...." 3.1-3(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure Activities of Daily Living (ADL, activities related to personal care) were completed for 4 of 24 residents	F 0677	1. -Residents 57, 15, 34 and 38 were provided ADL care as needed. Staff educated on expectation of daily ADL care. 2-All dependent residents have the	06/30/2023

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	reviewed for ADL care (Residents 57, 15, 34, and 38). Findings include: 1. During the initial observation of Resident 57, on 5/3/23 at 12:14 p.m., the resident was sitting in the dining room for her lunch meal. The resident was observed to have long chin hairs. During a random observation, on 5/31/23 at 10:10 a.m., the resident was observed during an activity in the dining room. The resident was observed to have long chin hairs. During a random observation, on 6/2/23 at 11:42 a.m., the resident was observed in dining room for her lunch meal. The resident was observed to have long chin hairs. During a random observation, on 6/5/23 at 9:31 a.m., the resident was observed sitting in the lounge area next to the bird aviary. The resident was observed to have long chin hairs. Resident 57's record was reviewed on 6/2/23 at 11:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to the need for assistance with personal care. A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents), on 4/20/23, indicated the resident had no cognitive deficit and required extensive assist of 1 with personal hygiene and was totally dependent with bathing. A care plan, dated 1/28/23, indicated the resident required assistance with ADLs. An intervention,		potential to be affected by the deficient practice. All residents were observed for nail care and unnecessary facial hair. Education provided to staff regarding daily ADL care. 3. DNS/designee will observe resident nail and facial hair daily to ensure residents are receiving necessary ADL care. All-staff inservice completed regarding ADL care for dependent residents. 4. UM/Designee to complete CQI…… weekly x4 weeks and monthly x6 months. If 95% compliance is not achieved an action plan will be implemented..	

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	dated 2/1/23, indicated to provide assistance with dressing, grooming, and hygiene. Review of shower sheets, dated 3/3/25 to 5/30/23, indicated the resident had been shaved on 4/14/23. The shower sheets lacked documentation of shaving having been completed on any other dates. During an interview, on 6/5/23 at 9:36 a.m., Certified Nursing Assistant (CNA) 12 indicated the resident's chin hair should have been removed during her daily care or during her showers. She could not remember a time when the resident refused her care. She was unsure why the care had not been completed. 2. On 5/30/23 at 12:05 p.m., Resident 15 was observed during lunch meal in the main dining room with dark debris under her fingernails while feeding herself with her bare hands. On 6/1/23 at 11:00 a.m., Resident 15 was observed in the main dining room with dark debris under her fingernails. On 6/2/23 at 9:42 a.m., Resident 15 was observed with dark debris under her fingernails. On 6/5/23 at 11:45 a.m., Resident 15 was observed in dining room with dark debris under her fingernails. On 6/6/23 at 9:00 a.m., Resident 15 was observed sitting outside the front of the building in a wheelchair with dark debris under her fingernails. On 6/1/23 at, 2:17 p.m., Certified Nursing Assistant (CNA) 15 indicated, Resident 15 required total assistance for activities of daily living (ADL) (activities related to personal care to include			

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bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) and staff were to trim and clean the residents' nails as needed.

On 6/02/23 at 9:45 a.m., the Activity Director indicated the activity department staff provided nail care on Wednesdays and Sundays. If a resident's nails were soiled, staff would clean the nails and apply polish if the resident wanted it done. At times, when the residents were in bed, the activities department staff were not able to get the residents' nails done.

On 6/2/23 at 9:51 a.m., CNA 7 indicated, she was supposed to clean the residents' nails during showers and when needed.

On 6/2/23 at 9:56 a.m., the DON indicated the ADL care including nail care and shaving facial hair was normally done on the resident's shower days as the resident allowed it.

The clinical record for Resident 15 was reviewed on 5/30/23 at 1:00 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset (a brain disorder that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks) and need for assistance with personal care.

A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 4/13/23, indicated the resident was an extensive assist for ADLs including bed mobility, transfers, eating, toileting, bathing, and personal hygiene assistance from the staff.

A care plan, dated 3/8/22, indicated the resident

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	required assistance with ADLs including bed mobility, transfers, eating and toileting with a goal of the resident had a desire to improve current functional status. Review of the shower sheets from 5/2/23 to 5/31/23, indicated the resident received a total of 14 showers with nail care provided 7 times. 3. On 5/30/23 at 12:00 p.m., Resident 34 was observed during the noon meal in the main dining room with dark debris under her fingernails. On 6/1/23 at 11:00 a.m., Resident 34 was observed in the main dining room her fingernails were soiled with dark debris under the fingernails. On 6/5/23 at 11:45 a.m., Resident 34 was observed in the main dining room with dark debris under her fingernails. On 6/6/23 at 9:00 a.m., Resident 34 was observed sitting outside in the front of the building in a wheelchair with her fingernails heavily soiled under the nails with dark debris. On 6/2/23 at 9:50 a.m., the Activity Director indicated the activity department staff provided nail care on Wednesdays and Sundays. If a resident's nails were soiled, the activity staff would clean the fingernails and apply polish if the resident wanted it done. At times, when the residents were in bed, the staff were not able to get the residents' fingernails done. On 5/30/23 at 1:30 p.m., the clinical record for Resident 34 was reviewed. Diagnoses included, but were not limited, hemiplegia (one-sided muscle paralysis or weakness), hemiparesis (a relatively mild loss of strength) following cerebral infarction			

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	(occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting the left non-dominant side, contracture of muscle left forearm, contracture of muscle left hand, muscle weakness, and need for assistance with personal care. A care plan, dated, 10/19/22, indicated Resident 34 enjoyed self-care of going to the beauty shop and the ability to express her preferences with a goal of the resident strengths will be maintained and encouraged. A care plan, dated 7/24/2018, indicated Resident 34 required staff assistance with ADLs including bed mobility, transfers, eating and toileting, with a goal of the resident had a desire to improve current functional status. Review of the shower sheets, from 5/1/23 to 5/29/23, indicated the resident received a total of 4 showers, refused 5 showers, and received nail care on one day. 4. On 5/31/23 at 9:58 a.m., Resident 38 was observed with dark debris under her fingernails. On 6/2/23 at 11:39 a.m., Resident 38 was observed with dark debris under her fingernails. On 6/5/23 at 12:00 a.m., Resident 38 was observed with dark debris under her fingernails. On 6/2/23 at 11:41 a.m., Resident 38 was observed sitting in a wheelchair in the main dining room at a table waiting on the noon meal service with dark debris under the resident's fingernails. Registered Nurse (RN) 17 indicated the Resident 38's fingernails were dirty with dark debris and should be soaked and cleaned to remove the debris.			

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	On 5/30/23 at 2:00 p.m., the clinical record for Resident 38 was reviewed. Diagnoses included, but were not limited, muscle weakness (generalized), atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain or discomfort that keeps coming back) and (a condition which affects the arteries that supply the heart with blood. It is usually caused by atherosclerosis which is a buildup of plaque inside the artery walls). A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 4/27/23, indicated, the resident required extensive assistance which included assistance with personal hygiene care, nutrition, hydration, bathing and dressing. A care plan, dated 4/20/23, indicated the Resident 38 required assistance and/or monitoring AM/PM care, nutrition, hydration, and elimination with an intervention included, but not limited to, the resident will have activities of daily living (ADL) which included assistance with personal hygiene care, nutrition, hydration, bathing, and dressing. Review of the shower sheets from 5/1/23 to 5/29/23, indicated the resident received a total of 13 showers and nail care was provided on 11 days. On 6/2/23 at 1:48 p.m., the Executive Director provided and identified a document as a currently facility policy, titled "Resident Rights," revised dated 11/16. The policy indicated, "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper			

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	delivery of care...." 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to document, report, and address a skin condition on a resident for 1 of 24 residents reviewed for skin conditions (Resident 28). Findings include: During an initial observation, on 5/30/23 at 12:11 p.m., a faded bruise-like discoloration was observed on Resident 28's left temple area. During a family telephone interview, on 5/31/23 at 9:44 a.m., the resident's family member indicated she was not aware of any incident or a discolored area on the resident's temple. She had visited the week prior and did not notice any skin issues at that time. During an interview, on 5/31/23 at 10:01 a.m., the Director of Nursing (DON) indicated she was not aware of the resident having a discolored area to the side of her head.	F 0684	-Resident 28's condition was immediately addressed. Education provided to nurses regarding proper documentation and notification of new areas/injuries. -All residents have the potential to be affected by the deficient practice. All staff educated on identifying and reporting injuries. -All staff educated on identifying and reporting skin discrepancies. Skin sweeps to be completed immediately and monthly thereafter. -Observational rounds will be completed on weekly X 4 weeks then monthly X 5 months & then quarterly thereafter until 2 quarters of consecutive compliance is maintained by DNS/Designee. Results of the audits will be brought to QAPI meeting & if threshold of 100% is not achieved	06/30/2023

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	During the initial pool record review, on 5/30/23 at 2:16 p.m., the record lacked documentation of any event where the resident had received an injury. Resident 28's record was reviewed on 6/2/23 at 10:19 a.m. The profile indicated the resident's diagnoses included, but were not limited to, encephalopathy (any disease of the brain that alters brain function or structure) and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). A significant change Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 4/18/23, indicated the resident was rarely/never understood, had no documented behaviors, was total dependence of 2 with transfers, had no fall history and had no documented skin issues. A care plan, dated 5/24/18, indicated the resident was at risk for skin breakdown. An intervention, dated 5/31/23, indicated when resident was agitated, staff were to support resident's head away from Hoyer bar during transfer. A weekly skin assessment, dated 5/28/23, lacked documentation of any discoloration or any abnormal markings on the resident's body/face. An event documentation, dated 5/31/23, indicated a discoloration to the resident's left temple had been discovered. The event lacked documentation of a cause. On 6/1/23 at 2:10 p.m., Licensed Practical Nurse (LPN) 9 provided a document which indicated on		then an action plan will be developed.	

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CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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	5/25/23, she and a night shift Certified Nursing Assistant (CNA) had been transferring the resident via Hoyer Lift (a device which allows a person to be lifted and transferred with a minimum of physical effort). During the transfer the resident jerked forward and bumped her left temple on the side of the Hoyer lift. A small red mark appeared, but no bruising had been noted. The progress notes lacked documentation of the resident bumping her head on the side of the Hoyer lift and of any red mark as a result. A progress note, dated 6/1/23 at 2:18 a.m., indicated yellow discoloration continued to resident's left temple area. An IDT (Interdisciplinary team) Initial Wound Review progress note, dated 6/1/23 at 7:11 p.m., indicated the type of skin injury was a non-ulcer (i.e. skin tear, rash, bruise, abrasion, lesions, burns, surgical wound, other trauma) was described as yellow/green discoloration to left side of head, temple area. No pain noted. No signs or symptoms of infection. Interventions in place prior to wound / skin injury development included staff assist with ADLs (activities of daily living), transfers...Root-cause determination: hit head on bar of Hoyer lift. New interventions initiated: when resident is agitated, staff to support resident's head away from Hoyer bar during transfer. Therapy referral warranted: No. Current treatment order: observe site for complications. Family and physician had been notified. During an interview, on 6/2/23 at 11:13 a.m., the DON indicated the Executive Director (ED) had begun to look for a policy related to reporting findings when the issue had been brought to the staff's attention. Any new event involving a			

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	resident, should be reported and documented immediately. On 6/2/23 at 12:00 p.m., the DON provided a document, dated 7/2020, titled, "Documentation Guidelines for Nursing," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To accurately document in an organized manner all information related to the resident in the medical record...8. New skin event: Initiate for any newly identified skin conditions.... 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (a semi-flexible plastic tube with one end inserted into the bladder) which is attached to a urinary drainage bag did not touch the floor and staff failed to follow the proper procedure for changing a urinary drainage leg bag (a urinary drainage device attached to the resident's leg) to a standard urinary drainage bag for 1 of 1 resident reviewed for catheter care (Resident 55). Findings include: On 5/30/23 at 3:30 p.m., Resident 55 was observed sitting in a wheelchair with a urinary catheter drainage bag within a dignity bag (a cloth bag that covered the urinary catheter drainage bag) laying on the floor under the wheelchair. On 6/1/23 at 11:16 a.m., during an observation the resident was lying in a bed and the resident's catheter drainage bag and tubing was on the floor next to the bed. On 6/2/23 at 12:00 p.m., Certified Nurse Aide (CNA) 3 was observed removing an unbagged	F 0690	-Resident 55's catheter drainage bag has been replaced and tubing is now up off the floor -Staff re-educated on care for catheter. -all residents requiring an indwelling catheter have the potential to be affected. All residents with catheter's were audited to ensure no tubing was touching the floor. All staff educated to check for catheter and tubing to be always off floor. Nursing staff re-educated on care for resident catheters. -Catheter QAPI Tool to be completed for all residents with an indwelling catheter weekly x4 weeks and monthly for x4 months following by the UM/designee.	06/30/2023

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	used urinary drainage bag from a grab bar in the resident's shared bathroom. CNA 3 detached Resident 55's urinary drainage leg bag tubing from the urinary catheter tubing and placed the drainage leg bag tubing on the bed, then attached a standard urinary drainage bag without cleaning the urinary drainage bag tubing tip with alcohol prior to attaching to the catheter tubing. At the same time CNA 3 indicated, she should have washed the urinary drainage tubing tip with hot water and then should have cleaned the tubing with an alcohol wipe, prior to attaching the urinary drainage tubing to the catheter tubing. On 6/5/23 at 11:59 a.m., the Director of Nursing (DON) and Executive Director (ED) were asked if they allowed the urinary drainage bag to touch the floor. The DON indicated, she had never been asked that question before and would have to look for a policy. The clinical record for Resident 55 was reviewed on 5/30/23 at 2:00 p.m. Diagnoses included, but were not limited to, unspecified displaced fracture of fifth cervical vertebra, (a bone broken in the cervical (neck) region of the spine.), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems), and need for assistance with personal care. The quarterly Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) assessment, dated 4/10/23, indicated the resident had an indwelling urinary catheter related to the diagnosis of neuromuscular dysfunction of bladder. A care plan, dated 11/11/2022, indicated the			

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	resident had neuromuscular dysfunction of bladder and required a urinary catheter placement. On 6/5/23 at 1:37 p.m., the Executive Director (ED) provided and identified a document as a current facility policy, Titled "Nursing," with a revised date of 6/2023. The policy indicated, "...Component/Guidelines: ...2 Resident Care Equipment...b. Urinary catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bag or tubing from touching the ground...ii. Place soiled equipment in plastic bag...v. Clean and disinfect equipment per facility guidelines...vii. Place cleaned/disinfected equipment in clean plastic bag...." On 6/5/23 at 1:38 p.m., the Executive Director (ED) provided and identified a document as a current facility policy, titled "Converting A Urinary Drainage Bag To A Leg Bag," with a revised date of 3/2012. The policy indicated, "...Procedure Steps: ...7. Place paper towel or cloth towel under tubing at the point the catheter connects with the urinary drainage bag tubing...10. With the catheter tubing kinked in one hand to prevent urinary drainage during the transition, gently twist the catheter tubing and urinary drainage tubing in an effort to separate the two at the connection...12. Cap the open end of the tubing leading to the urinary drainage bad with an available cap or cover the open end of the tubing with alcohol swabs to prevent contamination...14. Remove the cape on the leg bag drainage tubing and gently insert and secure into the open end of the catheter tubing...." 3.1-41(a)(2)			

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure pharmacy recommendations were addressed and initiated for 2 of 5 residents reviewed for unnecessary medications (Residents 22 and 25). Findings include: 1. Resident 22's record was reviewed on 6/1/23 at 11:36 a.m. The profile indicated the resident's diagnoses included, but were not limited to, vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect	F 0757	-Resident 22's was assessed and had no adverse effects from missed pharmacy recommendation & is now on the recommended medication. -Recommendations were reviewed by the physician with orders followed. -all residents pharmacy recommendations have been reviewed & all are in place -All residents have the potential to be affected. -Nursing staff have been educated	06/30/2023

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	the blood vessels in the brain), atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time), and atherosclerotic heart disease (a common condition that develops when a sticky substance called plaque builds up inside your arteries). An annual Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 9/6/22, indicated the resident had moderate cognitive deficit and received an anticoagulant medication (a substance that is used to prevent and treat blood clots in blood vessels and the heart). A physician's order, dated 8/30/19, indicated Plavix (clopidogrel-an antiplatelet medicine which reduces the risk of blood clots forming) 75 milligram (mg) tablet, once daily due to atherosclerotic heart disease. A physician's order, dated 6/3/22, indicated Xarelto (rivaroxaban-an anticoagulant medication) 15 mg tablet, once daily for atrial fibrillation. A pharmacy recommendation, dated 3/3/23, indicated the resident received the antiplatelet medication and had not received gastroprotection (protection of gastric tissue against aggressive conditions). The resident had additional risk factors for gastrointestinal (GI-the organs that take in food and liquids and break them down into substances that the body can use for energy, growth, and tissue repair) ulceration (the formation of a break on the skin or on the surface of an organ) which included, but were not limited to, age 65 and concomitant (occurring or existing		on pharmacy recommendations -Pharmacy Recommendation QAPI Form to be completed monthly x6 months.	

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	at the same time as something else) use of anticoagulant medication. The recommendation was to initiate pantoprazole (a type of medicine called a proton pump inhibitor [PPI] which inhibits acid production in the stomach). A historical review of the resident's physician's orders lacked documentation that the pantoprazole had ever been ordered or initiated. During an interview, on 6/2/23 at 10:09 a.m., the Director of Nursing (DON) indicated she was unsure why the recommendation had not been addressed. The recommendations should always be addressed when received. 2. Resident 25's record was reviewed on 6/1/23 at 9:45 a.m., The profile indicated the resident's diagnoses included, but were not limited to, Paroxysmal atrial fibrillation (occurs when a rapid, erratic heart rate begins suddenly and then stops on its own within 7 days), Gastro-esophageal reflux disease without esophagitis (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach (esophagus). An admission Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 4/20/23, indicated the resident had moderate cognitive deficit and did not receive an anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart).within the 7 day look back period. A physician's order, dated 12/1/22, indicated Clopidogrel (it prevents platelets (a type of blood cell) from sticking together and forming a dangerous blood clot) 75 mg tablet once daily.			

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	A physician's order indicated Xarelto (rivaroxaban-an anticoagulant medication which is used to prevent blood clots from forming due to a certain irregular heartbeat (atrial fibrillation) 15 mg tablet, once daily. Unnecessary medication record review indicated the resident was on Clopidogrel 75 mg daily (QD). Pharmacy recommendation, dated 3/3/23, indicated a recommendation to begin Pantoprazole 20 mg QD. Physician agreed and signed recommendation on 3/30/23. Medical record did not indicate this order was implemented. On 06/01/23 9:58 a.m., the DON reviewed the pharmacy recommendation and indicated she was unable to find supporting documentation in the medical record of the order being implemented. On 6/2/23 at 1:47 p.m., the Executive Director (ED) provided a document, with a revision dated of 3/3/20, titled, "LTC (Long Term Care) Facility's Pharmacy Services and Procedure Manual: Medication Regimen Review," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...7. Facility should encourage the Prescriber/Physician...receiving the medication regimen review (MRR) and Director of Nursing (DON) to act upon the recommendations contained in the MRR...8. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner...11. The attending physician should address the consultant pharmacist's recommendation no later than their next visit to the facility to assess the resident, either 30 or 60 days per applicable regulation...." 3.1-48(a)(1)			

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	3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure proper food handling for 1 of 2 dining observations and failed to ensure proper handwashing for 3 of 3 dining observations. Findings include: 1. During a dining observation, on 5/30/23 at 11:32	F 0812	- No residents were effected by the alleged deficient practice -Staff educated regarding safe handling of food/ice and handwashing. -All residents have the potential to be affected. All staff educated on safe handling and handwashing. -Meal observations to be	06/30/2023

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	a.m., Activity Assistant 14 was preparing drinks for the residents. She scooped ice into 2 glasses and returned the scoop into the ice bucket. The Activity Assistant served the drinks to 2 residents and returned to the cart to prepare more drinks. At 11:41 a.m., the ice scoop remained in the ice bucket. At 11:43 a.m., another staff member approached the ice bucket and placed the ice scoop into an empty pitcher next to the ice bucket. During an interview, on 6/5/23 at 11:01 a.m., the Culinary Manager indicated staff were not to leave the ice scoop in the ice bucket. They were to return it to the empty pitcher on the cart by the ice bucket. On 6/5/23 at 1:37 p.m., the Executive Director provided a document, dated 2/02 with a revised date 5/23, titled. "Food Storage," and indicated it was the policy currently used by the facility. The policy indicated, " ...Scoops are not to be stored in the food ...." 2. During a dining observation of the closed unit, on 5/30/23 at 12:15 p.m., Activity Assistant 5 was observed to wash her hands for less than 20 seconds and touched the faucet handles with bare hands, without paper towels, when turning off the water. Activity Assistant went to the food cart to begin serving trays to the residents. 3. During a dining observation of the closed unit, on 6/1/23 at 9:19 a.m., Certified Nursing Aid (CNA) 4 was observed to wet a washcloth at the sink. She proceeded to add soap to the washcloth and touched the faucet handles with bare hands, without paper towels, when she turned off the water. CNA 4 then went to the table and placed the washcloth down by the resident she assisted with the breakfast meal. The washcloth was later		completed weekly x4 weeks and monthly x4 months. -6/30/23	

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	used to clean Resident 18's face and hands. During an interview, on 6/2/23 at 9:31 a.m., CNA 11 indicated staff were to wash their hands for a total of 40-60 seconds and they were to turn off the faucet handles by using a paper towel. Staff were not to touch the faucet handles with their bare hands. During an interview, on 6/2/23 at 10:47 a.m., the Culinary Manager indicated staff were not to touch the faucet handles with their bare hands and the process of handwashing should last 40-60 seconds in total. On 6/2/23 at 11:35 a.m., the Culinary Manager provided a document, dated 3/18 with a revised date 12/21, titled, "Hand Hygiene Policy," and indicated it was the policy currently used by the facility. The policy indicated, " ...To provide a standardized approach to hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees ...." 3.1-21(a)(3)			