STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00426662, IN00426952, and IN00427329. Complaint IN00426662 - Federal/state deficiencies related to the allegations are cited at F585 and F804. Complaint IN00426952 - Federal/state deficiencies related to the allegations are cited at F610. Complaint IN00427329 - No deficiencies related to the allegations are cited. Survey dates: February 5, 6, 7, 8 & 9, 2024 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 119 Total: 119 Census Payor Type: Medicare: 9 Medicaid: 88 Other: 22 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2024.	F 0000	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. This provider respectfully requests that this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review on, or after February 28, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric P. Ahlbrand	CEO-Administrator	03/03/2024

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

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F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable			

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	expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the			

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	pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on interview and record review, the facility failed to utilize the grievance process to promptly resolve resident grievances/concerns/complaints and follow up with a corrective action for 2 of 2 residents reviewed for grievances (Resident F and G) and 6 of 6 residents interviewed in a group setting. Findings include: Confidential interviews were completed during the survey. During a confidential interview, it was indicated there was nothing to look forward to when it came to meals. The portion sizes were much like toddler portions and they would still be hungry if family didn't keep their room stocked with groceries. The pizza tasted like a biscuit with ketchup on it and a small amount of cheese. Yesterday, the sweet	F 0585	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **The Activity Director and the Activity Assistant received education regarding the grievance policy on 2/21/24 that**	02/28/2024

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	potatoes were water-logged, lacked flavor due to being over cooked, and mushy. Many of the different meats were gray on the inside and tough, and were difficult to chew. The bread was served soggy on the plate along with undrained vegetables. Nearly every meal, the food needed to be reheated which made the tough meat worse. As recent as last night, grilled cheese was served so hard they could not eat it. Menus were not provided to the residents, so they did not know what was being served. They had voiced these concerns to the aides multiple times a week for months and had also spoken to the Administrator about one month ago, but no one had followed up with a response or action taken to resolve the dietary concerns. During a confidential interview, it was indicated the food was bland and served in an unpleasant manner. The meals were cold at least 4 out 7 days each week. Pancakes were chewy if reheated. Bread was always served on the plate, swimming in vegetable juices. A variety of meats were tough and gray on the inside, so it was difficult to determine what kind of meat was served. The eggs were always scrambled and rubbery. The grilled cheese was over cooked so hard it would knock a person out if she threw it at them. These concerns were reported every week to the aides on days shift and second shift, for a very long time. They were not aware of any action taken to correct the reported concerns. Today the food was hot, which was very unusual. Last night, they served a chicken thigh and it was very tough. Staff were aware, but did not offer a replacement, which would have been another burnt grilled cheese sandwich so they ate a Lunchable from their room for supper. During a group Resident Council interview, on		**if concerns are addressed in the resident council and or the food committee the process to follow to ensure the grievance process has been initiated for the resident to receive follow through with their concerns.** **The Interdisciplinary Team was re-educated on 2/19/24 regarding the facilities Grievance process to ensure any resident concerns will be addressed and followed through with.** **How the facility identified other residents:** **The facility completed an audit of the last 30 days of resident councils' concerns, food committee concerns and resident concern's audit to be completed by 2/28/24 to ensure any resident concerns were addressed and followed up on.** **Measures put into place/ System changes** **All staff will be re-educated beginning 2/19/24 regarding the facilities Grievance process to ensure any resident concerns will be addressed and followed through with.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit any resident grievance, resident council concerns and food committee concerns to**	

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	2/8/24 at 11:00 a.m., the following food related concerns were expressed: Six of six residents indicated the food arrived at rooms cold, hard, and sometimes undercooked. Six of six residents indicated the meal presentation was poor, and the food did not look good enough for them to want to eat. Three of six residents indicated they spent money ordering take-out every week. The residents indicated these concerns have been raised multiple times and there had been no correction by the facility. Six of six residents present indicated management did not provide any follow-up related to concerns, complaints, or grievances. They felt like the facility managers did not listen to them and did not work to assist them in solving issues or problems. During confidential employee interviews the following concerns were expressed regarding grievances/concerns/complaints: Residents regularly complained regarding food quality and quantity. Facility leadership was aware of the resident dissatisfaction with food, but little changes had been made. Residents regularly disliked the food. They often times said it lacked flavor and was over or under-cooked. The facility leadership was aware of the food dissatisfaction. However, little changes seem to have been made. Residents ordered food delivery on a regular basis.		**ensure that any concerns were addressed and followed through with. This audit will be completed 2 x weekly X 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals. The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24** ="" p="">br="">	

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	Residents frequently complained about food quality and quantity. Residents stated the food was without any flavor and meat was dry and chewy. Facility leadership was aware of the resident complaints and little was changed. Residents reported poor palatability, pasta was served too often, and a lack of menus or knowledge of what was being served. This information was provided to an available staff member in the kitchen. They were unaware of a process in which the residents and staff could voice their concerns and receive feedback or a solution to their concern. There had been at least three dietary concerns reported to them, by different residents, on a daily basis. The following ongoing concerns included poor palatability, cold and rubbery food, burnt grilled cheese, late meals, and tough meat. These concerns were reported to an available dietary staff member and had also been reported to the Administrator over the last three months. There were grievance forms available, but not completed for the residents' mentioned concerns. Review of the "Food Committee Meeting Minutes" from 8/2023 to 1/2024 indicated the concerns mentioned in the minutes from the previous meeting were not addressed, nor responded to, in the nex scheduled meeting. During an interview on 2/7/24 at 1:55 p.m., the Administrator indicated the resident did not have menus provided in the resident's rooms. The menu was only posted daily on the menu board at the kitchen. During an interview on 2/7/24 at 2:21 p.m., the Administrator indicated he was the grievance			

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	official. During an interview on 2/9/24 at 11:33 a.m., the Administrator indicated he was unaware of any individual resident's food concerns in the last 3 months, other than the concerns brought to the food committee. Residents could attend the food committee to voice their concerns. He confirmed the grievances for the last 3 months lacked regularly reported dietary concerns and responses. There was a dietary manager change, but this was due to leadership. Any concerns were required to be reported to management and placed on a grievance form. Grievances could be reported to the facility by residents, staff, or visitors. These concerns were assigned to the proper department so feedback would be given to the person who reported the concern. The facility could do a better job closing the loop on grievances. A current facility policy, dated 9/15/23, titled "Grievances / Complaints," provided by the DON on 2/9/24 at 11:53 a.m., indicated the following: "Policy Statements... The resident has the right to voice grievances without discrimination or reprisal and without fear of discrimination or reprisal. This policy is to ensure the prompt resolution of resident grievances. GUIDELINE: 1. The Administrator will assign the responsibility of the investigating grievances and complaints... 2. Residents and resident representatives have the right to file grievances orally or in writing and the right to file grievances anonymously... 3. The grievance or complaint and the corrective action taken will be documented... 4. With each Grievance and Complaint Report, the designated department will begin an investigation. 5. The investigation and report will include... a. The date the incident took place b. The nature of			

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	grievance and complaint... f. Follow-up/Recommendation for corrective action g. Resolution h. Date resolution reported i. The signature of the Individual who filed the grievance or complaint and a copy given to the resident/resident representative per facility policy... 7. All Grievances and Complaint Reports will be reviewed by the Administrator... 8. ...The resident or person acting on behalf of the resident... will be informed of the findings upon completion of the investigation, as well as any corrective actions the facility will implement... 15. The facility will maintain evidence of the result of all grievances for no less than 3 years from the date the grievance decision was issued...." This tag relates to complaint IN00426662. 3.1-7(a)(1) 3.1-7(a)(2)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the			

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	alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to complete thorough investigations of alleged abuse for 2 of 3 residents reviewed for abuse. (Residents E and L) Findings include: 1. Resident E's clinical record was reviewed on 2/6/24 at 4:33 p.m. Diagnoses included unspecified dementia without behavioral disturbance, need for assistance with personal care, and other reduced mobility. A Nurse's Note, dated 12/13/23 at 4:19 p.m., indicated the resident verbalized a CNA was mean to her. The resident was more tearful and had increased confusion. The family, provider, and DON were aware. A review of the facility's investigation of the abuse allegation was completed on 2/7/24 at 4:04 p.m. The investigation documentation, dated 12/13/23, lacked interviews/statements from the following individuals: the alleged perpetrator, the nurse on duty during the alleged event, and other staff members who worked with the alleged perpetrator. The file included an undated skin assessment. The alleged perpetrator continued to work with residents during the investigation. During an interview on 2/8/24 at 12:01 p.m., CNA 18 indicated, on 12/13/23 at approximately 10:45 a.m., Resident E told Certified Occupational Therapy Assistant (COTA) 19 that CNA 18 abused her. CNA 18 remained at work, on her current assignment, while the Administrator did the investigation that day. She was allowed to continue to work because the allegation was	F 0610	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:** **Resident E was assessed on 2/20/24 for any psychosocial concerns and no concerns were identified. The Administrator was re-educated on the Abuse Prohibition Policy by the Vice President of Operations on 2/20/24.** **How the facility identified other residents:** **The facility completed an audit of the last 30 days of reportable events to ensure the investigation process had been completed. No other residents were found to have been affected.** **Measures put into place/ System changes:** **The Interdisciplinary team received re-education on the Abuse Prohibition Policy on**	02/28/2024

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	unsubstantiated after the investigation. She could not recall if she was asked for a statement regarding the alleged abuse. During an interview on 2/8/24 at 1:52 p.m., the DON indicated the file folder provided during survey contained the facility's entire abuse investigation for Resident E's abuse allegation. During an interview on 2/8/24 at 2:06 p.m., COTA 19 indicated, on 12/13/23, the resident was sobbing uncontrollably in the 900 Unit hallway as CNA 18 assisted her in her wheelchair to the nurse's station. She reported the alleged abuse to LPN 20 at the nurse's station, the Therapy Manager, and the Administrator. She remained with the resident and took her immediately out of the situation and to the therapy room. A skin assessment was not completed by the nurse prior to taking the resident to therapy. The resident remained in therapy until approximately 2:00 p.m. During an interview on 2/8/24 at 4:20 p.m., LPN 20 indicated alleged abuse from staff to resident required immediate separation of the staff member, reporting to the Administrator, and an immediate head to toe skin assessment of the resident. She was sitting at the nurse's station on 12/13/23 when she overheard Resident E report the alleged abuse to COTA 19. CNA 18 continued to work on the unit while the investigation was underway. During an interview on 2/9/24 at 12:29 p.m., the DON indicated Resident E's abuse investigation on 12/13/23 was completed by the Administrator. During an interview on 2/9/24 at 3:01 p.m., the Administrator indicated he completed the investigation for the resident's alleged abuse on 12/13/23. The abuse was reported to the		**2/20/24 regarding to ensure appropriate investigation process completed.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit all reportables to ensure accuracy of the investigation process. This audit will be completed weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of compliance: 2/28/24** ="" p=""> br="">	

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	Administrator on 12/13/23 at 11:02 a.m. and the investigation was started. Resident E and her roommate had severe cognitive impairment and were both interviewed regarding the alleged abuse. Other interviewable resident room numbers were included and indicated 81 interviewable residents denied any concerns with care or staff. The residents' names were not included. The investigation should have included a statement from the alleged perpetrator and any witnesses. Interviews from other staff members who worked with the alleged perpetrator would have also ensured a thorough investigation, but were not included. A suspension of CNA 18 should have been included in the abuse investigation. During an interview on 2/9/23 at 3:27 p.m., the Staff Development Coordinator indicated CNA 18's personnel file lacked any suspension in her record. 2. The clinical record for Resident L was reviewed on 2/6/24 at 2:25 p.m. Diagnoses included right side hemiplegia, acute respiratory failure, dysphagia, diabetes mellitus type II, anxiety disorder, and heart disease. Review of the facility self reportable, dated 1/24/24, indicated on this date, staff reported a CNA had been rough when repositioning Resident L in her bed. Review of a Resident Investigation Tool for Allegation of Abuse, Neglect, Misappropriation of Resident Property form, provided by the Administrator on 2/8/24 at 4:00 p.m., indicated residents on the 600 hall were interviewed without concerns or issues. A list of ten resident names were included. The record lacked specific questions asked or resident responses.			

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	During an interview on 2/9/24 at 11:35 a.m., the Administrator indicated the investigation file provided was the complete documentation of the investigation. Staff and resident's were interviewed, but no specific documentation of all the interviews were completed. A current facility policy, revised 9/15/23, titled, "Abuse, Neglect and Misappropriation of Property," provided following entrance conference on 2/5/24, indicated the following: "...E. Investigation Guidelines...2. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 3. To the extent possible and applicable, provide complete and thorough documentation of the investigation...." This citation relates to Complaint IN00426952. 3.1-28(d)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in			

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	155242	A. BUILDING 00 B. WING	02/09/2024

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	accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing			

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	and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey			

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	Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to notify the Ombudsman of resident discharge for 2 of 3 residents reviewed for Ombudsman notification. (Residents 112 & G) Findings include: 1. Resident 112's closed clinical record was reviewed on 2/8/24 at 11:21 a.m. The resident's discharge diagnoses included acute duodenal ulcer with perforation, peptic ulcer, and anemia. The resident was discharged to the hospital via ambulance on 12/12/23 and was admitted. The resident chose not to return to the facility following his hospitalization. Review of a facility email indicated the Ombudsman notification of residents who were discharge in December 2023 was sent to the Ombudsman 2/9/24. The December 2023 "Discharge and Transfer Form Ombudsman Fax Log", listed Resident 112's name and date of discharge. During an interview, on 2/9/24 at 12:18 p.m., the Social Services Director indicated the December 2023 discharge form had not been sent in January as required. The lack of timely notification was caused by a human and computer error. 2. Resident G's clinical record was reviewed on 2/6/24 at 3:10 p.m. Diagnoses included acute on chronic diastolic congestive heart failure, chronic respiratory failure with hypoxia, and major depressive disorder. The resident was transferred to the hospital on 11/28/23 and returned to the facility on 12/1/23. The clinical record lacked an	F 0623	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **The facility notified the ombudsman of resident 112 discharge to the hospital on 2/16/24. The Social Service Director was re-educated on the notification to ombudsman of residents who have been discharged from the facility or transferred to the hospital on 2/16/24.** **How the facility identified other residents:** **The ombudsman has been notified of the last 90 days of residents who have discharged from the facility and or to the hospital on 2/16/24.** **Measures put into place/**	02/28/2024

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	Ombudsman notification for a transfer/discharge on the above mentioned date. During an interview on 2/9/24 at 11:49 a.m., the SSD indicated the State Ombudsman Notifications for transfers/discharges should have been emailed to the Ombudsman the first week of each month. Ombudsman notifications for November 2023 and December 2023 were not sent timely. Resident G was omitted from the November 2023 Ombudsman notifications. Both months were emailed to the Ombudsman on 2/9/24, after the information was requested during the survey. A current facility policy, dated 9/15/23, titled "Transfer/Discharge Notice," provided by the DON on 2/9/24 at 12:23 p.m., indicated the following: "POLICY STATEMENT... The appropriate notice will be provided to the resident and/or resident representative, along with other required organizations, if it is necessary to transfer or discharge a resident from a facility... "FACILITY-INITIATED DISCHARGE/TRANSFER: ... 4. Facility will notify the Office of the State LTC Ombudsman as close as possible to the actual time of a facility-initiated transfer or discharge... For transfers to the acute care setting the facility will notify the Ombudsman monthly...." 3.1-12(a)(6)(A)(iv)		**System changes:** **The Social Service Director and Social Service Assistant received re-education on the Discharge Planning Process and notification to the Ombudsman of resident who have discharged from the facility and or the hospital on 2/16/24.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit discharges to ensure that the ombudsman's has been notified of the discharge status. This audit will be completed weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. Date of compliance: 2/28/24 ="" p="">br="">	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on observation, interview, and clinical record review, the facility failed to develop a discharge care plan and assist a resident to obtain his discharge goals for 1 of 1 residents who desired to discharge home following therapy. (Resident 12) Findings include: During an interview on 2/6/24 at 10:53 a.m., Resident 12 indicated he had come to the facility for therapy and desired to return to a home living environment now that his therapy was completed. He didn't really know what the plan was. He believed he needed to get on a list for income based housing. He needed some help with the process and hoped the facility would help him. At this point, he was unsure of what was happening. During an observation at this time, the resident was neat and clean. He was dressed appropriately for the weather. He was wearing rubber soled shoes and walking independently with a cane. Resident 12's clinical records was reviewed 2/8/24	F 0624	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified: Resident 12 and resident guardian received assistance with the discharge planning process by the Social Service Director on 2/10/24. Resident 12 care plan was revised on 2/12/24 to reflect the discharge planning process. The Social Service Director received**	02/28/2024

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	at 10:33 a.m. Current diagnoses include, chronic obstructive pulmonary disease (COPD), anxiety, and atrial fibrillation. A 11/13/23 at 4:52 p.m., admission progress note indicated the resident planned to rehab to home. The resident had previously set up his medications for himself at home. He used a cane at home. He used a local transit company to attend doctors appointments, and had received assistance from a home health agency, but could not remember the name of the agency. The clinical record lacked a care plan for discharge planning or documentation regarding discharge assistance and planning. During an interview on 2/9/24 at 9:46 a.m., the Rehab Manager indicated Resident 12 had finished his rehabilitation therapy on 12/12/23. The resident's goal had been to rehab to home. The resident finished therapy with the ability to walk independently with a cane. His record indicated he needed assistance with obtaining a new apartment or a less restrictive living place. During an interview on 2/9/24 at 9:53 a.m., the Social Services Director (SSD) indicated Resident 12 had a legal guardian. She knew the resident desired a less restrictive environment and an assisted living or income based apartment would be a good choice. She would review to see if she had developed and implemented a care plan for discharge planning. She would also review for any documentation of keeping the resident informed and involved. During an interview on 2/9/24 at 11:32 a.m., the SSD indicated Resident 12 did not have a care plan for discharge planning nor was there any		**re-educated on the discharge planning process to include care planning of the discharge planning process.** **How the facility identified other residents:** **The facility completed an audit of the last 30 days of residents who have been admitted into the facility to ensure that the resident has received assistance with the discharge planning process and the care plan reflects the discharge panning process. Audit to be completed by 2/28/24.** **Measures put into place/ System changes:** **The Social Service Director and Social Service Assistant received re-education on the Discharge Planning Process as well as ensure that the resident has a discharge planning process care plan on 2/16/24.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit admissions to ensure the discharge planning process has been initiated to include the resident and or the responsible party in the discharge planning process and to ensure that the resident has a discharge planning care plan. This audit will be completed weekly x 12 weeks. Any identified concerns**	

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	documentation regarding discharge planning or resident involvement. A current, 11/1/22, facility policy titled, "Discharge Planning", which was provided by the DON on 2/9/24 at 11:53 a.m., indicated the following: "...The facility will ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each residents. The discharge planning process generally involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge...." 3.1-12(a)(21)		**will be immediately addressed to the responsible individuals. The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24** ="" p="">br="">="" span="">br="">	
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 record review and interview, the facility failed to notify the physician of weights outside	F 0684	*This Plan of Correction is the center's credible allegation of*	02/28/2024

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	the ordered parameters for 1 of 2 residents reviewed for edema. (Resident 265) Findings include: The clinical record for Resident 265 was reviewed on 2/6/24 at 3:27 p.m. Diagnoses included diabetes mellitus type II, diastolic congestive heart failure, acute osteomyelitis right foot/ankle, and peripheral vascular disease. A current physician's order, dated 1/18/24, indicated to obtain daily weights and to notify the physician or nurse practitioner for a greater than two pound weight gain in one day or greater than five pound weight gain in a week. A care plan, dated 1/29/24, indicated the resident was at risk for actual fluid imbalance related to diuretic therapy. The goal included the resident would be free of complications from fluid overload. An approach for the care plan included to obtain weights as indicated and to report significant changes to the physician or nurse practitioner. The resident had weights documented as follows: On 1/18/24, the resident's weight was documented as 220 pounds. The weight one week later, on 1/25/24, the resident's weight was 229.8 pounds; a 9.8 pound weight gain. The clinical record lacked physician or nurse practitioner notification. On 1/19/24, the resident's weight was documented as 221.6 pounds. The weight one week later, on 1/26/24, the resident's weight was 230 pounds; an 8.4 pound weight gain. The clinical record lacked physician or nurse practitioner notification.		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **The provider evaluated resident 265 weight on 2/16/24. Resident 265 had no adverse outcome. Resident 265 was discontinued off daily weights on 2/20/24.** **How the facility identified other residents:** **The facility completed an audit on 2/20/24 of all residents receiving daily weights for the last 30 days to ensure no other residents were affected. Any resident with a order for a daily weight was forwarded to the provider to evaluate for any changes in the resident plan of care. No resident had any adverse outcome.** **Measures put into place/ System changes:** **The licensed nurses will receive re-education beginning 2/16/24 that any resident who is on daily weights when a weight has been identified to**	

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	On 1/20/24, the resident's weight was documented as 221 pounds. The weight one week later, on 1/27/24, the resident's weight was 230.6 pounds; a 9.6 pound weight gain. The clinical record lack physician or nurse practitioner notification. During an interview on 2/9/24 at 11:32 a.m., the DON indicated the nurse practitioner was notified of the resident's weight gain and had determined it was due to the wound vacuum weight. There was no documentation regarding the gain attributed to the wound vacuum and she just learned this information from RN 14 today. The wound vacuum was present continuously since admission, but staff may have been placing it on the floor prior to the resident being on the weight scale. She was unsure. The electronic health record did not have a specific indication of the physician or nurse practitioner being notified regarding weight gain of greater than five pounds in a week. A progress note should have been entered of any notification. A current facility policy, revised 9/15/23, titled, "Notification of Change of Condition," provided by the DON on 2/9/24 at 2:20 p.m., indicated: "...Guidelines...2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3....The medical provider will provide guidance related to the change of condition...." 3.1-37(a)		**be outside of the physician parameters the provider will be notified of the variance.** **The Qualified medication aide will receive re-education beginning 2/16/24 that any resident who is on daily weights when a weight has been identified to be outside of the physician parameters the licensed nurse will the notify the provider of the weight variance.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit daily any resident who are on daily weights with weights outside of the physician's parameter to ensure provider notification. This audit will be completed daily x 12 weeks.** **Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is**	

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			required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24 ="" p=""> br="">	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			

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	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 1 of 5 medication carts reviewed for medication storage. (800 hall cart) Findings include: During a medication storage observation of the 800 hall cart, accompanied by LPN 11 on 2/9/24 at 11:02 a.m., the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications: In December 2023- 12/6: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 12/7: 7:00 p.m.- 7:00 a.m. shift 12/8: 7:00 p.m.- 7:00 a.m. shift 12/9: 7:00 p.m.- 7:00 a.m. shift 12/10: 7:00 p.m.- 7:00 a.m. shift 12/11: 7:00 p.m.- 7:00 a.m. shift 12/16: 7:00 p.m.- 7:00 a.m. shift 12/21: 7:00 a.m.- 7:00 p.m. shift 12/26: 7:00 p.m.- 7:00 a.m. shift 12/27: 7:00 a.m.- 7:00 p.m. shift 12/28: 7:00 p.m.- 7:00 a.m. shift In January 2024- 1/1: 7:00 p.m.- 7:00 a.m. shift 1/2: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/3: 7:00 p.m.- 7:00 a.m. shift 1/8: 7:00 p.m.- 7:00 a.m. shift 1/9: 7:00 p.m.- 7:00 a.m. shift	F 0755	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **All medication carts narcotic reconciliation sheets were validated for accuracy against the narcotic shift to shift count record on 2/19/24. No resident had any adverse outcomes.** **How the facility identified other residents:** **The facility completed an audit of all medication carts on 2/20/24 to ensure the shift to shift narcotic reconciliation sheets were validated with the nurse's signature from shift to shift.** **Measures put into place/ System changes:** **The licensed nurses and the Qualified medication aides was**	02/28/2024

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	155242	A. BUILDING 00 B. WING	02/09/2024

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	1/10: 7:00 p.m.- 7:00 a.m. shift 1/13: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/14: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/15: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/16: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/17: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/18: 7:00 p.m.- 7:00 a.m. shift 1/19: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/20: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/21: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/22: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 1/24: 7:00 p.m.- 7:00 a.m. shift 1/29: 7:00 p.m.- 7:00 a.m. shift 1/30: 7:00 p.m.- 7:00 a.m. shift In February 2024- 2/3: 7:00 p.m.- 7:00 a.m. shift 2/4: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 2/5: 7:00 a.m.- 7:00 p.m. shift and 7:00 p.m.- 7:00 a.m. shift 2/7: 7:00 p.m.- 7:00 a.m. shift During an interview at the time of the observation, LPN 11 indicated both the incoming and outgoing nurses were to do a narcotic count and sign the "Narcotics Sheet Count" page at the start and end of the shift. During an interview on 2/9/24 at 3:40 p.m., the DON-in-training indicated the expectation for the		**re-educated beginning 2/19/24 regarding the validation of the narcotic shift to shift count process to ensure narcotic have been validated for accuracy against the narcotic in the medication cart.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit medication carts weekly to ensure that the narcotic shift to shift sheets have the nurse's signature ongoing and off going that the narcotic have been validated. This audit will be completed weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	nursing staff was for shift to shift narcotic counts to be completed at every change of shift. The nurses should both sign the "Narcotics Sheet Count" form. A current, revised 11/13/23, facility policy, titled, "Controlled Medication Policy," provided by the DON on 2/9/24 at 2:15 p.m., indicated the following: "... 2. At each shift change or when keys are rendered, a physical inventory of all controlled medication is conducted by two staff members who are either licensed nurses, medications technicians, or appropriate staff per state regulations and is documented on the controlled medications accountability record..." 3.1-25(b)(3)		**Date of compliance: 2/28/24** ="" p="">br="">	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. A. Based on observation and interview, the facility failed to ensure medications stored in the medication refrigerator in the hall medication storage room were labeled with resident identifiers and directions for 1 of 2 medication storage rooms reviewed (100 hall) and for 13 of 13 residents' treatments stored in the treatment carts. (800 and 500 halls) Findings include: 1. During a medication storage observation of the 100 unit medication room, accompanied by LPN 8 on 2/8/24 at 9:47 a.m., sixteen unlabeled 650 mg (milligrams) acetaminophen (to treat fevers or mild pain) suppositories were in the refrigerator. During an interview, at the time of the observation, LPN 8 indicated there were no labels present on the medication and she did not know why the suppositories were stored in the medication room. 2. During a medication storage observation of the treatment cart for the 800 and 500 halls, accompanied by LPN 11 on 2/9/24 at 11:30 a.m., the following medications were observed without resident identifiers and directions: Two tubes of "Woun'Dres" collagen hydrogel (to promote wound healing) cream One tube "Aleve Arthritis" (for pain relief) gel One tube "Medihoney" (to treat wounds) wound	F 0761	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **On 2/9/24 the medication was disposed of by the Unit Manager. ADON/DON assessed all other medication carts, medication storage rooms and treatment carts and no other medication were identified to have not had a label on the medication.** **How the facility identified other residents:** **The facility completed an audit on 2/9/2024 of all other medication carts, medication storage rooms and treatment carts to ensure no other medication did not have a**	02/28/2024

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	and burn gel One tube bacitracin (an antibiotic ointment) ointment One tube clobetasol propionate (a topical steroid) 0.05% cream One tube diclofenac sodium (to reduce inflammation) 1% topical cream One tube miconazole nitrate (an antifungal medication) 2% topical cream One tube sodium fluoride 5000 plus (to prevent tooth decay) paste One tube capsaicin (to relieve pain) 0.0025% cream One bottle of "Nystatin" (an antifungal medication) powder 100,000 units Two tubes of triamcinolone acetinide (a corticosteroid) 0/1% lotion During an interview, at the time of the observation, LPN 11 indicated the medications stored in the treatment cart were used by the wound nurse for residents on the 800 and 500 halls. She was not able to say which residents these medications were for and did not know why they did not have labels. A current facility policy, dated 1/23, titled "Medications and Medications Labels", provided by the DON on 2/9/24 at 2:15 p.m., indicated the following: "... Medications are labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medications use following state and federal laws.... 1. Each prescription medication will be labeled to include: a. Resident's name. b. Specific directions for use, including route of administration. c. Medication name... d. Strength of medication... e. Prescriber's name. f. Date medication is dispensed. g. Quantity dispensed. h.		**label on the medication. No others medication was identified with not having had a label on the medication.** **Measures put into place/ System changes:** **All licensed nurses and Qualified medication aides will be educated beginning 2/9/24 related to ensuring all medication on the medication carts have an label on the medication.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit the Facility medication cart, medication storage room, and treatment carts to ensure a label is on the medication. This audit will be completed 2 x weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is**	

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	Expiration or end-of-use date... i. Name, address, and telephone number of dispensing pharmacy. j. Prescription number. k. Accessory/precautionary labels... l. Dispensing pharmacist's initials..." 3.1-25(j) 3.1-25(k)		**required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24** ="" p="">br="">	
F 0804 SS=E 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, interview, and record review, the facility failed to ensure food was attractive, palatable, and contained satisfying portions for 12 of 12 residents reviewed for food satisfaction and palatability, and 6 of 6 residents interviewed in a group setting. Findings include: Confidential interviews were completed during the survey. During confidential resident interviews, the following concerns were expressed regarding food attractiveness, portion size, and palatability:	F 0804	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:**	02/28/2024

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	a. "The portions are not large enough. I am usually hungry after I finish eating. The food is often unappetizing. Regarding a recent breakfast, all I got was a biscuit, nothing else. I did not have funds to purchase a snack." b. "They are frequently not careful when they place the food on the plate. They got a lot of veggie juice on the plate and the roll would be all wet and soggy, so I didn't eat it. It was not attractive or palatable." c. "Many times, the menu does not reflect what was served. Last night, the tray card that lists menu items to be served, listed tomato soup and grilled cheese. The tray had what appeared to be uncooked French fries and no soup. The portions served at meals are like kiddy portions." She felt she had not gotten enough to eat at some meals. d. "The food "sucks." She had suggested to management to eat the food and not tell the kitchen so they could really see how bad the food really was. She recently was served a grilled cheese that she was unable to bite into because it was so hard. There also was no tomato soup on the tray either, which was not a great lose as the tomato soup in the past, tasted like ketchup and water. She ended up ordering food through a delivery service because she was hungry. e. The menu card on the tray said bacon was to be served, but the plate had sausage. She indicated she did not feel she gets enough to eat. Portions on her plate are very small. She did not get a menu to order from, but one comes on the meal tray. She can ask for an alternative, but it takes awhile. f. They list banana on the menu but it's not on the tray. The menu is not usually posted by the dining rooms. She did not get a menu daily or a way to order alternative meals. It's always a surprise what is served. She had been eating delivery a lot lately. Sunday night, her grilled		**No resident had no adverse outcome from not receiving the appropriate diet. Education was completed by the Regional Dietary Manager on 2/8/2024 regarding the appropriate palpability and potion size. A resident food committee was convened on 2/22/24 every resident was notified of the meeting in writing.** **How the facility identified other residents:** **The Registered Dietician, Regional Dietary Manager and Dietary Director completed a tray line audit of all resident diets to ensure palatability and portion size to ensure accuracy on 2/16/24. No other residents were identified to have been affected.** **Measures put into place/ System changes:** **All Dietary staff received re-education regarding palatability and portion size by the Regional Dietary Manager and the Dietary Director beginning 2/8/24.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC, Clinical Consultant, Dietary Manager or the Registered Dietitian will audit tray lines to ensure resident tray palatability and portion size accuracy. This audit will be**	

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	cheese sandwich was like a brick and she was unable to bite into it. g. "The food here is terrible, last night's dinner was two hard grilled cheese sandwiches and still-frozen French fries." h. "The food here is just awful." i. "The food here is poor, it's cold and keeps getting served later and later than the scheduled time." j. "The chicken was dry, I didn't like it, I did not eat anything else on the tray either." k. "There is nothing to look forward to when it comes to meals. The portion sizes are much like toddler portions. I would still be hungry if my family didn't keep my room stocked with groceries. The pizza tastes like a biscuit with ketchup on it and a small amount of cheese. Yesterday, the sweet potatoes were water logged, lacked flavor due to being over cooked, and mushy. Many of the different meats are gray on the inside and tough. This was difficult to chew. The bread was served soggy on the plate along with not drained vegetables. Nearly every meal, I need to have the food reheated which makes tough meat worse. As recent as last night, grilled cheese was served so hard I could not eat it." A wide variety of personal food items were in the room. They indicated menus were not provided to the residents, so they do not know what was being served. "I have voiced these concerns to the aides multiple times a week for months. I also spoke to the Administrator about one month ago, but no one has followed up with a response or action taken to resolve the dietary concerns reported to staff. I refused the meal today except for the pie. Staff delivered the pie, but I could not eat it because it had terrible flavor." l. "Food is bland and served in an unpleasant manner. Food is cold at least 4 out of 7 days each week. Pancakes as recent as two days ago were		**completed 2 x weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals. The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24** ="" p="">br="">"	

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	served cold. Pancakes are chewy if they are reheated. Bread is always served on the plate swimming in vegetable juices. A variety of meats were tough and gray on the inside, so it was difficult to determine what kind of meat was served. The eggs are always scrambled and like rubber. The grilled cheese was over cooked so hard it would knock a person out if she threw it at them." The resident kept a supply of her own dietary items so she would not be hungry or do without. These concerns were reported every week to the aides on day shift and second shift for a very long time. " I am unaware of any action taken to correct the reported concerns. Today the food was hot which was very unusual. I cannot remember the last time the tray was served hot. Last night they served a chicken thigh and it was very tough. I could not chew it so I told the aide. They did not offer another tray. I did not ask for a replacement because I did not want another burnt grilled cheese sandwich so I ate a ""Lunchable"" out of my refrigerator for supper." Personal dietary items were stored in the resident's refrigerator, on top of the refrigerator, and in the top drawer of the end table. During a Resident Council group interview, on 2/8/24 at 11:00 a.m., the following food related concerns were expressed: a. Six of six residents indicated the food arrived to rooms cold, hard, and sometimes undercooked. b. Six of six residents indicated the meal presentation was poor and the food does not look good enough for them to want to eat. c. Three of six residents indicated they spent money 'ordering out' every week. The residents indicated this concern has been raised multiple times and there has been no correction by the facility.			

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	During confidential employee interviews, the following concerns were expressed regarding food satisfaction and palatability: a. Residents regularly complained regarding food quality and quantity. Residents who were supposed to get double portions were not always served double portions. There were often inconsistent portion sizes. Two trays side by side would not always have the same portion sizes. The residents complained that the food had "no flavor". The food was often cold. Facility leadership was aware of the resident dissatisfaction with food, but little changes have been made. b. Residents regularly disliked the food. They stated it didn't taste good and was unappetizing. They often times said it lacked flavor and was over or under cooked. The facility leadership was aware of the food dissatisfactions. However, little changes seem to have been made. Residents ordered food delivery on a regular basis. c. Residents frequently have complained about food quality and quantity on a regular basis. Residents who are supposed to get double portions often times received single portions. Residents state the food tastes bland without any flavor. They said meat was dry and chewy. Facility leadership was aware of the resident complaints and little has changed. d. Dietary concerns have been ongoing since they have worked at the facility. Dietary concerns included: poor palatability, lack of menus, or knowledge of what is being served. This information was provided to an available staff member in the kitchen. e. There were at least three dietary concerns reported to staff by different residents on a daily basis. The following concerns included: poor palatability, cold and rubbery food, burnt grilled cheese, late meals, and tough meat. These items			

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	were reported to an available dietary staff member and had also been reported to the Administrator over the last three months. "Food Committee Meeting Minutes" for 1/2024 to 8/2023 were reviewed and indicated the following: a. 1/30/24 - Six (6) residents were in attendance. "Review of minutes or actions form the last meeting:"- [Resident name]- no seafood. The ideas discussed during the last meeting were not addressed. "Any menu items that are generally not liked or product that are not liked (need specifics)?- Capri veggies, tilapia "Are you offered and alternate meal or beverages?" -Depends on the CNA. b. 12/29/23- Eight (8) residents were in attendance. "Review of minutes or actions form the last meeting:" blank "Any menu items that are generally not liked or product that are not liked (need specifics)?- country fired steak, Capri veggies [a vegetable blend which usually contained carrots, green beans, yellow squash and zucchini). "Are you offered and alternate meal or beverages?" - sometimes c. 11/21/23 - 9 residents in attendance. No other topic addressed. "Review of minutes or actions form the last meeting:" Take salad off always available, put chicken tenders back on always available or chicken sandwich "Any menu items that are generally not liked or product that are not liked (need specifics)?- Tilapia "Are you offered and alternate meal or beverages?" - yes d. 10/10/23- 9 residents in attendance- Different form and different topics.			

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	"Want new items," "Kitchen will go through menu and residents will decide what items they enjoyed and want to get away with [sic]," e. 9/28/23- 7 residents in attendance "Review of minutes or actions form the last meeting:" Changed always available menu removed chicken tenders, replaced with chef salad. No other issues were addressed. "Rolls get soggy...Put rolls in bags instead of on plate." f. 8/3/23- 9 residents in attendance. "Review of minutes or actions from the last meeting:"- "Resident choice was delicious." No other issues were addressed. "Any menu items that are generally not liked or product that are not liked (need specifics)?- Capri vegetable blend Although Capri blend and tilapia were often mentioned as dislikes, this issue was never addressed in the following meeting. Review of the menu for the week of 2/4/24 to 2/20/23 included the following: a. When scrambled eggs were served on Sunday, Tuesday, Wednesday, and Friday, the portion size for eggs was 1/4 cup which equals 1 egg. b. Tuesdays breakfast was 1 egg with cheese (1/4 cup) and one biscuit. c. Tuesday's lunch had Capri blend vegetables d. Monday's dinner had Tilapia e. Friday's lunch had Tilapia f. Three (3) meals had pasta or casserole dishes served in 8 ounce/1 cup portions for the entire entree. Monday-lunch, Wednesday- dinner, and Friday dinner. An untitled document provided by the Administrator on 2/9/24 at 11:32 a.m., indicated on Monday 2/5/24, 116 of the facility's 119 residents			

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	consumed food orally. During an interview on 2/7/24 at 1:55 p.m., the Administrator indicated the residents did not have menus provided in the resident's rooms. The menu was only posted daily on the menu board by the kitchen. During an interview on 2/7/24 at 2:21 p.m., the Administrator indicated he was the grievance official. During an interview on 2/9/24 at 11:33 a.m., the Administrator indicated he was unaware of any individual residents' food concerns in the last three months other than the concerns brought to the food committee. Resident can attend food committee meetings to voice their concerns. He confirmed the grievances for the last three months lacked regularly reported dietary concerns. There was a dietary manager change but this was due to leadership. Any concerns were required to be reported to management and placed on a grievance form. Grievances could be reported to the facility by residents, staff, or visitors. These concerns were assigned to the proper department so feedback would be given to the person who reported the concern. The facility could do a better job closing the loop on grievances. This tag relates to complaint IN00426662. 3.1-21(a)(2) 3.1-21(a)(3)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§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 food was prepared, served, and distributed in a manner to prevent possible cross contamination for 1 of 1 food service line observations on 2/7/24 lunch meal service. This deficient practice had the potential to impact 116 of 116 resident who consumed meals prepared in the facility kitchen. Findings include: During an observation of the lunch meal service line on 2/7/24 from 11:30 a.m. to 11:48 a.m., the following concerns regarding possible cross contamination of foods were observed: At 11:40 a.m., the Dietary Manager (DM), using gloved hands, touched a bun, left the meal service area wearing the same gloves, opened drawers and retrieved utensils with the same gloves, and	F 0812	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **No resident was identified to have been affected. The Regional District Manager completed re-education on**	02/28/2024

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	returned to the food service area wearing the same contaminated gloves. Using the same contaminated gloves, she touched lettuce, cheese, pickles, and tomatoes. She left the food service area again and returned to the area with the same gloves and continued meal service. At 11:41 a.m., Cook 2 touched a bread slice with her gloved hand. She then touched Styrofoam containers, scoops, countertops, meal tickets, and meal trays with the same contaminated gloved hands. She continued this process of touching food, bread, lettuce, buns, scoops, Styrofoam containers, counter tops, meal tickets, trays with the same contaminated gloves, until 11:48 a.m. At 11:47 a.m., the DM began serving food again using her gloved hand. She touched buns, pickles, cheese, tomatoes and lettuce. During an interview on 2/7/23 at 11:48 a.m., the DM and Cook 2 both indicated food should be served using utensils such as tongs and should not be touched with gloved hands. They both agreed their gloved hands had touched many objects. An untitled document provided by the Administrator on 2/9/24 at 11:32 a.m., indicated on Monday, 2/5/24, 116 of the facilities 119 residents consumed food orally. A current facility policy, dated 2/2023, titled, "Food Preparation," provided by the DON on 2/7/23 at 12:14 p.m., indicated the following: "...All staff will use appropriate serving utensils appropriately to prevent cross contamination...." 3.1-21(i)(1)		**2/8/24 with the dietary staff regarding not handling residents' food items with gloves that have been touched by other surfaces.** **How the facility identified other residents:** **The Registered Dietician, Regional District Manager and Dietary Manager completed a tray line audit of all residents' meals to ensure sanitary accuracy by the dietary staff on 2/16/24. No other concerns identified in reference to sanitary issues.** **Measures put into place/ System changes:** **All Dietary staff received re-education beginning 2/8/24 regarding tray line preparation in maintaining sanitary conditions by the Regional Dietary Manager and Dietary Director beginning 2/8/24.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC, Clinical Consultant or Registered Dietician will audit tray lines to ensure staff are maintaining sanitary accuracy. This audit will be completed 2 x weekly x 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update**	

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			and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24 ="" p="">br=">	
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 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			

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	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 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			

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	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 follow infection control guidelines related to isolation procedures for 1 of 1 residents on isolation precautions. (Resident 267) Finding include: During an observation on 2/5/24 at 10:00 a.m., Resident 267's room door had signage indicating Enhanced Barrier Precautions and had a personal protective equipment (PPE) cart outside her door. RN 15 and an unidentified CNA were observed entering the resident's room to pull her up in the bed. The staff had not donned PPE. During an interview at the time of the observation, RN 15 indicated she was unsure if the resident was actually on transmission based precautions and thought the PPE was not longer necessary. She had not had a chance to check. During an observation on 2/7/24 at 12:33 p.m., the resident's door continued to have signage indicating Enhanced Barrier Precautions and a PPE supply cart outside her door. Resident 267's clinical record was reviewed on 2/7/24 at 12:40 p.m. Diagnoses included	F 0880	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** **Resident 267 was assessed on 2/9/24 and had no adverse outcome from the staff member not utilizing the appropriate PPE when entering the resident room. Resident 267 has since been discharged from the facility. The CNA and Nurse 15 received education by the DON on use of PPE when entering resident room to provide care on 2/9/24.**	02/28/2024

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	vancomycin-resistant enterococcus (resistant bacterial infection) of abdominal fluid and colostomy. A current health care plan, dated 2/5/24, indicated the resident had a decline in her ability to perform activities of daily living and needed assistance with bed mobility, transfers, eating and toileting related to decreased mobility, surgery and pain. Approaches for the care plan included to provide assistance as needed with all activities of daily living to ensure daily needs were met. A current health care plan, dated 2/5/24, indicated the resident had an active peritonitis infection and indicated use of personal protective equipment as indicated. During an interview on 2/8/24 at 4:06 p.m., RN 15 indicated she should have donned a gown and gloves prior to assisting the resident up in her bed. She had thought the resident's transmission based precautions had been lifted and the signage should have been removed, then realized the resident remained in TBP. A current facility policy, dated 1/30/24, titled, "Enhanced Barrier Precautions Policy," provided by the DON on 2/9/24 at 11:30 a.m., indicated: "...Policy Statement. This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Guidelines:...4. When a resident is placed on Enhanced Barrier Precautions, appropriate signage is place on the room entrance so that personnel and visitors are aware of the need for and the type of precautions. a. The signage informs the staff on instructions for use of PPE,		**How the facility identified other residents:** **The facility completed an audit of all other residents who were on transmission-based precautions on 2/9/24 to ensure proper use of PPE when entering the resident rooms with no further concerns identified. Resident 267 has since been discharged from the facility and no other resident are on transmission-based precautions.** **Measures put into place/ System changes:** **All staff will be educated on the use of PPE when entering the resident room to ensure proper PPE application beginning 2/9/24.** **How the corrective actions will be monitored:** **Effective 2/26/24 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit any resident receiving transmission-based precaution to ensure that the proper PPE when entering the resident room has been donned. This audit will be completed 3 x weekly X 12 weeks. Any identified concerns will be immediately addressed to the responsible individuals.** **The facility through the QAPI program will review, update and make changes, as necessary to this plan of**	

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	and/or instructions to see a nurse before entering the room...." 3.1-18(a)		**correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 2/28/24** ="" p="">br=">	