STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING 00 B. WING	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 30, 31 and June 1, 2, 2023. Facility number: 000181 Provider number: 155283 AIM number: 100266860 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 3 Medicaid: 25 Other: 1 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/6/23.	F 0000	**F000** The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. 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 June 23, 2023.	
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, record review, and	F 0684	**F 684 (D)**	06/23/2023

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

Dena Kerschner | HFA | 06/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	interview, the facility failed to ensure an edema glove was in use as ordered for 1 of 2 residents reviewed for edema. (Resident 16) Finding includes: On 5/30/23 at 3:16 p.m., Resident 16 was observed sitting in a wheelchair in her room. Her left hand was in a fist. The resident indicated the staff usually put a glove on her hand but had not done so that day. On 5/31/23 at 10:12 a.m., Resident 16 was observed sitting in a wheelchair in her room. Her left hand was a in fist and there was not a glove on the hand. Record review for Resident 16 was completed on 5/31/23 at 10:20 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus, hemiplegia, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/23, indicated the resident was cognitively intact. The resident required an extensive 2+ person assistance for dressing and personal hygiene. The May 2023 Physician's Order Summary (POS) indicated an order for a compression sleeve to be placed on the left arm upon rising for edema to the left hand and arm. The sleeve was to be worn 12 hours as the resident allowed. The sleeve was to be placed by the CNA and verified by the nurse for placement. Interview with CNA 1 on 5/31/23 at 10:38 a.m., indicated the resident would sometimes refuse to wear the compression sleeve. She had informed		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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Resident #16 now wears the compression sleeve as ordered. Staff communicate refusals to the charge nurse and the nurse documents any refusals. All residents with edema were audited for orders and use of edema gloves or sleeves. In addition, staff educated on which residents require these interventions with correct documentation and communication of refusals. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents in the facility with edema glove/sleeve orders have the potential to be affected by the same alleged deficient practice. Residents with orders for edema gloves or sleeves will be monitored by the nurse for placement and correct documentation.	

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	the nurse the resident had refused it that day. Interview with LPN 1 on 5/31/23 at 10:41 a.m., indicated no one had told her the resident had refused to wear the compression sleeve. If she was refusing to wear it, then the CNA's should have notified the Nurse. 3.1-37(a)		*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* All nursing staff will be in-serviced on the alleged deficient practices and will be educated in accordance with facility policy and the professional standards of care (see attached policies and/or related documents). DON/designee to audit progress as per audit tool. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *WSV F684-20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful	

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			completion. *By what date the systemic changes for each deficiency will be completed?* June 23, 2023	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure PRN (as needed) pain medication was available for 1 of 1 residents reviewed for pain. (Resident 21) Finding includes: On 5/31/23 at 8:49 a.m., Resident 21 was observed sitting on the side of her bed. She was rubbing her right knee and indicated she had constant pain in her knee since a knee replacement in March 2023. She no longer had her PRN pain medication and the nurses would not re-order it because they didn't think the doctor would give her another prescription. The ibuprofen (nonsteroidal anti-inflammatory drug) she was receiving was not helping the pain. Record review for Resident 21 was completed on 6/1/23 at 2:38 p.m. Diagnoses included, but were not limited to, joint replacement surgery, chronic pain and arthritis.	F 0697	**F697 (D)** 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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Resident #21 now receives pain medication as ordered/needed. Resident 21 and all other residents were administered a pain assessment. All complaints of pain reported to the Physician, documented, and medications ordered as needed. In addition, audit completed by DON to ensure	06/23/2023

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	The Annual Minimum Data Set (MDS) assessment, dated 5/27/23, indicated the resident was cognitively intact. The resident had received a scheduled and PRN pain medication for occasional pain of a 5 out of a 10. The resident had a knee replacement. A Care Plan, dated 3/23/23, indicated the resident had an alteration in musculoskeletal status related to bilateral knee pain. An intervention included to give analgesics as ordered by the physician. The June 2023 Physician's Order Summary (POS) indicated an order for Percocet (opioid pain medication) 10-325 mg (milligrams), give 1 tablet every 4 hours as needed for pain to the right knee. The May 2023 Medication Administration Record (MAR) indicated the last time the resident received the PRN Percocet was on May 6. A Pain Assessment, dated 5/26/23, indicated the resident had pain daily to the right knee. She had pain of a 7 and acceptable pain level was a 4. Interview with QMA 2 on 6/1/23 at 4:14 p.m., indicated the resident did not have any Percocet left and she thought the order had been discontinued. Interview with the Director of Nursing (DON) on 6/1/23 at 4:32 p.m., indicated they had sent a refill to the pharmacy on 4/29/23 indicating that the resident was almost out of the medication. They were waiting on a response from the pharmacy. She indicated the nurses should have contacted the doctor to let him know the resident was out of the PRN Percocet and ask if he wanted to re-order any more or discontinue the prescription.		all resident's pain medication was ordered and received from pharmacy and that the MD is aware of any difficulty receiving medication from pharmacy. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents with pain have the potential to be affected by the same alleged deficient practice. All residents were assessed for pain and MD notified. DON performed audit on pain medications to ensure all pain medications was ordered and received from pharmacy and that the MD is aware of any difficulty receiving medication from pharmacy. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* All nursing staff in-serviced on pain management, MD notification, and ordering/receiving medications. DON/designee to perform audits as per audit tool. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*	

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	3.1-37(a)		Progress toward the successful completion of this POC will be monitored using the *WSV F697 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* June 23rd, 2023	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve			

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	as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 12 out of 16 days reviewed. This had the potential to affect all 29 residents residing in the facility. Finding includes: On 6/2/23 at 9:43 a.m., the Payroll Based Journal (PBJ) Staffing Data Reports for 10/2022, 11/2022, and 12/2022 were reviewed. It had triggered for no RN hours on 10/9/22, 10/16/22, 10/23/22, 10/29/22, 10/30/22, 11/5/22, 11/6/22, 11/13/22, 11/20/22, 11/27/22, 12/4/22, 12/10/22, 12/11/22, 12/18/22, 12/25/22, and 12/31/22. The nursing schedules for the above dates indicated there was no RN scheduled on 10/9/22, 10/16/22, 10/23/22, 10/29/22, 10/30/22, 11/6/22, 11/13/22, 11/27/22, 12/4/22, 12/10/22, 12/11/22, and 12/31/22. Interview with the MDS Nurse on 6/2/23 at 1:37 p.m., indicated there was not 8 hours of RN coverage on the above dates. 3.1-17(b)(3)	F 0727	**727 (F)** 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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Nursing schedules have been reviewed to ensure coverage of a Registered Nurse for 8 consecutive hours a day, 7 days a week. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents have the potential to be affected by the same alleged deficient practice. Nursing schedules have been reviewed to ensure coverage of a Registered Nurse for 8 consecutive hours a day, 7 days a week.	06/23/2023

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing schedulers/DON in-serviced on requirements of RN coverage. A Registered Nurse will be scheduled for 8 consecutive hours each day and will be used to fill shifts prior to other licensed nursing staff. DON/designee to review schedule as per audit tool and as needed. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *WSV 727 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful	

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not			

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	to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to have accurate daily nurse staffing postings. This had the potential to affect all 29 residents residing in the facility. Finding includes: On 6/2/23 at 9:43 a.m., the Payroll Based Journal (PBJ) Staffing Data Report for 12/2022 was reviewed. It had triggered for no RN hours on 12/4/22, 12/10/22, 12/11/22, 12/18/22, 12/25/22, and 12/31/22. The nursing staffing schedule, dated 12/10/22 and 12/31/22, indicated there was no RN scheduled. The nursing staffing posting, dated 12/10/23, indicated there was 8 hours of RN coverage on evening shift. The nursing staffing posting, dated 12/31/23, indicated there was 8 hours of RN coverage on the day shift and 8 hours on the evening shift. Interview with the MDS Nurse on 6/2/23 at 1:37 p.m., indicated there was no RN coverage on 12/10/22 and 12/31/22. The daily nursing staffing posting sheets should have been updated with the correct information.	F 0732	**F732 (C)** 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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Daily Nursing staff postings have been reviewed for accuracy and updated daily. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents have the potential to be affected by the same alleged deficient practice. Daily Nursing staff postings have been reviewed for accuracy and updated daily. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*	06/23/2023

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			Nursing staff in-serviced on requirements of daily nursing staff posting. Daily posting to be reviewed each shift to ensure accuracy and updated as needed. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *WSV 732 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* June 23rd, 2023	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were labeled correctly related to insulin for 1 of 2 residents observed during medication administration (Resident 27) and medications were labeled with instructions on how to administer for 1 of 2 medication carts observed during the medication storage review. (300 Hall Medication Cart) Findings include:	F 0761	**F761 (D)** 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. *What corrective action(s) will be*	06/23/2023

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	1. On 5/31/23 at 11:51 a.m., during a medication administration pass observation, LPN 2 pulled out a bag with two insulin pens inside it. The Novolog flex pen which was being administered had no name listed or administration orders on the pen. The storage bag was labeled correctly for the second insulin pen (Basaglar kwikpen). There was no labeling on the bag for the Novolog flexpen. Interview with LPN 2 at that time, indicated the resident's name had been listed on the Novolog flexpen in black marker, but hand sanitizer had smeared it and made it illegible. LPN 2 indicated the insulin pen belonged to Resident 27. 2. On 6/01/23 at 09:12 a.m., during a medication storage observation with QMA 3, a nicotrol inhaler (nicotine inhaler) and two Alka seltzer (antacid) boxes were observed in the medication cart. The nicotrol inhaler was in a bag with the resident's name and labeled with the date the inhaler was opened. There were no administration orders listed on the bag or the inhaler. The two Alka seltzer boxes were labeled with the resident's last name. No administration orders were listed on either box. Interview with QMA 3 at that time, indicated the resident would take the Alka seltzer as needed and had an order for it. She indicated she would put a label with the administration orders on the medications. 3.1-25(j) 3.1-25(k)		*accomplished for those residents found to have been affected by the deficient practice?* Resident 27's Novolog Flexpen was labeled with resident name and administration directions. All boxed or bagged medications and inhalers were labeled with resident name and administration directions. All insulins and medications audited for correct labeling to include resident name, administration directions, and date opened as applies. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents have the potential to be affected by the same alleged deficient practice. All insulins and medications audited for correct labeling to include resident name, administration directions, and date opened as applies. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Nursing staff in-serviced on requirements of labeling drugs and biologicals. Audits on medication carts to be completed per DON/designee as indicated on audit tool. *How the corrective action(s) will be*	

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			monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Progress toward the successful completion of this POC will be monitored using the *WSV 761 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* June 23rd, 2023	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-			

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	§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure a resident	F 0791	**F791(D)**	06/23/2023

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	received routine and/ or emergency dental services related to a resident not being seen by the dentist and a resident not being offered dental services for 2 of 2 residents reviewed for dental services. (Residents 4 and 22) Findings include: 1. On 5/30/23 at 11:47 a.m., Resident 4's family member was interviewed. He indicated the resident complained sometimes about trouble eating because she had some missing teeth. The facility was supposed to make her an appointment to get new dentures made, but he was unsure if that appointment had been made. Record review for Resident 4 was completed on 5/31/23 at 11:10 a.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia, anxiety, depression, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/23/23, indicated the resident was cognitively impaired. The resident required an extensive 1 person assistance for personal hygiene. The resident did not have broken or loosely fitting dentures. A Dental Services consent was signed for the resident on 7/14/22. There was no documentation to indicate the resident had been seen by a dentist since the consent was signed. Interview with the Social Services Director (SSD) on 6/1/23 at 9:14 a.m., indicated she had sent the paperwork in to the dental service after the family had signed the consent last July. The dental service would then put the resident on the list to be seen. The dental service was at the facility in November 2022 and April 2023 and the resident		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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Resident 4 has been scheduled with Dentistry on first available date August 31, 2023 and resident 22 has been scheduled with Dentistry on first available date August 2, 2023. In addition, resident 4's and resident 22's consents reviewed and updated as needed. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* Any resident with dental issues has the potential to be affected by the same alleged deficient practice. All residents audited for need of dental services, for consents and scheduling of services to ensure all are receiving dental services as requested and/or as needed. *What measures will be put into place and what systemic changes will be made to ensure that the*	

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	was not seen and she was unsure why. She had not followed up with the dental services to find out why the resident had not been seen or notified the family the resident had not been seen. Interview with the Administrator on 6/1/23 at 9:31 a.m., indicated she had spoken to the dental service and they were unsure why the resident had not been on the list. The SSD should have followed up on why the resident had not been seen after the first dental visit in November 2022. A policy titled, "Dental, Vision, Hearing, Podiatry Services" and received as current form the Director of Nursing (DON) on 6/1/23, indicated, "...Just prior to the Consultant's visit, the SSD shall review the list of referrals with Nursing to insure all Resident's needing to be seen are on the list...." A policy titled, "Availability of Services", and received as current from the DON on 6/1/23, indicated, "...1. Dental services are available to all residents requiring routine and emergency dental care..." "...4. All requests for routine and emergency dental services should be directed to Social Services to assure that appointments can be made in a timely manner. 5. Inquiries concerning the availability of dental services should be referred to Social Services or to the Director of Nursing..."2. On 5/30/23 at 11:48 a.m. Resident 22 was observed drinking his coffee. The resident indicated he did not look forward to lunch because his brother had his dentures, and it affected how he ate. Record review for Resident 22 was completed on 05/31/23 10:07 a.m. Diagnoses included, but were not limited to, hypertension, diabetes, anxiety, post traumatic stress disorder, depression,		*deficient practice does not recur?* All staff in-serviced on requirements of Routine/Emergency Dental Services. Audits on need of dental services, consents, and scheduling of services to be completed by SSD/Designee as per audit tool. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *WSV 791 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will*	

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	anorexia, and legal blindness. A Care Plan Meeting CNA Input document, dated 9/28/22, indicated the resident lost his dentures. On 4/10/23, a speech therapy referral was ordered by the Physician due to the resident's request to be upgraded to a regular solid diet. On 3/27/23, a SLP (speech, language, pathologist) Evaluation and Plan of Treatment was conducted and indicated the resident had missing teeth and had mild, clinical signs and symptoms of dysphagia (difficulty swallowing) with effortful mastication (chewing) and excessive mastication time. A Progress Note, dated 2/22/22, indicated the resident was asking for mechanical soft foods. The resident indicated, "I have no teeth or dentures." When asked if he needed dentures, the resident indicated "not at this time." There was no documentation to indicate the resident had been asked about dental services since February 2022. Interview with Social Service Director (SSD) on 5/31/23 at 11:03 a.m., indicated that dental services were in the facility on 5/28/23, and that the resident had never complained of not having dentures. Follow up interview with the SSD on 5/31/23 at 11:46 a.m., indicated the resident had no documentation for dental services. There was nothing signed by the resident that he was offered dental services or had declined dental services. She had spoken with the resident and he was interested in getting dentures and receiving		*be completed?* June 23rd, 2023	

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	dental services. Interview with Administrator on 5/31/23 at 3:15 p.m., indicated the resident had requested mechanical soft foods and had indicated he had not wanted dentures previously, as per the Progress Note dated 2/22/22. 3.1-24(a)(1)			
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 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:			

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	(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 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			

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	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented related to not performing hand hygiene before and after resident interaction during medication administration for 2 of 2 residents observed during medication administration and for a random observation for not wearing gloves during the administration of eye drops for 1 of 1 random observations. (QMA 1) Findings include: 1. On 6/1/23 at 11:13 a.m., medication administration pass was observed with QMA 1. QMA 1 opened the medication cart, pulled out a medication card and prepared the resident's medication. The QMA entered the resident's room and handed the medication and water cup to the resident. The resident swallowed the medication and handed the medication and water cup back to QMA 1. QMA 1 disposed of the medication and water cup in the trash and proceeded back to the medication cart. QMA 1 had not completed hand hygiene before or after medication administration. QMA 1 then proceeded with medication pass and pulled another resident's medication card from the medication cart. One pill was popped into a medication cup, water was then poured into a cup from a water jug placed on the cart, and then the medication card was placed back into the drawer. She then locked the medication cart and grabbed the medication and walked to the therapy room where the resident requested her medication be given. The resident was verified by QMA 1, then she handed the medication and water cup to the resident. The resident swallowed the medication	F 0880	**F880(D)** 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. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Infection prevention and control protocols will be maintained and followed in accordance with facility policy and the professional standards of care; including, but not limited to: hand hygiene, gloving protocols, medication and eye drop administration. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* All residents have the potential to be affected by the same alleged deficient practice. Infection prevention and control protocols will be maintained and followed in accordance with facility policy and the professional standards of care; including, but not limited to hand hygiene, gloving protocols,	06/23/2023

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	and handed the medication and water cup back to QMA 1. The medication and water cup were disposed of back at the medication cart. QMA 1 then indicated her medication pass was complete. QMA 1 had not performed hand hygiene before or after medication administration. Interview with the Director of Nursing (DON) on 6/1/23 at 11:19 a.m. indicated that all staff should be using hand hygiene at all times, especially during a medication pass. 2. During a random observation on 6/1/23 at 11:26 a.m., QMA 1 was observed administering eye drops to a resident sitting in a wheelchair in the dining room. The QMA was not wearing gloves to administer the eye drops. Interview with the QMA after the administration indicated she used hand sanitizer so she did not need to use gloves to administer the eye drops. Interview with the Director of Nursing (DON) on 6/1/23 at 11:40 a.m., indicated the QMA should have donned gloves prior to administering the resident's eye drops. A policy, titled "Eye Drop Administration" and received as current from the facility on 6/1/23, indicated "...Procedures 6. With a gloved finger, gently pull down the lower eyelid to form a "pouch" while instructing the resident to look up..." 3.1-18(b)		medication and eye drop administration. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* All staff in-serviced on Infection prevention and control protocols will be maintained and followed in accordance with facility policy and the professional standards of care; including, but not limited to hand hygiene & gloving protocols. Nursing staff in-serviced on Infection prevention and control protocols as relates to medication and eye drop administration. DON/designee to perform ongoing education and audits as indicated on audit tool. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *WSV 880 - 20230602 Audit Tool*. Progress will be monitored on business days for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be	

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