STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK TERRACE VILLAGE	25 S BOEHNE CAMP RD EVANSVILLE, IN 47712

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00427103 This visit was in conjunction with the Investigation of Complaint IN00428384. Complaint IN00427103 - State deficiencies related to the allegations are cited at F9999. Survey dates: February 12, 13, 14, 15, 16, 19, 20, & 21, 2024 Facility number: 000221 Provider number: 155328 AIM number: 100267620 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 1 Medicaid: 46 Other: 20 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 1, 2024.	F 0000	The creation and submission of this Plan of Correction 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 the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claudia Schafer	Executive Director	03/15/2024

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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	that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 2 of 2 residents observed with medications in their room. (Resident 32, Resident 30) Findings include: 1. On 2/15/24 at 10:15 A.M., QMA (Qualified Medication Aide) 7 was observed taking medication into Resident 32's room. QMA 7 left the medication cup with pills in it on the resident's bedside table without watching the resident take the medication. On 2/15/24 at 10:58 A.M., Resident 32's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, congestive heart failure, hyperlipidemia, and major depressive disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/21/23, indicated Resident 32 was cognitively intact. The clinical record lacked an order or evaluation for self administration of medications. On 2/16/24 at 9:16 A.M., LPN (Licensed Practical Nurse) 14 indicated there weren't any residents who were allowed to self administer all of their medications.2. During an observation on 2/13/24 at 8:59 A.M., Resident 30 was observed administrating her own nebulizer treatment. On 2/14/24 at 1:26 P.M., Resident 30's clinical record was reviewed. Diagnoses included but	F 0554	**F544 Resident Self-Admin Meds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Residents #32 and #30 were assessed and had no ill effects related to self-administration of medication including nebulizer treatments and are receiving medication according to their assessments. - QMA#7 was in-serviced by DNS on policy for self-administration and the need for a licensed nurse to observe all residents taking their medication unless they have an approved self-administer order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit was completed by DNS/designee to determine any resident with desire to self-administer medications, with self-administration assessments completed for any resident identified. All staff in-serviced by DNS/designee on policy for self-administration and need to observe all residents taking their	03/20/2024

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	were not limited to, acute and chronic respiratory failure with hypoxia and paroxysmal atrial fibrillation. Resident 30's most recent Admission MDS (Minimum Data Set) Assessment, dated 12/11/23 indicated Resident 30 was cognitively intact but needed extensive assistance of one for mobility, transfer, and toileting. The current physician orders lacked a self-medication order for medication. The current care plan lacked a care plan for self-medication. During an interview on 2/13/24 at 9:00 A.M., Resident 30 indicated the nurses will bring medication to her, place it in the container, and then leave. During an interview on 2/20/24 at 9:06 A.M., the Clinical Regional Nurse indicated Resident 30's chart lacked a Self-Medication Assessment, the chart lacked an order to self-medicate, and the care plan lacked a care plan for self-medication also. On 2/15/24 at 12:03 P.M., the Administrator provided a current policy "Self-Administration of Medication" dated 11/2015. The policy indicated..."an alert and self-sufficient resident may request that his or her physician provide a written order to the Community indicating an ability to self-administer medications. The physician must indicate the resident is capable of taking medications unsupervised..." On 2/15/24 at 12:05 P.M., the Administrator provided a current nursing skills sheet "Nebulizer		medication unless they have an approved self-administer order. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - An audit tool will be completed by DNS/designee daily to ensure that any resident requesting to be assessed for self-administration of medication receives the self-administration assessment. - An audit tool will be completed by DNS/designee daily to ensure that all residents receive supervision with medication administration according to their assessments. **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?** - The DNS/designee will complete Self Administration QAPI tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including	

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	(Small Volume Nebulizer-SVN-Medicated Aerosol Therapy) dated 5/2023. The skills sheet indicated"... the nurse was to stay with the resident during the entire medication administration..." On 2/16/24 at 9:16 A.M., LPN (Licensed Practical Nurse) 14 indicated there weren't any residents who were allowed to self administer all of their medications. On 2/15/24 at 12:03 P.M., a Self Administration of Medications policy, dated 11/15, indicated "an alert and self-sufficient resident may request that his or her physician provide a written order to the Community indicating an ability to self-administer medications. The physician must indicate the resident is capable of taking medications unsupervised ... The nurse at the Community must also evaluate each resident who self-administers his or her medication by completing the "Self-Administration of Medication Assessment" form". 3.1-11(a)		termination of responsible employee.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 3 residents reviewed for MDS discrepancy. (Resident 32) Finding includes: On 2/15/24 at 10:58 A.M., Resident 32's clinical	F 0641	**F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - MDS assessment for resident # 32 was corrected during survey. Upon review, this was	03/20/2024

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	record was reviewed. Resident 32 was admitted to the facility on 6/5/23. Diagnoses included, but were not limited to, end stage renal disease, acquired absence of right leg above knee, and generalized muscle weakness. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/21/23, indicated Resident 32 was cognitively intact, was dependent on 2 or more staff for transfers, and had no falls since the prior assessment on 8/21/23. Progress notes indicated Resident 32 sustained falls on 8/25/23, 8/26/23, 10/25/23, and 11/5/23. On 2/20/24 at 10:45 A.M. the Administrator indicated the 11/21/23 MDS quarterly assessment should be marked yes for falls for Resident 32 and was unsure why it had been marked no. At that time, she indicated the facility followed the RAI (Resident Assessment Instrument) user's manual.		noted to have been human error. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be effected by the alleged deficient practice. MDS/designee will complete audit of all residents last quarterly assessment to ensure falls were coded accurately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - MDS will be in-serviced by RAI Specialist on accurately coding falls on the MDS assessments. - MDS/designee will complete 100% audit of current residents' last Quarterly MDS to ensure falls were coded accurately, with corrections completed 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?** - MDS/designee will complete MDS Accuracy QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2	

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			consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, the action plan will be modified as indicated.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's comprehensive care plan interventions were implemented for 1 of 1 residents reviewed for urinary catheter care. (Resident 57) Findings include: On 2/12/24 at 2:54 P.M. Resident 57 was observed sitting near the front door. Resident 57's catheter bag was hanging from the back of the wheelchair. There was no protective pouch covering the bag. On 2/15/24 at 7:34 A.M. Resident 57 was observed in the hall with the catheter bag hanging on the armrest of the wheelchair above waist level. There was no protective pouch covering the bag. On 2/16/24 at 8:47 A.M., Resident 57 was observed in the hall with the catheter bag hanging on the armrest of the wheelchair above waist level. There was no protective pouch covering the bag.	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #57 was assessed and no ill effects related to lacking a dignity bag for catheter and catheter not placed below waist level. Resident 57 has care plan interventions to address his non-compliance with catheter care plan, and to ensure dignity maintained with catheter use and catheter is placed below waist level. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	03/20/2024

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	On 2/14/24 at 9:15 A.M., Resident 57's clinical record was reviewed. Resident 57's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), and type 2 diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment was completed on 12/26/23 and indicated resident 57 was cognitively intact. Resident 57's MDS indicated he required assistance of 1 staff for mobility, transfers, and toileting. Resident 57's care plan included interventions to "position catheter bag below waist level", dated 6/14/23, and "store catheter collection bag inside a protective dignity pouch", dated 6/14/23. During an interview on 12/20/24 at 12:55 A.M., the Administrator stated current care plans should be followed, or updated if a care plan intervention no longer applies. On 2/21/24 at 10:03 A.M., the Clinical Regional Nurse indicated there was not a specific policy relating to catheter care plans and provided a form titled Catheter Care Skills Competency. 3.1-35(a)		**corrective action will be taken?** All residents with foley catheters have the potential to be affected. All residents with foley catheters reviewed to determine dignity bags were in place and resident catheter bags were below waist level. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - CEN/designee will in-service nursing staff to ensure residents with foley catheters have dignity bags and catheter bags remain below waist level. - Observational rounds will be completed daily by DNS/designee to ensure all foley catheters have dignity bags and are maintained per the plan of care. **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?** - DNS/designee will complete Catheter QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, the action plan will be	

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			modified as indicated.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent a friction abrasion from occurring for 1 of 2 residents observed for facility acquired skin alterations. (Resident 29) Findings include: During an observation on 2/12/24 at 2:12 P.M., Resident 29's mattress was observed to have a deep impression, and the metal bar of the bed frame beneath the mattress could be felt through the dip in the mattress. The resident expressed the wound on her bottom had occurred multiple times as a result of transferring over the spot in the mattress where the bar was palpable. She indicated the staff were aware of the defective mattress and the pressure it was causing against her skin. A new or different mattress was not provided. No grab bar was observed on the left	F 0686	**F686** **Treatment to Prevent/Heal Pressure Ulcer** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Friction injury for Resident #29 has healed, and appropriate interventions are in place to prevent further injury. Resident was provided new mattress and grab bar present to left side of bed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	03/20/2024

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	side of Resident 29's bed. On 2/14/24 at 8:27 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and type 2 diabetes mellitus. Resident 29's most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/2/24, indicated Resident 29 was cognitively intact and required limited assistance of 1 staff for transfers. Resident 29's current care plan included, but was not limited to, the following interventions related to prevention of skin breakdown: Left grab bar to bed, dated 9/26/23. Pressure redistribution mattress on bed, dated 10/21/22. A progress note on 1/24/24 noted Resident 29 was assessed by the NP (Nurse Practitioner) and indicated a finding of a new abrasion wound on the right gluteal fold. A progress note on 1/30/24 noted Resident 29 was assessed by the NP and indicated a subsequent visit for the wound located on the right gluteal fold. A progress noted on 2/6/24 noted Resident 29 was assessed by the NP and indicated the wound on the right gluteal fold was resolved. A progress note on 2/13/24 noted Resident 29 was assessed by the NP and indicated a wound was assessed on the right gluteal fold; Resident 29 was complaining of tenderness. During an observation on 2/16/24 at 9:00 A.M.,		All residents at risk for pressure injuries have the potential to be affected by the alleged deficient practice. An audit was completed by ED/designee to identify existing orders for enabler bars, and condition of resident mattresses. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Observational rounds will be completed daily by DNS/designee to ensure presence of ordered grab bars and any concerns with condition of mattresses. - An in-service will be completed by DNS/designee related to ensuring grab bars are present per plan of care, and ensuring skin breakdown prevention interventions (mattresses, cushions) are in good condition. **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?** - The DNS/designee will be responsible for the completion of a Skin Management QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by	

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	there was not a grab bar on the left side of Resident 29's bed to assist with transferring. During an interview on 02/20/24 at 2:58 P.M., the Administrator indicated Resident 29's defective mattress had been removed on 2/14/24. On 2/16/24 at 2:40 P.M., the Administrator provided a policy titled "Skin Management Program", revised 5/22, and stated "A plan of care will be initiated to include resident specific risk factors and contributing factors with the appropriate interventions implemented." 3.1-40(a)(1)		the QAPI committee overseen by the ED. If threshold of 100% is not achieved, the action plan will be modified as indicated.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents received supervision and consistent implementation of interventions to prevent falls for 2 of 4 residents reviewed for accidents related to falls. Fall interventions were not consistently implemented, thorough assessments of post fall needs was lacking, and care plans were not updated following falls. (Resident 32, Resident 60) Findings include:	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #32 had no ill effects related to the alleged deficient practice. Resident careplan was reviewed and updated to indicate accurate	03/20/2024

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	1. On 2/13/24 at 2:30 P.M., QMA 12 was observed transferring Resident 32 from a chair to his bed using a slide board and no gait belt. On 2/15/24 at 10:58 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on 6/5/23. Diagnoses included, but were not limited to, end stage renal disease, acquired absence of right leg above knee, and generalized muscle weakness. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 11/21/23, indicated Resident 32 was cognitively intact, was dependent on 2 or more staff for transfers, and had no falls since the prior assessment. Progress notes indicated Resident 32 fell 14 times since admission. Fall 1 6/6/23 at 5:30 P.M. Fall was not witnessed. Resident was walking in his room without staff assistance when he lost his balance and fell. Interventions "nonskid footwear", "encourage [name of resident] to ask for assistance, use call light", "therapy screen", and "personal items in reach" were added to the care plan on 6/8/23. Fall 2 6/7/23 at 4:40 P.M. Fall was not witnessed. Resident was changing his clothes in the restroom and his knees "gave out". Interventions "assist with toileting upon rising, before and after meals, at HS (bedtime) and PRN (as needed)" and "pharmacist to review meds upon admit, monthly and PRN" were added to the care plan on 6/13/23. Fall 3		transfer status - QMA #12 in-serviced on providing ordered transfer status for residents using profile - CNA #1 in-serviced on resident #32 for appropriate transfer status - Resident #60 colored tape added to call light and sign to remind resident to use call light was placed in room - IDT in-serviced by RDCS on fall reviews being completed next business day with interventions being added and careplan updated **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents at risk for falls have the potential to be affected by alleged deficient practice. Profile audit completed by care companions/IDT to ensure accurate transfer status indicated on careplan and profile. Nursing staff in-serviced by CEN/designee on providing appropriate transfer status and current fall interventions using current plan of care and profiles. IDT inservice completed by RDCS related to evaluation of existing fall care plans, and development of new interventions for residents with falls. **What measures will be put into place or what systemic changes you will make to**	

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	6/27/23 at 5:16 P.M. Fall was not witnessed. Resident was attempting to self transfer. Intervention "staff to offer increased assistance d/t (due to) current condition more frequent checks" was added to the care plan on 6/28/23. Fall 4 6/28/23 at 7:06 P.M. Fall was unwitnessed. Resident attempted to get up from his wheelchair and lost his balance. Intervention "offer to lay resident down after HS meal" was added to the care plan on 6/29/23. Fall 5 6/29/23 at 1:30 A.M. Fall was unwitnessed. Resident rolled out of bed. Intervention "place sign in room reminding resident to use call light for transfers. NP (nurse practitioner) to evaluate medications with focus on newly added medications" was added to the care plan on 6/29/23. Fall 6 6/29/23 at 6:30 P.M. Fall was unwitnessed. Resident was attempting to self transfer from his bed to the wheelchair. No intervention was added to the care plan at that time. Fall 7 7/10/23 at 9:00 P.M. Fall was unwitnessed. Resident was attempting to grab items in a bag on his wheelchair and fell. Intervention "Request NP and Pharmacist review meds (medications)" was added to the care plan on 7/11/23.(Intervention was repeated from 6/29/23). Intervention "nonslip socks when not wearing shoes" was added to the care plan on 7/19/23. (Repeated intervention from 6/8/23) Fall 8		**ensure that the deficient practice does not recur?** - Daily rounds will be completed by DNS/designee to ensure appropriate transfer levels are being utilized per order and plan of care. - Daily rounds will be completed by DNS/designee to ensure profile interventions are in place per plan of care. **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?** - The DNS/designee will be responsible for the completion of a fall QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, the action plan will be modified as indicated.	

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	8/21/23 at 2:53 P.M. Fall was witnessed. Resident slid off his wheelchair while on the facility bus. Intervention "Dycem to w/c (wheelchair)" was added to the care plan on 8/22/23. Fall 9 8/25/23 at 1:00 A.M. Fall was unwitnessed. Resident rolled off his bed and indicated he was having difficulty feeling bed boundaries due to his recent amputation. Interventions "staff to encourage resident to be assisted to center of bed before leaving room", "keep night stand away from bed to help prevent injury", and "move bed against wall for bed boundaries r/t (related to) amputation" were added to the care plan on 8/28/23. Fall 10 8/26/23 at 11:15 A.M. Fall was unwitnessed. Resident attempted to grab a personal item from the bedside table and leaned too far forward. Interventions "staff to provide resident with a bag to keep personal items within closer reach" and "staff to ensure bedside table is within reach so that resident can reach personal items" were added to the care plan on 8/28/23. Fall 11 10/25/23 at 7:53 A.M. Fall was unwitnessed. Resident rolled out of bed. Intervention "scoop mattress" was added to the care plan on 10/26/23. (Third occurrence rolling out of bed.) Fall 12 11/5/23 at 7:57 A.M. Fall was unwitnessed. Resident slid off the side of the bed while watching tv. Interventions "education on use of nonskid footwear when not wearing shoes" (repeated intervention from 6/8/23 and 6/29/23) and "nonskid strips next to bed" were added to the			

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	care plan on 11/6/23. Fall 13 1/24/24 at 11:30 P.M. Fall was unwitnessed. Resident fell asleep while sitting on the side of the bed and fell forward off the bed. Intervention "recliner in room" was added to the care plan on 1/26/24. Fall 14 1/31/24 at 3:10 P.M. Fall was unwitnessed. Resident attempted to self transfer. Intervention "replace non skid strips in front of bed" was added to the care plan on 2/2/24. Discontinued physician orders included, but weren't limited to: Transfer resident with mechanical lift and assist of 2 staff members, dated 08/16/23 and discontinued on 02/14/24 A current risk for falls care plan, revised 2/14/24, included, an intervention, initiated 8/15/23 and discontinued on 2/14/24, which indicated "all transfers to be done with mechanical lift and assist of 2". On 2/15/24 at 10:18 A.M., Resident 32 indicated staff transferred him by using a sliding board and a gait belt. On 2/15/24 at 10:36 A.M., CNA (Certified Nurse Aide) 1 indicated Resident 32 required standby assistance for transfers. She indicated the resident transferred himself using a slide board and did not require a gait belt.2. On 2/15/24 at 12:11 P.M., Resident 60's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and type 2 diabetes mellitus.			

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	The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/18/24, indicated Resident 60 was cognitively intact and required supervision assistance of 1 staff for transfers, eating, and toileting. Resident 60's fall event history indicated 7 falls in the past 3 months and interventions placed by the IDT (interdisciplinary team) following each fall: Witnessed fall on 11/18/23 at 9:30 A.M.; Resident was trying to transfer from couch to wheelchair, staff assisted resident to the floor. Intervention put in place: Therapy will evaluate and staff will assist x 1 with transfers. Unwitnessed fall on 11/19/23 at 9:00 A.M.; Resident was using bathroom, staff found resident sitting in bathroom floor. Intervention put in place: Put up all before you fall sign. Unwitnessed fall on 11/22/23 at 10:34 A.M.; Resident fell out of chair and was found on floor by staff. Intervention put in place: Bright colored tape to call light. Unwitnessed fall on 11/22/23 at 8:40 P.M.; Resident fell out of bed, staff found sitting on floor. Intervention put in place: Resident started on a toileting program. Unwitnessed fall on 11/23/23 at 4:30 P.M.; Resident fell out of bed, staff found resident sitting on floor. Intervention put in place: Resident started on a toileting program. Unwitnessed fall on 12/6/23 at 1:30 P.M.; Resident was transferring from bed to wheelchair, staff found resident on knees at end of bed.			

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	Intervention put in place: Nonskid strips at bedside. Unwitnessed fall on 2/12/24 at 3:48 A.M.; Resident was transferring from bed to restroom, staff found on floor next to bed. Intervention put in place: Nonskid strips at bedside. (Repeated intervention from 12/6/23) During an observation on 2/15/24 at 10:45 A.M., no colored tape was observed on the call light, no call before you fall sign was able to be located in Resident 60's room. During an observation on 2/20/24 at 2:15 P.M., no colored tape was observed on the call light, no call before you fall sign was able to be located in Resident 60's room. During an interview on 2/20/24 at 12:55 P.M., the Administrator acknowledged it would be expected for a new intervention to be implemented for each fall event, the IDT reviews each fall after a fall event is created, and the IDT creates a fall note indicating the final intervention. On 2/16/24 at 2:28 P.M., a current Fall Management Policy, revised 1/23, indicated "All falls will be discussed...to determine root cause and other possible interventions to prevent future falls ... The care plan will be reviewed and updated". 3.1-45(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled, oxygen and medication for respiratory complications were properly administered, or proper tracheostomy suction was provided for 5 of 7 residents at risk for respiratory complications. (Resident B, Resident 30, Resident 55, Resident 62, Resident 119) Findings include: 1. On 2/14/24 at 9:15 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 3/26/19. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), Congestive Heart Failure, and chronic respiratory failure with hypoxia. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 1/12/24, indicated resident B had moderate cognitive impairment and was receiving oxygen. Current orders included, but were not limited to: Furosemide tablet; 40 mg (milligram) Take for SOB (shortness of breath) or lower extremity edema PRN (once a day), start date 1/6/24. The administration history indicated there had been no administrations of the PRN Furosemide since the start date, 1/6/24.	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #30 oxygen tubing was changed with new bag with date added. Nebulizer tubing was changed and bag for storage was provided with mask placed in bag. - Resident #55 new humidifier bottle provided and dated - Resident #62 oxygen tubing was changed and bag for storage was provided with date of change. New humidifier bottle provided. - Resident #119 oxygen tubing was changed and bag provided with date of change for storage as needed - Resident B oxygen is receiving oxygen per order and utilizing compression stockings as ordered. Resident Lasix was made routine per NP order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	03/20/2024

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	Oxygen at 4 liters per nasal cannula every shift, start date 1/6/24. A progress note on 2/12/24 at 2:16 A.M. indicated Resident B was using 3 liters of oxygen. A progress note on 2/16/24 at 8:55 A.M. indicated Resident B was using 3 liters of oxygen. A weekly skin assessment dated 1/19/24 indicated Resident B was exhibiting edema in the lower extremities. A weekly skin assessment dated 1/28/24 indicated Resident B was exhibiting edema in the lower extremities. A weekly skin assessment dated 2/4/24 indicated Resident B was exhibiting edema in the lower extremities. During an observation on 2/12/24 at 1:33 P.M., Resident B's portable oxygen tank in use at the time was observed with the dial set to 3 liters, and the oxygen tubing not dated. Resident B had noticeable edema in both lower extremities and was not wearing any compression stockings. During an observation on 2/15/24 at 1:06 P.M., Resident B's portable oxygen tank in use at the time was observed with the dial set to 2.5 liters. During an observation on 2/16/24 at 1:40 P.M., Resident B's oxygen concentrator in use at the time was observed with the dial set to 3.5 liters. Resident B was using a pulse oximetry device that read 77% oxygen. Resident B stated the nurse had removed the nail polish from the finger the pulse oximerty was on to read the oxygen level.		An audit was completed to identify any resident with orders for oxygen, nebulizers, or tracheostomies. All residents who use respiratory equipment have potential to be affected by alleged deficient practice. Residents using respiratory equipment were audited to ensure correct liter of oxygen and humidification is being provided, oxygen/respiratory tubing is being changed per order and bag provided for storage. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - Inservice for all nursing staff completed by DNS/designee related to following physician orders for oxygen flow and humidification, along with proper storage of respiratory equipment. - Daily rounds will be completed by DNS/Designee to ensure oxygen is being delivered at correct liter per order. **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?** - The DNS/designee will be responsible for the completion of a respiratory equipment QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until	

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	RN 4 and QMA 3 entered Resident B's room; RN 4 confirmed the oxygen level did read 77% on the pulse oximetry device, and QMA 3 stated the oxygen liters did appear to be set below 4 because it is hard to read where the ball that measures the liters is sometimes. On 2/20/24 at 2:50 P.M., the Clinical Regional Nurse provided a copy of the PRN administration history for Furosemide 40 mg. The record lacked administration of the medication following assessments that indicated edema presented in Resident B. On 02/20/24 at 12:55 P.M., the Administrator indicated PRN medications should be administered if a resident requests them or if a nurse indicates a need for a PRN medication during an assessment. 2. On 2/13/23 at 8:59 A.M., Resident 30's oxygen tubing was observed with no date on the tubing or a bag to place the tubing in. The nebulizer's tubing was not dated and the bag for the tubing was on the floor this was dated 2/12/24. On 2/15/24 at 8:48 A.M., Resident 30 was observed in bed with oxygen and nebulizer tubing not dated, On 2/14/24 at 1:26 P.M., Resident 30's clinical record was reviewed. Diagnoses included but were not limited to, acute and chronic respiratory failure with hypoxia and paroxysmal atrial fibrillation. Resident 30's most recent Admission MDS (Minimum Data Set) Assessment, dated 12/11/23 indicated Resident 30 was cognitively intact, used oxygen, but needed extensive assistance of one for mobility, transfer, and toileting.		continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, the action plan will be modified as indicated.	

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	Current Physicians orders included but were not limited to, Oxygen at 2 to 6 liters per nasal cannula. Special Instructions: Comfort measures. Every Shift - PRN (as needed) the order was dated 1/10/24. On 2/15/24 at 8:51 A.M.,QMA (Qualified Medicine Aide) 13 indicated the day shift or night shift will change the initial bag once a week and it will be labeled with the dated. If not in use they will stay in the bag on the concentrator. 3. On 2/12/24 at 2:27 P.M., Resident 55 was observed lying in bed with a tracheostomy attached to an aerosol collar that had a humidification bottle that was not dated. There was used oxygen tubing in a bag without a date on the concentrator. On 2/16/24 at 10:19 A.M., Resident 55 was observed lying in bed with a tracheostomy attached to an aerosol collar that had a humidification bottle that was not dated and dry. On 2/19/24 at 12:59 P.M., RN (Registered Nurse) 5 was observed during tracheostomy care on Resident 55. During the procedure, removed the tracheostomy's inner cannula with clean gloves. The resident required suction during the care and the RN suctioned the resident without the inner cannula in place. On 2/21/24 at 8:44 A.M., Resident 55 was observed laying in bed with a tracheostomy attached to an aerosol collar that had a humidification bottle that was not dated. On 2/16/24 at 8:40 A.M., Resident 55's clinical			

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	review was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, Tracheotomy, unspecified asthma. Resident 55's most current significant change status MDS (Minimum Data Set) Assessment dated 1/10/24 indicated the resident was cognitively intact,had a tracheostomy with oxygen. Resident 55 needed extensive assistance for transferring, mobility, and toileting. Current physician orders, included but were not limited to: Change nebulizer tubing/set once a day on Sunday dated 11/15/23. Tracheostomy orders: Change trach setup weekly on Sunday: mask/collar, oxygen tubing and humidifier dated 11/15/23. Tracheostomy orders: Change tracheostomy inner cannula. Special Instructions: with tracheostomy care dated 11/15/23. The current care plan indicates the resident has a tracheostomy and to use oxygen as ordered dated. 4/17/23. During an interview on 2/19/24 at 1:28 P.M., LPN (Licensed Practical Nurse) 23 indicated they do not suction the tracheostomy unless the inner cannula is in place. On 2/21/24 at 12:15 P.M., the Clinical Regional Nurse presented a current skill checklist "Tracheostomy Suctioning Procedure" dated 9/2022. The checklist indicated "... insert the catheter into the trach stoma until resistance is felt without applying any suction..." The Clinical Regional Nurse indicated there was no written policy but the policy for the facility was to suction			

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	the trach without the inner cannula and use the skill sheet for reference. The facility did not have a written policy addressing all aspects of the provision of tracheostomy care, including suctioning. Professional reference for the tracheostomy suctioning from the National Center of Biotechnology of Information, National Institute of Health "... Suctioning should never be performed through a fenestrated tube without first inserting a non-fenestrated inner cannula, or severe tracheal damage may occur." 4. On 2/12/24 at 11:41 A.M., Resident 62 was observed laying in bed with oxygen tubing unlabeled and no bag located. On 2/16/24 at 1:45 P.M., Resident 62 was observed laying in bed with oxygen tubing in nostrils, but the humidification bottle was dry. On 2/12/24 at 11:37 A.M., Resident 62's clinical record was reviewed. Diagnoses included, but were not limited to, Malignant neoplasm of ventral surface of tongue, acute respiratory failure with hypoxia, and other pulmonary embolism without acute core pulmonale. The current Significant Change MDS (Minimum Data Set) Assessment dated 1/24/24 indicated Resident 62 was cognitively intact and needed extensive assistance with toileting, mobility, and eating. Current physician orders included, but were not limited to, oxygen at 3 liters per nasal cannula dated 10/12/23. 5. On 2/12/24 at 10:42 A.M., Resident 119 oxygen			

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	was observed laying across the bed without a date. On 2/15/24 at 8:54 A.M., the oxygen tubing was observed laying across the headboard of Resident 119's bed. On 2/21/24 at 8:37 A.M., Resident 119 oxygen tubing was not bagged and laying across the top of the bed. On 2/15/24 at 9:01 A.M., Resident 119's clinical record was reviewed, Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, and acute and chronic respiratory failure with hypercapnia. The current Admission MDS (Minimum Data Set) Assessment dated 1/31/24 indicated Resident 119 was cognitively intact, used oxygen, and needed partial help with transfer and mobility. Current physician orders included, but were not limited to: Change nebulizer tubing/set once a week on Sunday dated 1/24/24. Change oxygen tubing and humidity once a week on Sunday dated 1/24/24. The current care plan indicated the resident has a potential for impaired gas Resident has potential for impaired gas and has an intervention for being non-compliant with the use of oxygen and refused to allow tubing to be bagged date 2/2/24. During an interview on 2/16/24 at 1:45 P.M., the Clinical Regional Nurse indicated there was no Oxygen policy the facility follows [company name] policy for oxygen. O2 (oxygen) tubing is changed weekly and placed in a dated bag. If O2			

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	tubing is not being used the oxygen should be a bag. Nebulizers tubing is changed weekly, and tubing is in a bag. Medication should not be left in resident room unless there is a self-administration order and assessment. This is for all forms of medications. On 2/15/24 at 10:00 A.M., the Administrator provided a current, undated, policy titled "Oxygen Concentrator" that stated "Adjust the flow meter control knob to the flow setting prescribed by the physician." "Place [nasal cannula] in a labeled bag when not in use." "If prescribed, attach the humidifier bottle to the oxygen outlet connection and ensure there is water in the bottle." On 2/2024 at 2:50 P.M., the Clinical Regional Nurse provided a current policy titled "PRN Medications", dated 11/15, that stated "PRN medications are those medications to be given to a resident on an as needed basis. These medications are to be given to residents based on their symptoms." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
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:			

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	(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 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, record review, and interview, the facility failed to ensure accurately completed staff sheets were posted daily for 8 of 8 days during the survey. (2/12,2/13,2/14, 2/15, 2/16, 2/19,2/20,2/21) Findings include: On 2/12/24 at 8:48 A.M., a staffing sheet was observed sitting on a table across next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours	F 0732	**F732 Posted Nursing Staffing Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - No residents were affected by the alleged deficient practice. · The resident census information is posted each day by the scheduler and includes actual hours worked.	03/20/2024

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	for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked when the discipline does not work a full 12 hour shift denitrified on the form (7 A.M. to 7 P.M. and 7 P.M. to 7 A.M.). On 2/13/24 at 8:00 A.M., a staffing sheet was observed sitting on a table across next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/14/24 at 8:00 A.M., a staffing sheet was observed sitting on a table across next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/15/24 at 8:00 A.M., a staffing sheet was observed sitting on a table across from next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Scheduler will be in-serviced by DNS/designee on the accuracy of the posted nursing staff information. Daily staffing hours are reviewed and will be updated as needed by DNS/designee to include actual hours worked. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - Daily observational rounds will be completed by ED/designee to ensure posted staffing information is updated and accurate to include actual hours worked **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?** - The ED/designee will complete posted staffing QA tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the	

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	discipline when the full shift was not worked during the specified shift. On 2/16/24 at 8:04 A.M., a staffing sheet was observed sitting on a table across from next to the receptionist desk. The sheet included, but was not limited to the following information: Shift hours for RN, LPN, and CNA Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/19/24 at 8:00 A.M., a staffing sheet was observed sitting on a table across next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/20/24 at 8:05 A.M., a staffing sheet was observed sitting on a table across next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/21/24 at 8:00 A.M., a staffing sheet was observed sitting on a table across from next to the receptionist desk. The sheet included but was not limited to the following information: Shift hours		QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift Total hours of RN, LPN, and CNA for each shift The sheet lacked specific hours worked by each discipline when the full shift was not worked during the specified shift. On 2/16/24 at 8:30 A.M., the Administrator provided the staffing sheets dated 2/12/24, 2/13/24, 2/14/24, 2/15/24. 2/16/23. The sheets included but were not limited to the following information: Shift hours for RN, LPN, and CNA. Total number of RN, LPN, and CNA for each shift. Total hours of RN, LPN, and CNA for each shift. The sheets did not specify which actual hours were worked by each discipline during the specified shift when the total hours worked were not equal to the number of staff. On 2/21/24 at 9:38 A.M., the Administrator provided the staffing sheets dated 2/19/24, 2/20/24, 2/21/24. The sheets included but were not limited to the following information: Shift hours for RN,LPN, and CNA. Total number of RN, LPN, and CNA for each shift. Total hours of RN, LPN, and CNA for each shift. The sheets did not specify which actual hours were worked by each discipline during the specified shift when the total hours worked were not equal to the number of staff. During an interview on 2/19/24 at 10:05 A.M., the Administrator indicated she was not able to find the actual hours worked when asked to distinguish. On 2/19/24 at 1:23 P.M., the Administrator provided a current "Posted Nurse Staffing Data and Retention Requirements" policy dated 7/2019. The policy indicated the facility must post the			

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	following information at the beginning of each shift...The total and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for providing care per shift: Registered nurses, Licensed practical nurses, and Certified nursing aides...Total hours should include the total actual hours worked on each shift including partial shifts..." 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.			
F 0740 SS=D Bldg. 00	Based on interview and record review, the facility failed to monitor for behaviors in 1 of 2 residents reviewed for resident to resident altercations. (Resident 37, Resident 3) Findings include: On 2/12/24 at 9:48 A.M., Resident 3 indicated there was another resident (Resident 37) who was verbally aggressive with him, followed him around, and bothered him during the one time verbal altercation. He indicated the other resident (Resident 37) made him feel scared at that time but feels nervous sometimes now when he sees him in the hallway. At that time of the altercation, he indicated that he had made staff aware.	F 0740	**F740 Behavioral Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident 37 no longer resides in the facility. Resident #3 receives ongoing psychosocial monitoring to ensure he feels safe and comfortable in his environment. **How will you identify other residents having the potential to be affected by the same**	03/20/2024

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	On 2/16/24 at 1:16 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, mild intellectual disability, generalized anxiety, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/12/24, indicated Resident 3 was cognitively intact and had no behaviors. A progress note on 1/30/2024 at 7:57 P.M. indicated "Resident heard hollering at another resident in the smaller dining area. Per resident, another resident was being rude and making hateful comments towards him. Education provided to residents and separated them. No other issues thus far. Resident is in his room at this time". The clinical record for Resident 3 lacked a follow up, event, observation, or care plan related to that incident. On 2/19/24 at 12:25 P.M., Resident 37's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The most recent quarterly MDS assessment, dated 12/9/23, indicated Resident 37 was cognitively intact and had physical behaviors directed towards others that occurred 1 to 3 days during the 7-day look back period.		**deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit was completed by SSD/designee to identify any resident-to-resident behavioral incidents and to ensure interventions are in place and care plans are updated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - SSD/designee will complete daily monitoring of facility activity report to ensure any behavioral concerns receive appropriate IDT follow up and careplan reviews. - IDT will be inserviced by Regional Social Service/designee on behavioral monitoring program related to follow up documentation of resident-to-resident behaviors. **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?** - The SSD/designee will complete behavioral monitoring QA tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by	

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	Progress notes included, but weren't limited to, the following: 11/11/2023 at 6:00 P.M. "Resident came to nurses station to ask when residents were going to be going out to smoke and who would be taking them out. This nurse explained to resident that a staff member would be with the residents in a few minutes and that smoke break will be given to the residents. The resident continued to ask who was going to take the residents out to smoke. Another resident was reaching across him and pointing toward a staff member that was getting the things ready for smoke break. The resident continued asking when the [sic] would get to smoke, the other resident slapped him in the chest attempting to get the residents attention. When the other resident slapped him in the chest, this resident turned around and grabbed the resident my [sic] the shirt and was pushing and pulling the resident attempting to punch her. This nurse got up and went into the the [sic] day room and broke up the fight. The residents were sent to their rooms. This nurse called the DON (Director of Nursing) and social worker about the fight. Resident started on 15 min checks until further notice. Residents skin assessed with no abnormal findings. Resident in bed watching tv, call light in reach and water by bedside". An IDT (Interdisciplinary Team) note, dated 11/14/23, indicated there was an altercation with another resident. A care plan was created and included the interventions "encourage res (resident) to wait in his room or other quiet area prior to smoke break ". 11/23/2023 at 6:26 P.M. "while in dining room res turned up radio which agitated another res, the other res started hollering and swinging arms as if to hit [name of Resident] and [name of Resident]		the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	also was swinging arms as if to hit other res, no contact was made, both res removed from location, 1:1 (1 to 1 supervision) given, [name of Resident] calm after 1:1. later this shift he went into another res room without permission, redirected, 1:1 given, stated he understood he was not to go into rooms without permission. further into the shift he attempted to grab a cna between the legs at dinner time he was noncompliant with the dining room rules, refusing to cooperate, redirected 1:1 given by lpn (Licensed Practical Nurse), behav [sic] changed and remained in dining room without further incident. Responsible party [name of responsible party] updated and thanked staff for his care, [name of NP (nurse practitioner)] updated". 1/15/2024 at 7:57 P.M. "res attempted to go into another res room, redirected and res compliant, several minutes later he was attempting to go outside with outside temp 8 degrees, it took several redirections before he stopped attempting to go outside, res was frustrated that it was to [sic] cold to smoke outside today, after he quit trying to go outside he gave another res the middle finger for no known reason, afterwards when LPN was speaking to him he decided to go to bed early and rest, no further incidents". 1/30/2024 at 7:58 P.M. "Resident had behaviors this evening in the smaller dining room. Other residents reported that resident was making hateful and rude comments towards one of them. Resident followed the other resident (Resident 3) in his wheelchair. Staff separated the residents and education was provided. No other issues thus far". A current care plan, revised 1/5/24, indicated			

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	"Resident has hx (history) of becoming easily agitated and can become physical AEB (as evidenced by) hx of grabbing and attempting to hit others". Interventions included the following: "Staff will provide care with 2+ staff at all times and will use male caregivers to provide care when available", dated 1/5/24 "encourage res not to sit in crowded areas", dated 1/4/24 "Use of E-cig to eliminate the need to sit and wait for smoke breaks", dated 1/4/24 "encourage res to wait in his room or other quiet area prior to smoke break", dated 11/13/23 The care plan was not updated following the incidents on 11/23/23, 1/15/24, and 1/30/24. The clinical record lacked an IDT note following the incidents on 11/23/23, 1/15/24, and 1/30/24. A Behavioral Health Monthly Review, dated 11/13/23, indicated behaviors reviewed were "ran into nurse with wheelchair". A Behavioral Health Monthly Review, dated 1/18/24, indicated behaviors reviewed were "sexual behaviors, urinating on floor, telling staff he is going to give them a hard time". A Behavioral Health Monthly Review, dated 2/10/24, indicated behaviors reviewed were "sexual behaviors, depression, anxiety, pressing call light and laughing when staff come help him". The clinical record lacked a Behavioral Health Monthly Review for December 2023. An event labeled "Fight between residents" was created on 11/11/23 and closed on 11/14/23. There were no other events referencing resident to			

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	resident altercations. The clinical record lacked an order to monitor for behaviors. On 2/20/24 at 12:55 P.M., the Administrator indicated staff monitored for behaviors by using progress notes and care sheets in a behavior monitoring book. At that time, she indicated the care plan should be updated if a new intervention was placed. On 2/21/24 at 8:37 A.M., a binder titled "Behavior Monitoring" found at the nurses station was reviewed. A behavior monitoring form, dated January 2024, indicated Resident 37 had the targeted behaviors of sexual inappropriate language and inappropriate physical contact to staff on 1/1/24, twice on 1/5/24, and on 1/30/24. There were no other forms in the binder. On 2/21/24 at 8:43 A.M., CNA (Certified Nurse Aide) 17 indicated that Resident 37 "smacked staff members on the bottom" but was unaware of any other behaviors. On 2/21/24 at 8:44 A.M., the Social Services Director (SSD) indicated the forms in the binder weren't used anymore and behaviors got tracked monthly using the behavioral health monthly reviews for anyone who received an antipsychotic. She also indicated that any time a resident had a behavior, it was followed with an IDT note. On 2/21/24 at 9:26 A.M., the Clinical Regional Nurse indicated the behavior sheets found in the behavior monitoring binder were not a facility policy or supposed to be used in the facility, and were printed off from the Internet by a nurse.			

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	On 2/20/24 at 10:43 A.M., a current Behavioral Health policy, dated 10/22, indicated "ensure that each resident receives the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care". 3.1-37(a)			
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			

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	controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders for 1 of 5 residents reviewed for unnecessary medications. (Resident 15) Finding includes: On 2/12/24 at 10:59 A.M., Resident 15 indicated that on the evening of 2/7/24 she started having "uncontrollable tremors" and couldn't breathe. At that time, she learned from a nurse that she was out of lorazepam. She indicated the nurse left the room to retrieve lorazepam out of the emergency drug kit (EDK), but never returned. She began screaming for someone to come back, and after about an hour of no one coming, she called 911 for help. An ambulance arrived at the facility and she was transported to the hospital where she was diagnosed and treated for withdrawal. The resident indicated during that time she "felt the most lonely she had ever felt in life" and "wondered if she was going to die". On 2/16/24 at 8:28 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. The most recent quarterly MDS (Minimum Data Set) assessment, dated 1/15/24, indicated Resident 15 was cognitively intact, had no behaviors, and	F 0755	**F755 Pharmacy Services/Pharmacist/Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #15 is receiving her medication per order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Licensed nursing staff will be in-serviced on ordering refills for medications and documenting the request from NP/MD for scripts appropriately. QMAs in-serviced on notifying their supervisor of medications that are unavailable when identified. DNS/Designee will review the med cart for all current residents to ensure medications are available as prescribed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	03/20/2024

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	received an antianxiety medication during the 7-day look back period. Current physician orders included, but was not limited to: lorazepam (a benzodiazepine used to treat anxiety) - Schedule IV tablet; 1 mg (milligram) orally four times a day, dated 1/03/2024 A GDR (Gradual Dose Reduction) report, dated 3/6/23, indicated a GDR for lorazepam was "contraindicated at this time as might lead to impaired functioning or cause psychiatric instability by excarbating [sic] a psychiatric disorder" and was signed by a physician. A GDR (Gradual Dose Reduction) report, dated 9/14/23, indicated a GDR for lorazepam was "contraindicated at this time as might lead to impaired functioning or cause psychiatric instability by excarbating [sic] a psychiatric disorder" and was signed by a physician. A GDR (Gradual Dose Reduction) report, dated 12/2/23, indicated a GDR for lorazepam was "contraindicated at this time as might lead to impaired functioning or cause psychiatric instability by excarbating [sic] a psychiatric disorder" and was signed by a physician. The MAR (medication administration record) indicated Resident 15 did not receive the 8:00 P.M. dose of lorazepam on 2/5/23 and did not receive any doses of lorazepam on 2/6/23 and 2/7/23. Notes indicated "waiting on pharmacy". A communication document was provided, signed by the Nurse Practitioner (NP) and dated 2/6, that indicated Resident 15 needed a new script for lorazepam 1 mg.		**practice does not recur?** - Daily audit to be completed to review any medications not provided due to unavailable from pharmacy with DNS/designee follow up. **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?** - The DNS/designee will complete pharmacy service QA tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	Progress notes included, but were not limited to: 2/07/2024 at 11:15 P.M. (Recorded as Late Entry on 2/08/2024 at 2:03 A.M.) "Resident was upset with previous shift because her medication was not available. Resident stated she was calling an ambulance to take her to the hospital because she had not eaten in 4 days". 2/07/2024 at 11:30 P.M. (Recorded as Late Entry on 2/08/2024 at 2:05 A.M.) "Received call from ambulance dispatch that they were on their way to pick up Resident". Hospital discharge papers, dated 2/8/24, indicated Resident 15 was discharged from the Emergency Department with a primary diagnosis of benzodiazepine withdrawal. On 2/13/24 at 10:30 A.M., the Administrator indicated that there was a communication error with the NP, and the request for a new script for the lorazepam was signed by the NP, but the script was never written and the medication was never ordered. On 2/16/24 at 9:16 A.M. LPN (Licensed Practical Nurse) 14 indicated refill requests were written in the communication binder and the NP would refill them. He indicated the NP was in the facility 4 to 5 times a week including weekends. At that time, he indicated if the NP was unable to refill the medication immediately, nurses could access the EDK by contacting the on call MD (medical doctor) and having the script sent to the pharmacy. The nurse would then contact the pharmacy for an authorization code and two nurses could sign to retrieve the needed narcotic from the EDK.			

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	On 2/16/24 at 10:06 A.M., QMA (Qualified Medication Aide) 11 indicated lorazepam was kept in the EDK. On 2/16/24 at 12:31 P.M., a Reordering, Changing, and Discontinuing Orders policy, revised 1/1/22, indicated "Schedule III-IV Controlled substances...requires a new prescription from the Physician/Prescriber". 3.1-25(a)			
F 0761 SS=E 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			

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	dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were secure, labeled correctly, stored at proper temperatures, and the temperature monitor logs were complete in 3 of 3 medication carts observed. (B/D/E hall medication carts) Findings include: 1. On 2/16/24 at 9:30 A.M., the medication cart for B hall was observed with the narcotic box within the medication cart unlocked. 2. On 2/16/24 at 9:44 A.M., the medication cart for E hall was observed with the narcotic box within the medication cart unlocked. There was a box in the top drawer of the cart that contained an opened vial of Tubersol (used to test for tuberculosis) with an open date 11/8/93. Two loose pills were observed in the cart; a pink oval pill with 5 on one side and 894 on the other, and an orange round pill with 277 on one side. During an interview on 2/16/24 at 9:50 A.M., RN 4 indicated the narcotic boxes should be locked and the loose pills should not be in the cart and then disposed of the loose pills in a drug buster solution located in the medication room. RN 4 indicated the TB (Tubersol) solution should be stored in the refrigerator and that she was unsure of the accuracy of the date on the TB solution. RN 4 removed the TB vial from the medication cart and took the TB solution to the Clinical Regional Nurse. During an interview on 2/16/24 at 10:30 A.M., the Clinical Regional Nurse observed the TB solution and indicated she had no idea what the open date wrote on the box was supposed to be but	F 0761	**F761 Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - No residents were identified during survey. - All carts have been locked, loose pills, nasal spray, and cough syrup were discarded. The temperature for the refrigerator is now monitored and to read 36 to 46 degrees. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Medication carts/medication storage refridgerator were audited by DNS/designee to ensure all medications are stored and labeled with open dates per policy. Nurses and QMAs will be in-serviced by CEN/designee on medication storage and labeling/dating. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - Daily audit to be completed of medication carts to ensure	03/20/2024

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	confirmed it did appear to read as 11/8/93. On 2/20/24 at 2:15 P.M., the Administrator provided the manufacturer guidelines insert from the Tubersol solution box. The guidelines indicated the solution should be stored at 35 to 46 degrees Fahrenheit, and should be discarded 30 days after first use, or after the manufacturer expiration date. 3. On 2/16/24 at 9:50 A.M., the medication cart for D hall was observed. A pink round pill with an M on one side and 2 1/2 on the other side, two opened, undated bottles of nasal spray, and an opened, undated bottle of cough syrup were observed in the medication cart. On 2/16/24 at 9:55 A.M., QMA 11 indicated the loose pill should not be in the bottom of the cart and disposed of the pill in the sharp's container on the side of the medication cart. 4. On 2/16/24 at 9:57 A.M., the medication room behind the skilled nurse's station was observed. The refrigerator that stored overflow medications had a temperature of 34 degrees Fahrenheit. The equipment temperature monitoring sheet lacked 4 of 16 days filled out for day shift (2/1, 2/4, 2/7, 2/14) and 3 of 15 days filled out for night shift (2/3, 2/6, 2/12). On 2/16/24 at 10:01 A.M., QMA 11 indicated the sheet should be filled out each shift and provided a copy of the refrigerator temperature log for the month of February 2024. On 2/16/24 the Clinical Regional Nurse provided a current policy titled "Storage and Expiration Dating of Medications", revised 7/21/22. The policy stated the following: "Facility should store		appropriate storage and open dates are being used. **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?** - The DNS/designee will complete medication storage QA tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	Schedule II-V Controlled Substances, in a separate compartment within the medication carts and should have a different key or access device." "Once any medication is opened, Facility should follow manufacturer guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container." "Facility should monitor the temperature of medication storage areas at least once per day and monitor cold storage containing vaccines two times a day per CDC guidelines." "Facility should destroy medications with incomplete or missing labels." 3.1-25(j) 3.1-25(n) 3.1-25(o)			
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 that food was served at palatable temperatures for 1 of 1 trays tested for temperature. Finding includes: On 2/12/24 at 10:13 A.M., Resident 51 indicated	F 0804	**F804 Nutritive Value/Appear, Palatable/Prefer Temp** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #51, #15, #60,	03/20/2024

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	she was one of the last residents to get served food and her breakfast was not always hot. On 2/12/24 at 10:56 A.M., Resident 15 indicated the food was occasionally cold when it arrived to her room. On 2/12/24 at 11:29 A.M., Resident 60 indicated she had an issue with the temperature of the food. On 2/12/24 at 11:29 A.M., Resident 17 indicated the food was not always hot when it arrived to his room. On 2/12/24 at 1:27 P.M., Resident 45 indicated the food was not hot when served. On 2/12/24 at 1:47 P.M., Resident 52 indicated that the food was occasionally cold when it arrived to his room. On 2/13/24 at 2:30 P.M., Resident 32 indicated the food didn't taste good and the temperatures weren't consistently palatable. On 2/15/24 at 12:56 P.M., a test tray was obtained from the C Hall. The following temperatures were observed and recorded: Baked beans - 112 degrees Fahrenheit (F) Tenderloin - 139 degrees F Coleslaw - 46 degrees F Apples - 42 degrees F On 2/15/24 at 1:09 P.M., the Dietary Manager indicated she expected serving temperatures to be no less than 160 degrees F for hot food and no greater than 40 degrees F for cold food. On 2/19/24 at 12:45 P.M., a current Food		#17, #45, #52, #32 had no ill effects related to alleged deficient practice. - Food is being served at appropriate temperatures per policy **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have to potential to be affected by the alleged deficient practice. Residents will be interviewed about food concerns. Food service manager/registered dietitian will audit food temperatures before and during meal times to ensure food is served at an appropriate temperature and that food is palatable. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - Culinary and nursing staff will be reeducated on appropriate food temperatures and timely food delivery to residents. - Each day meal rounds will be completed to monitor temperature and food quality. **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**	

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	Temperatures policy, revised 6/23, indicated "All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food". 3.1-21(a)(2)		**into place?** - The culinary manager will complete a Food temperature monitoring QA tool weekly times 4 weeks, monthly x6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The tools will be reviewed in QAPI. If threshold of 100% is not achieved, an action plan will be developed.	
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,			

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	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 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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were in 2 of 2 residents observed during care. Staff was observed not performing hand hygiene, changing gloves during care.(Resident 55, Resident 29) Findings include: 1. On 2/19/24 at 12:59 P.M., RN (Registered Nurse) 3 was observed during tracheostomy care on Resident 55. The following was the observation of the procedure: RN 3 did not wash hands after gloves were removed following the cleaning of the aerosol collar for the tracheostomy and the inner cannula. RN 3 placed sterile gloves on hands and handles the yankauer (suction tool) with both sterile hands. RN 3 did not wash hands prior to the application of clean gloves, before the trach stoma was cleaned with sterile water and Q-tip. RN 3 did not change gloves prior to the application of ointment on the 4 x 4 dressing around the stoma. RN 3 did not wash hands after the removal of soiled gloves and applying sterile gloves, before the changing of the inner cannula. 2. On 2/20/24 at 9:58 A.M., RN (Registered Nurse) 18 was observed providing wound care to	F 0880	**F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #55 was assessed with no ill effects noted related to alleged deficient practice. Resident is receiving tracheostomy care per policy. - RN# 3 currently on FMLA and will be in-serviced prior to next scheduled shift - Resident #29 was assessed with no ill effects related to alleged deficient practice. Resident is receiving wound care per policy. - RN#18 was in-serviced by Regional Director of Clinical Services regarding hand hygiene during wound care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be effected by alleged deficient practice. All staff will be in-serviced on infection control practices regarding hand hygiene. Nurses will be in-serviced regarding hand hygiene during wound care as well	03/20/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 29. RN 18 sanitized her hands for 9 seconds, and applied clean gloves. RN 18 removed a dressing dated 2/19/24 from the top of Resident 29's left foot. RN 18 cleansed the wound with wound cleanser spray and gauze, then disposed of the soiled gauze in a trash bag. RN 18 opened a package of petroleum gauze and used the index finger of her hand to remove excess petroleum from the top of the gauze and rub it on Resident 29's wound. Resident 29 began to complain of pain the left foot. RN 18 then removed the petroleum gauze from the package, placed it over the wound and covered the wound with a border gauze dressing. RN 18 removed her gloves and dated the dressing, gathered the trash, and exited the Resident's room. During an interview on 2/20/24 at 10:12 A.M., RN 18 indicated hand hygiene should be performed before, during, and after wound care is provided. During an interview on 2/19/24 at 1:28 P.M., LPN (Licensed Practial Nurse) 23 indicated hands should be washed before and after changing gloves and anytime when doing a new activity such as doing a sterile procedure. On 2/20/24 at 2:50 P.M, the Clinical Regional Nurse provided a current policy titled "Hand Hygiene Policy", revised 12/2021, that stated "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water... Before moving from work on a soiled body site to a clean body site on the same resident" and "Indication for hand-rubbing but not limited to... After contact with body fluids or erections, mucous membranes, non-intact skin, and wound dressing."		as trach care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** - Daily rounding observations will be completed by DNS/Designee regarding hand hygiene practices. **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?** - The DNS/designee will complete hand hygiene QA tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	02/21/2024

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	3.1-18(b) 3.1-18(l)			
F 9999 Bldg. 00	1.3 Administration and Management (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to report an unusual occurrence to the Indiana Department of Health (IDOH) for 1 of 1 residents reviewed for unusual events. (Resident B) Finding includes: On 2/14/24 at 9:15 A.M. Resident B's clinical record was reviewed. Resident B was admitted on 3/26/19. The most recent significant change MDS (Minimum Data Set) Assessment, dated 1/12/24, indicated resident B had moderate cognitive impairment. The physicians orders did not contain any medication or treatment which would involve a syringe and /or needle.	F 9999	**F9999 Final Observation, Not reporting unusual occurrences** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident B was assessed and had no ill effects related to alleged deficient practice. - Event was reported to IDOH per protocol by ED. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •All residents have to potential to be affected by the alleged deficient practice. •The ED was in-serviced by the Regional Vice President on reporting unusual occurrences to IDOH. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • ED will review Facility Activity Report daily to ensure any unusual occurrences were reported per policy. •Staff will be in-serviced by	03/20/2024

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	During an interview on 02/20/24 at 12:55 P.M., the Administrator indicated there had been a recent occurrence that was not reported, that involved two residents and family. The Administrator disclosed that on 1/31/24, Resident B's previous roommate had found a needle and syringe under Resident B's bed and brought it to the DON (Director of Nursing) to be disposed of, and was very uncomfortable and worried for her safety and requested to be moved to a different room. During a confidential interview on 2/20/24 at 1:30 P.M., a peer who had been one of Resident B's roommates indicated they had found the syringe with an attached needle and gave the material to Resident B's family, so the material could be taken to and disposed of by nursing staff. The peer then stated the next day they found the syringe and needle under Resident B's bed again and took the material to the DON (Director of Nursing) to be disposed of, and requested to be moved to a different room for safety concerns. During the exit conference on 2/21/24 at 1:10 P.M., the Clinical Regional Nurse stated she was aware of a needlestick that had occurred when Resident B's roommate found the needle and syringe, and that bloodwork for the peer had been completed. This information was not previously discussed or documented in Resident B's record or former roommate's record. A policy relating to reporting unusual occurrences within the building was requested and not provided. This citation relates to Complaint IN00427103.		ED/designee on timely reporting of unusual occurrences to ED. **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?** •The ED/designee will complete reportable QAPI tool weekly x4 weeks, monthly x6months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.	