STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00399080, IN00398585, IN00398595, IN00394527, IN00394315, IN00393698, IN00393329, IN00390411, IN00389130, and IN00397833. Complaint IN00399080 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F690. Complaint IN00398585 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F690. Complaint IN00398595 - Unsubstantiated due to lack of evidence. Complaint IN00394527 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F657, and F677. Complaint IN00394315 - Unsubstantiated due to lack of evidence. Complaint IN00393698 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F677. Complaint IN00393329 - Unsubstantiated due to lack of evidence. Complaint IN00390411 - Unsubstantiated due to lack of evidence. Complaint IN00389130 - Unsubstantiated due to lack of evidence.	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. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caley Nixon	Executive Director	02/17/2023

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

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	Complaint IN00397833 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: January 9, 10, 11, 12, 13, 17, and 18, 2023 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 132 Total: 132 Census Payor Type: Medicare: 11 Medicaid: 70 Other: 51 Total: 132 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/2/23.			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on record review and interview, the facility failed to provide a correct physician order for the resident's resuscitation wishes for 1 of 2 residents reviewed for advanced directives. (Resident 69) Finding includes: An initial record review on 1/10/2023 at 3:06 P.M.,	F 0578	**F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Dir** A. It is the practice of this facility to ensure that all residents have a correct physician order for the resident's resuscitation wishes	02/10/2023

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	indicated Resident 69 had a physician's order for a resuscitation choice of a full code on 10/31/2023. A POST (Physician Orders for Scope of Treatment) form on 11/1/2022, indicated Resident 69's wish was to have a do not resuscitate physician's order. An interview with Resident 69 on 1/11/2023 at 9:35 A.M., indicated Resident 69's wish was to have an order for do not resuscitate. On 1/12/2023 at 9:34 A.M., a record review was completed. Diagnoses included, but were not limited to: displaced fracture of the second and sixth cervical vertebra, fracture of the forearm, osteoporosis, and hypertension. An Admission MDS (Minimum Data Set) Assessment on 11/4/2022, indicated Resident 69 was cognitively intact. A Care Plan on 10/31/2022, indicated Resident 69 had established an advanced directive and wished to be a full code. Interventions included to refer to the Physician Orders for Scope of Treatment (POST) for Designation of Patient's Preferences and to honor decision regarding healthcare choices. During an interview on 1/13/2023 at 1:40 P.M., LPN 26 indicated if a code was called for Resident 69, she would call the code Resident 69, perform CPR, and have the crash cart available. LPN 26 reviewed the POST form and indicated the POST form did not match the physician's order. She indicated the issue needed to be fixed. LPN 26 indicated in the case of the POST form, she would provide comfort care and allow natural death and would not apply CPR.		regarding advanced directives. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 69- Code status was reviewed with resident, physician orders and care plan updated to reflect resident advanced directive wishes. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents advance directives/code statuses were reviewed for accuracy and updated to reflect any changes. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident code status, physician orders, and advanced directives. The Director or Nursing/Designee will audit all resident code statuses weekly for long-term residents and daily, Monday through Friday, for any new admissions to ensure all physician	

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	On 1/18/2023 at 10:56 A.M., the Assistant Director of Nursing indicated that Resident 69 had a physician's order for a full code, and her POST form indicated a do not resituate. She indicated the Medical Records Coordinator uploaded the form prior to a physician's order being completed. On 1/18/2023 at 3:12 P.M., the Executive Director provided a policy titled, "Advanced Directives". The policy indicated, " ...The Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care ...." 3.1-4(f)(5)		orders are correct and match resident wishes for advance directives. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “POST - Physician Order for Scope of Treatment” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure that one resident's responsible party was notified in advance of obtaining laboratory tests and X-rays, (Resident D), and that another resident's physician and responsible party was notified of significant weight loss. (Resident G). Findings include: 1. On 1/10/2022 at 2:10 P.M., Resident D's clinical records were reviewed. The resident's Admission Record indicated an admission date of 3/05/2019 with diagnoses that included, but were not limited to: macular degeneration, type 2 diabetes, and osteoarthritis. Resident D's most recent comprehensive Minimum Data Set (MDS) Assessment, was a Quarterly assessment dated 9/06/2022 and indicated the resident had a Brief Interview for Mental Status of 4, indicating the resident was severely cognitively impaired. 10/13/2022 for a CBC with Diff (Complete Blood Count with Differential), discontinue when completed 10/24/2022. Review of Resident D's progress note dated 10/25/2022 at 2:18 P.M., indicated that labs were drawn and sent to local hospital. There was no indication the responsible party was notified. On 1/19/2023 at 9:30 A.M., an interview with the Assistant Director of Nursing indicated the resident's responsible party was always notified	F 0580	**F580 – Notify of Changes (Injury/Decline/Room, etc.)** A. It is the practice of this facility to ensure that all residents and responsible parties are notified of any new physician orders, treatments, or changes in condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D – residents responsible party has been updated. Resident G – residents responsible party and physician has been updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents noted to have new orders and/or changes of condition have been reviewed to ensure responsible parties have been updated as appropriate. **What measures will be put into**	02/10/2023

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	of medical procedures, but there was not evidence of notification of the lab work completed on 10/25/2022 and should have been documented. 2. On 1/13/2023 at 11:00 A.M., an interview with Resident G indicated she has had unplanned weight loss since admission. The resident indicated she has not had an appetite and that no one from nursing, dietary, nor the physician have talked to her about concerns they may have regarding her weight loss. The resident indicated she had not been offered any form of supplements for her weight loss. On 1/13/2023 at 11:00 A.M., an interview with Resident G's responsible party, indicated there was not a plan nor desire for the resident to lose weight, and that no one at the facility had informed her that the resident had a significant weight loss. 1/13/2023 at 11:34 A.M., an interview with the Assistant Director of Nursing indicated the Interdisciplinary Team was discussing Resident G's weight loss and was going to start the resident on a dietary supplement. On 1/13/0323 at 1:30 P.M., Resident G's clinical record was reviewed. The resident's Admission Record indicated an admission date of 12/05/2022 and the most recent comprehensive Minimum Data Set dated 12/12/2022 for Admission Assessment indicated Resident G had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident required supervision and setup help for eating. Diagnoses included but were not limited to diabetes, acquired absence of parts of digestive tract, femoral fracture, kidney		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident change of condition; including new physician orders and notification of changes. The Director or Nursing/Designee will audit all resident orders and changes in condition daily to ensure that physicians and responsible parties have been notified. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Change of Condition” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the	

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	failure, stroke, hemiplegia, and surgical wound for femoral fracture repair. Review of Resident G's physician's dietary orders dated 12/05/2022, indicated a reduced carbohydrate diet regular texture, thin consistency. Orders for Active Liquid Protein to be given one time a day for supplement, and Ensure Plus to given 2 times daily for poor appetite were both ordered on 1/13/2023. Review of Resident G's Care Plans included but were not limited to: At risk for fluid imbalance due to diabetes type 2, hemiplegia and hemiparesis following a stroke, kidney disease, edema. Interventions included but were not limited to, diet as ordered, document intake, weights as ordered, and to notify physician of significant weight changes. At risk for complications and symptoms of hypoglycemia or hyperglycemia due to diagnosis of diabetes. Interventions included but were not limited to document meal/snack intake. Both Initiated 12/07/2022. And a potential for nutritional risk related to potential for delayed healing process secondary to diabetes type 2, chronic kidney disease, and left femur fracture. Interventions included but were not limited to, document food/fluid intakes, which was initiated on 12/12/2022. Review of the Resident G's documented weights indicated an admission weight on 12/06/2022 of 218 lbs, and on 1/04/2023 Resident G's weight was 195 lbs which indicated a 10.55 % Loss. Review of Resident G's documented meal intake percentage record from 12/16/22 to 1/04/23, indicated there was no meal intake documentation on the following dates: 12/17/2022 breakfast and lunch		Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	12/19/2022 breakfast and lunch 12/20/2022 breakfast and lunch 12/21/2022 breakfast lunch and dinner 12/22/2022 breakfast and lunch 12/23/2022 dinner 12/24/2022 breakfast lunch and dinner 12/25/2022 breakfast and lunch 12/26/2022 breakfast and lunch 12/29/2022 breakfast and lunch 12/30/2022 breakfast and lunch 12/31/2022 breakfast and lunch 1/1/2j023 breakfast and lunch 1/3/2023 breakfast and lunch 1/4/2033 breakfast Review of the resident's progress notes indicated no communication to the physician that the resident had a significant weigh loss between 12/06/2022 and 1/04/0223. On 1/13/2023 at 2:00 P.M., the policy titled, "Resident Weight Monitoring", dated 10/2018, was provided by the Executive Director indicating it was the current facility policy. The policy indicated, "...A weight report will be generated monthly and reviewed by the DM [Dietary Manager], RD [Registered Dietician], DNS [Director of Nursing Services], and MDS [Minimum Data Set] for significant changes. A significant weight change is defined as 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. The resident's physician and family/guardian will be notified of any verified significant weight change...." On 1/18/2023 at 3:12 P.M., a policy titled, "Notification of Change", dated 2022, was provided by the Executive Director and reviewed at that time, the policy indicated, "...The purpose of this policy is to ensure the facility promptly			

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	informs the resident, consults the resident's physician;...the resident's representative when there is a change requiring notification...[to] commence a new form of treatment to deal with a problem..." This Federal tag relates to complaint IN00393698. 3.1-5(a)(2)(3)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to prevent mental anguish to 1 of 3 residents reviewed for abuse. (Resident 16) Finding includes: A clinical record review was completed, on 1/9/2023 at 3:18 P.M. Resident 16 diagnoses included, but were no limited to: hypertension, hemiplegia, anxiety, depression, diabetes and seizures.	F 0600	**F600 – Free from Abuse and Neglect** It is the practice of this facility to ensure that all residents are free from abuse, neglect, misappropriation of resident property, and exploitation including mental anguish. **What corrective action(s) will be accomplished for those**	02/10/2023

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	A Quarterly MDS Assessment, dated 12/12/2022, indicated the residents' BIMS (Brief Interview for Mental Status) score was 15, cognition intact. Required extensive assist of 2 staff for bed mobility, dressing, toilet use, total assist of 2 staff for transfers and bathing and limited assist for eating During an interview, on 1/9/2023 at 4:06 P.M., Resident 16 indicated a staff member came to the room and asked what! The resident indicated she needed to pee and needed the bedpan, the resident stated the aide stomped in the room and got the bed pan and stated "you didn't have to wait until right before you needed to go." During an interview, on 1/10/2023 at 10:07 A.M., the Administrator indicated she had reported the allegation to the state and had started an investigation. A Progress Note, dated 1/9/2023 at 5:40 P.M., indicated: Resident informed staff that she had concern with one employee and her attitude when she puts her call light on for care. ED (Administrator) informed and interviewed resident, nurse completed a head to toe assessment with no findings. The resident ensured she felt safe in facility at this time. ED informed resident that investigation would begin, and employee would not be working with her, resident content. NP (Nurse Practitioner) updated at this time and resident own responsible party. Social services updated and will continue follow up with resident. A state reportable, dated 1/9/2023, indicated: Brief Description of Incident: resident reported that employee can be rude while providing care to resident. Resident was interviewed, head to toe		**residents found to have been affected by the deficient practice:** Resident 16 – was immediately assessed and resident safety ensured. ISDH reportable sent and investigation completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Multiple residents interviewed during investigation related to potential abuse with no further concerns indicated from any other residents. Weekly resident abuse interviews to continue to be completed by staff with all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of abuse prevention and reporting. The Executive Director/Designee will audit all resident interviews weekly	

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	assessment completed with no injuries or concerns of any new injuries. Employee was identified and suspended pending further investigation. Other like residents and staff to be interviewed. Social Service updated and will continue to monitor resident. On 1/9/2023 at 12:11 P.M., the Administrator provided the policy titled,"Abuse Prevention Program",dated March 2022, and indicated the policy was the one currently used by the facility. The policy indicated"...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom... Abuse- The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. ...Exploitation. Means the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats, or coercion... 3.1-27(a)(b)		to ensure all residents remain free from abuse, neglect, and exploitation; all staff will ensure that any concerns of abuse, neglect, and exploitation are reported immediately to the Executive Director. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Abuse Prohibition and Investigation” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report the follow-up to a reportable timely for 1 of 3 residents whose reportable's were reviewed. (Resident 18) Finding includes: On 1/17/2023 at 3:03 P.M., a facility reportable was reviewed for Resident 18. The reportable, dated	F 0609	**F609- Reporting of Alleged Violations** A. It is the practice of this facility to ensure that all alleged violations are reported in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been**	02/10/2023

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	3/18/2022, indicated the resident had reported she had missing money of $80.00. An investigation was initiated, but unable to determine who took the resident's money. A follow-up report was sent to the State Department of Health on 3/29/2022, 11 days after the initial incident had been reported. During an interview, on 1/17/2023 at 3:09 P.M., the Administrator indicated she was unsure of why the follow-up report had been sent in late. On 1/9/2023 at 12:11 P.M., the Administrator provided the policy titled, "Abuse Prevention Program", dated March 2022, and indicated the policy was the one currently used by the facility. The policy indicated"... The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency, and if required by state or local laws the local police department, the ombudsman, and others as may be required be state or local laws, within five (5) working days of the reported incident..." 3.1-28(e)		**affected by the deficient practice:** Resident 18 – follow up reportable was submitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All reportable incidents reviewed to ensure that timely follow-up reporting has been completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of abuse prevention and reporting. The Executive Director/Designee will audit all reportables weekly to ensure all have been reported and followed up in a timely manner. **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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			into place: Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Abuse Prohibition and Investigation” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment			

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	instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.			

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	(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on observation, record review, and interview, the facility failed to complete an activity comprehensive assessment for 1 of 3 residents reviewed for activities comprehensive assessments. (Resident 280) During an initial interview on 1/10/2023 at 11:51 A.M., Resident 280 indicated she stayed in her room all day, including meals, and would like to participate in activities. Finding includes: On 1/11/2023 at 11:39 A.M., Resident 280 was observed lying in bed in a facility gown watching the television. An observation and interview on 1/12/2023 at 1:42 P.M., Resident 280 was observed lying in bed with a facility gown on. She indicated during an interview, she enjoys horseback riding, crocheting, listening to music and coloring. Independent activities were not observed in the room. During observations on 1/13/2023 at 11:12 A.M. and 2:58 P.M., Resident 280 was observed lying in bed with a facility gown on and the television playing. A clinical record review was completed on 1/18/2023 at 10:20 A.M. Diagnoses included, but	F 0636	**F636- Comprehensive Assessments & Timing** It is the practice of this facility to ensure that all residents receive an initial and periodic comprehensive, accurate, standardized reproducible assessment of function capacity assessment; including activity assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 280- new activity assessment reviewed and completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents reviewed and up to date with current activity assessments in place.	02/10/2023

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	were not limited to: displaced trimalleolar fracture of left lower leg, hemiplegia and hemiparesis following a cerebral infarction affecting non-dominant side, anxiety disorder, and osteoarthritis. An Admission MDS (Minimum Data Set) Assessment was completed on 1/3/2023. The assessment indicated that Resident 280 had moderate cognitive impairment. She required extensive assistance with one staff member for locomotion off her unit. The Interview for Daily and Activity Preferences was not assessed. During an interview on 1/18/2023 at 11:17 A.M., the Activity Director indicated that she interviews the residents about their interests and includes the questions for Section F of the MDS Assessment, Interview for Daily and Activity Preferences. She indicated she keeps the interview sheets of each resident. When asked to see Resident 280's interview sheet, the Activity Director indicated she did not have an interview for Resident 280. The Activity Director indicated she did not complete a comprehensive assessment for Resident 280. On 11/17/2023 at 3:22 P.M., a policy was provided by the Activity Director titled, "Activity Assessment". The policy indicated, " ...1. Within 14 days of a resident's admission to the facility, an Activity Assessment will be conducted to help develop an activity plan that reflects the choices and interests of the resident ...2. The resident's Activity Assessment is to be conducted by Activity Department personnel, in conjunction with other staff who will assess related factors such as functional level, cognition, and medical conditions that may affect activities participation. The resident's lifelong interests, spirituality, life		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All IDT staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of resident MDS assessments. The Executive Director/Designee will audit all resident MDS assessments weekly to ensure all resident assessments in review are complete and updated per policy. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “MDS Assessment” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and	

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	roles, goals, strengths, needs and activity pursuit patterns and preferences will be included in the assessment ...." 3.1-31(d)(1)		Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0656 SS=E 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			

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	its rationale in the resident's medical record. (iv)In consultation with the resident and the 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 comprehensive, person centered, care plans were in place and accurate for 4 of 4 residents review for care plans. (Residents G, H, 72, 280). Findings include: 1. On 1/13/2023 at 1:30 P.M., Resident G's clinical record was reviewed. The resident's Admission Record indicated an admission date of 12/05/2022. The residents' most recent comprehensive Minimum Data Set dated 12/12/2022 for Admission Assessment indicated Resident G had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident required supervision with set-up	F 0656	**F656 –Develop/Implement Comprehensive Care Plan** It is the practice of this facility to ensure that all residents have comprehensive, person centered, care plans in place and accurate. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident G – all residents care plans reviewed and updated as appropriate. Resident H – all residents care plans reviewed and updated as appropriate. Resident 72 – all residents care	02/10/2023

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	help for eating. Diagnoses included, but were not limited to: diabetes, acquired absence of parts of digestive tract, femoral fracture, kidney failure, stroke, hemiplegia, and surgical wound for femoral fracture repair. Review of Resident G's physician dietary orders dated 12/05/2022, indicated a reduced carbohydrate diet regular texture, thin consistency. Review of Resident G's Care Plans included but were not limited to: At risk for fluid imbalance due to to diabetes type 2, hemiplegia and hemiparesis following a stroke, kidney disease, edema. Interventions included but were not limited to, diet as ordered, document intake, weights as ordered/indicated, notify physician of significant weight changes. Initiated 12/07/2022. At risk for complications and symptoms of hypoglycemia or hyperglycemia due to diagnosis of diabetes. Interventions included but were not limited to document meal/snack intake. Initiated 12/07/2022. Potential for nutritional risk related to potential for delayed healing process secondary to diabetes type 2, chronic kidney disease, and left femur fracture. Interventions included but were not limited to, document food/fluid intakes. Initiated 12/12/2022. Review of Resident G's documented meal intake percentage record from 12/16/22 to 1/13/23, indicated there was no meal intake documentation on the following dates: 12/17/2022 breakfast and lunch 12/19/2022 breakfast and lunch		plans reviewed and updated as appropriate. Resident 280 – all residents care plans reviewed and updated as appropriate. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents care plans to be completely reviewed and updated in conjunction with resident MDS assessments. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All IDT staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the MDS Coordinator or Designee and will include a review of resident comprehensive care planning. The MDS Coordinator/Designee will audit all resident care plans in assessment window weekly to ensure all care plans are accurate, person-centered, and up to date. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	12/20/2022 breakfast and lunch 12/21/2022 breakfast lunch and dinner 12/22/2022 breakfast and lunch 12/23/2022 dinner 12/24/2022 breakfast lunch and dinner 12/25/2022 breakfast and lunch 12/26/2022 breakfast and lunch 12/29/2022 breakfast and lunch 12/30/2022 breakfast and lunch 12/31/2022 breakfast and lunch 1/1/2023 breakfast and lunch 1/3/2023 breakfast and lunch 1/4/2023 breakfast 1/5/2023 breakfast and lunch 1/6/2023 breakfast and lunch 1/8/2023 dinner 1/9/2023 breakfast and lunch 2. On 1/10/2022 at 3:30 P.M., Resident H's clinical records were reviewed. The resident's Admission Record indicated the resident was most recently admitted to the facility on date of 9/20/2021, with diagnoses that included, but were not limited to: chronic obstructive pulmonary disease, heart failure, stroke, need for assistance with personal care. Resident H's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/27/2022 and indicated the resident had a Brief Interview for Mental Status of 1, indicating moderate cognitive impaired. Resident H required extensive assistance of 2 persons for personal hygiene, bed mobility, transfers, dressing, toilet use, and was totally dependant on staff for bathing. The resident had an indwelling catheter, was always incontinent of bowel, received daily anticoagulants and diuretics. The MDS indicated there were no family members or representatives who participated in		**recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tools labeled "Comprehensive Care Plan Review" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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 H's Care Planning and goal setting. Review of the resident Physician's Orders included but were not limited to Oxygen to run at 3 liters per minutes via nasal cannula, dated 1/09/2023. Foley catheter for obstructive uropathy, dated 1/09/2023. Empty catheter drainage bag every shift every 8 hours, dated 1/09/2023. Foley catheter care every shift document out put, dated 1/09/2023. Resident H's Care Plans included but were not limited to Impaired gas exchange related to congestive heart failure, respiratory failure, sleep apnea, shortness of breath, morbid obesity with alveolar hypoventilation. Interventions included but were not limited to, oxygen at 4 liter per minute via nasal cannula continuous or per facility protocol. This care plan was initiated on 9/04/21 and not revised. There was not a care plan initiated for catheter care. 3. During an observation, on 1/10/2023 at 10:10 A.M., Resident 72's legs were wrapped with gauze dressings. The resident indicated she did not have any wounds, but they change the dressings about every 2 days. A clinical record review was completed on 1/17/2023 at 10:23 A.M. Resident 72's diagnoses included, but were not limited to: chronic obstructive pulmonary disease with acute exacerbation, vascular dementia without behavioral disturbance, and type 2 diabetes mellitus. A Quarterly MDS (Minimum Data Set) Assessment, dated 10/17/2022, indicated Resident			

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	72 had a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. The resident required limited assist of 1staff for bed mobility, transfers, dressing, toileting, hygiene, and total assist of 1staff for bathing. A current care plan, dated 3/19/2019, the resident was at risk for impaired skin integrity related to anticoagulant use, diabetes mellitus with insulin use, and incontinence. Interventions included, but were not limited to, report any discoloration or open areas on feet to Nurse/Wound Nurse, and skin assessment as ordered and PRN. During an interview, on 1/18/2023 at 1:28 P.M., the wound nurse indicated Resident 72 did not currently have any wounds on her legs, but she scratches and picks, so lotion is applied, and her legs are wrapped to protect the skin. She also indicated that it is not, but should be, on the care plan.4. During an initial interview on 1/10/2023 at 11:51 A.M., Resident 280 indicated, she stays in her room all day, including meals, and would like to participate in activities. On 1/11/2023 at 11:39 A.M., Resident 280 was observed lying in bed in a facility gown watching the television. An observation and interview on 1/12/2023 at 1:42 P.M., Resident 280 was observed lying in bed with a facility gown on. She indicated during an interview, she enjoys horseback riding, crocheting, listening to music and coloring. No independent activities were observed in the room. During observations on 1/13/2023 at 11:12 A.M. and 2:58 P.M., Resident 280 was observed lying in bed with a facility gown on and the television			

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	playing. A clinical record review was completed on 1/18/2023 at 10:20 A.M. Diagnoses included, but were not limited to: displaced trimalleolar fracture of left lower leg, hemiplegia and hemiparesis following a cerebral infarction affecting non-dominant side, anxiety disorder, and osteoarthritis. An Admission MDS (Minimum Data Set) Assessment was completed on 1/3/2023. The assessment indicated that Resident 280 had moderate cognitive impairment. She required extensive assistance with one staff member for locomotion off her unit. The Interview for Daily and Activity Preferences was not assessed. A Care Plan on 1/12/2023, indicated, Resident is involved in her own activity during the day, but welcomes visits from the activity staff. An intervention included, to provide materials that will help Resident 280 to be successful in her own activities during the day. During an interview on 1/18/2023 at 11:17 A.M., the Activity Director indicated that she interviews the residents about their interests and includes the questions for Section F of the MDS Assessment, Interview for Daily and Activity Preferences. She indicated she keeps the interview sheets of each resident. When asked to see Resident 280's interview sheet, the Activity Director indicated she did not have an interview for Resident 280. The Activity Director indicated she did not complete a comprehensive assessment for Resident 280. She indicated the care plans are basic and not person centered. On 1/18/2022 at 9:00 A.M., a policy titled, "Care			

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	Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "...A comprehensive care plan for each resident is developed within 7 days of the completion of the resident Minimum Data Set...A baseline care plan for each resident...which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality of care...." This Federal tag relates to complaint IN00394527. 3.1-35(a)(b)(1)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.			

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	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to provide care plan meetings for 6 of 6 residents reviewed for care plan meetings.(Residents 16, 46, 47, 71, 22, & H) Findings include: 1. During an interview, on 1/9/2023 at 2:50 P.M., Resident 16 indicated she had not attended any care plan meetings. A clinical record review was completed, on 1/9/2023 at 3:18 P.M. Resident 16 diagnoses included, but were no limited to: hypertension, hemiplegia, anxiety, depression, diabetes and seizures. A Quarterly MDS (Minimum Data Set) Assessment, dated 12/12/2022, indicated the residents' BIMS (Brief Interview for Mental Status) score was 15, cognition intact. The only electronic Care Conference sheet, was dated 1/4/2022. A review of the Progress notes, dated 1/2022 through 12/2022, lacked the documentation of any further Care Conference sheets indicating care plan meetings had not been held. During an interview,on 1/13/2023 at 9:32 A.M., Social Service staff 2 indicated she had gotten behind on the care plan meetings and there were no other meetings that had been held.	F 0657	**F657 – Care Plan Timing and Revision** It is the practice of this facility to ensure that all residents are provided care plan meetings. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 16 – care plan meeting has been offered and scheduled for resident. Resident 46- care plan meeting has been offered and scheduled for resident. Resident 47 – care plan meeting has been offered and scheduled for resident. Resident 71 – care plan meeting has been offered and scheduled for resident. Resident 22 – care plan meeting has been offered and scheduled for resident. Resident H – unable to correct the alleged deficient practice due to resident no longer residing in facility. **How other residents having the**	02/10/2023

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	2. During an interview, on 1/09/2023 at 11:30 A.M., Resident 46 indicated he had been to one care plan meeting. A clinical record review was completed on, 1/11/2023 at 10:53 A.M. Resident 46's diagnoses included, but were not limited to: chronic respiratory failure, Parkinson's disease, diabetes, obesity, Schizoaffective disorder, and dementia. A Quarterly MDS (Minimum Data Set) Assessment, dated 12/21/2022 indicated Resident 46 had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. The last date of a care plan conference that had been held was dated 11/2/2021. A review of the Progress notes, dated 1/2022 through 12/2022, lacked the documentation of any further Care Conference sheets indicating care plan meetings had not been held. During an interview on 1/13/2023 at 9:32 A.M., Social Service Staff 2 she had gotten behind with the care plan meetings and there were no other meetings that had been held.3. During an interview, on 1/10/2023 at 2:59 P.M., Resident 47 indicated she did not know what a care conference was and did not remember attending one. A clinical record review was completed on, 1/17/2023 at 9:52 A.M., and indicated Resident 47"s diagnoses included, but were not limited to: hypertensive heart disease, hemorrhagic disorder, spondylosis, major depressive disorder, hyperlipidemia, chronic respiratory failure, type 2 diabetes and muscle weakness.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents records have been audited to ensure facility has provided care plan meetings and meetings are being scheduled in conjunction with quarterly MDS assessments or as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All IDT staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of resident comprehensive care planning. The Social Services Director/Designee will audit all resident assessment schedules weekly ensure all resident care plan meetings are being offered and completed in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	A Quarterly MDS (Minimum Data Set) assessment, dated 12/21/202 indicated Resident 47 has a BIMS (Brief Interview for mental status) 12 indicating moderately impaired. During an interview on 1/17/2023 at 9:58 A.M., the Social Service Director indicated Resident 47 has not had a careplan meeting since 2021. She indicated at the time she was by herself and could not keep up with the meetings and indicated careplan meetings are supposed to be completed quarterly and as needed. 4. During an interview, on 1/2023 at 9:37 A.M., Resident 71's representative indicated that she had not participated in a care plan conference since she requested one in March of 2022. A clinical record review completed, on 1/13/2023 at 11:45 A.M., indicated the resident's representative attended a care plan conference on 2/8/2022 by phone. The clinical record lacked documentation of any other care plan conferences since March 2022. During an interview, on 1/13/2023 at 12:14 P.M., the Social Service Director indicated care plan conferences are very behind schedule and have not been done consistently and should have been done quarterly and/or as needed. 5. During an initial interview on 1/10/2023 at 9:46 A.M., Resident 22 indicated, she was not informed of medication changes and could not recall having a care plan meeting. A clinical record review was conducted on 1/13/2023 at 10:07 A.M. Diagnoses included, but were not limited to: chronic kidney disease, fibromyalgia, chronic obstructive pulmonary disease (COPD), and congestive heart failure.		Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Social Services Director/Designee will be responsible for completing the QAPI Audit tools labeled “Care Plan Meeting Audit” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	A Significant Change MDS on 12/31/2022 indicated Resident 22 was cognitively intact. Progress Notes for Resident 22 were reviewed for the past year. There was not an entry that indicated a care plan had occurred. The IDT (Interdisciplinary Team) Care Conference Summary was entered on 6/21/2022. This Summary was incomplete. During an interview on 1/13/2023 at 12:12 P.M., the Social Service Director indicated, she has been in the Social Service Department by herself, but reaches out to families. She indicated she had been behind on care plan conferences. She indicated the care plan conferences should be completed quarterly.6. On 1/10/2022 at 3:30 P.M., Resident H's clinical records were reviewed. The resident's Admission Record indicated the resident was most recently admitted to the facility on date of 9/20/2021, with diagnoses that included, but were not limited to: chronic obstructive pulmonary disease, heart failure, stroke, need for assistance with personal care. Resident H's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/27/2022 and indicated the resident had a Brief Interview for Mental Status of 1, indicating moderate cognitive impaired. Resident H required extensive assistance of 2 persons for personal hygiene, bed mobility, transfers, dressing, toilet use, and was totally dependant on staff for bathing. The resident had an indwelling catheter, was always incontinent of bowel, received daily anticoagulants and diuretics. The MDS indicated there were no family members or representatives who participated in Resident H's Care Planning and goal setting.			

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	On 1/10/2023 at 3:49 P.M., an interview with the resident's representative indicated she had not been invited to nor attended a Care Plan meeting for the resident at any time. On 1/13/2023 at 12:15 P.M., and interview with the Social Service Director indicated Resident H's most recent Care Plan conference was 6/09/22 and that the resident should have a Care Plan conference with his representative every quarter and was late on scheduling the resident's Care Plan conference. On 1/18/2022 at 9:00 A.M., a policy titled, "Care Planning-Interdisciplinary Team", dated 9/28/2017 was provided by the Executive Director who indicated it was the current policy. The policy was reviewed at that time and indicated, "...A comprehensive care plan for each resident is developed within 7 days of the completion of the resident Minimum Data Set...the resident, the resident's family and/or the resident's legal representative/guardian...are encouraged to participate in the development of and revisions to the resident's care plan. The care plan will be printed and reviewed for accuracy prior to Care Conference...A written summary or copy of the baseline care plan will be given to the resident and/or representative..." This Federal tag relates to complaint IN00394527. 3.1(a)(c)(1)(d)(2)(B)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure showers were provided timely for 7 of 8 residents reviewed for Adl care (Activities of Daily Living). (Residents 16, 46, 44, D, L, 180) Findings include: 1. During an interview, on 1/9/2023 at 2:51 P.M., Resident 16 indicated she does not get showers. A clinical record review was completed, on 1/9/2023 at 3:18 P.M. Resident 16 diagnoses included, but were no limited to: hypertension, hemiplegia, anxiety, depression, diabetes and seizures. An annual MDS (Minimum Data Set) Assessment, dated 9/16/2022, indicated: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? The response checked was Very Important. A Quarterly MDS Assessment, dated 12/12/2022, indicated the residents' BIMS (Brief Interview for Mental Status) score was 15, cognition intact. Required extensive assist of 2 staff for bed mobility, dressing, toilet use, total assist of 2 staff for transfers and bathing and limited assist for eating. A current care plan, dated 11/14/2017 and revised on 1/10/2020, indicated the resident required ADL assist related to weakness, stroke, rheumatoid arthritis, chronic pain syndrome and fibromyalgia. Interventions included but were not limited to: Bathing Monday & Thursday on the 2nd shift.	F 0677	**F677- ADL Care Provided for Dependent Residents** It is the practice of this facility to ensure that all residents receive showers per their preference. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 16 – residents bathing preferences reviewed and updated Resident 46- residents bathing preferences reviewed and updated Resident 44- residents bathing preferences reviewed and updated Resident D – resident no longer in facility Resident L – resident no longer in facility Resident 180 – residents bathing preferences reviewed and updated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents bathing preferences reviewed and updated. **What measures will be put into**	02/10/2023

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	Resident 16's shower documentation, dated 12/14/2022 to 1/13/2023, indicated the resident received a shower on 12/17/2022 and refused on 1/5/2023. There was no further documentation to indicate Resident 16 had received showers twice weekly. During an interview, on 1/13/2023 at 10:10 A.M., CNA 7 indicated the resident should have received a shower 2 times a week and did not. 2. During an interview, on 1/09/2023 at 11:29 A.M., Resident 46 indicated he does not receive showers twice a week. A clinical record review was completed on, 1/11/2023 at 10:53 A.M. Resident 46's diagnoses included, but were not limited to: chronic respiratory failure, Parkinson's disease, diabetes, obesity, Schizoaffective disorder, and dementia. A Quarterly MDS (Minimum Data Set) Assessment, dated 12/21/2022 indicated Resident 46 had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. Required limited assist of 1 staff for bed mobility, transfers, dressing, toilet use, limited assist for eating and total assist of 1 staff for bathing. A current care plan, dated 7/29/2016 and revised on 12/7/2020, indicated Resident 46 required ADL assist related to: weakness, polyneuropathy, low back pain, obesity, and history of Covid-19. Bathing: Extensive x 1 staff. Interventions included, but were not limited to: Bathing: Monday and Thursday on the day shift. Resident 46's shower documentation, dated 12/14/2022 to 1/13/2023, indicated the resident had received a shower		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident ADLs related to shower preferences. The Director or Nursing/Designee will audit all resident shower schedules daily to ensure that all residents are receiving showers per preference. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Shower QAPI” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	

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	on 12/17/2022 and 1/12/2023 and had no documented refusals. During an interview, on 1/13/2023 at 10:10 A.M., CNA 7 indicated the resident should have received a shower 2 times a week and did not.3. During an interview, on 1/09/2023 at 10:15 A.M., Resident 44 indicated he does not receive showers. During an observation, on 1/09/2023 at 10:15 A.M., Resident 44 was observed sitting in his recliner, hair appeared greasy, stains and food noted on the front of his shirt. During an observation, on 1/10/2023 at 1:15 P.M., Resident 44 was observed sitting in his recliner, hair appeared greasy and observed wearing the dirty shirt from previous day. During an observation, on 1/11/2023 at 10:08 A.M., Resident 44 was observed sitting in his recliner, hair appeared greasy, and observed wearing the dirty shirt that was observed on 1/09/2023 at 10:15 A.M. A clinical record review was completed on 1/11/2023 at 2:40 P.M., and indicated Resident 44's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, hypoxemia, heart failure, obstructive sleep apnea, chronic atrial pulmonary edema, pleural effusion, chronic pulmonary edema, chronic atrial fibrillation, hypoxemia, polyosteoarthritis, insomnia, visual hallucinations, benign prostatic hyperplasia, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, insomnia, mesothelioma and visual hallucinations.		**By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A 5 day MDS (Minimum Data Set) assessment, dated 1/6/2023, indicated Resident 44 had a BIMS (Brief interview for Mental Status) score of 15, indicating intact cognition. A 5 day MDS (Minimum Data Set) assessment, dated 1/6/2023, indicated Resident 44 required total dependence with bathing and extensive assist with personal hygiene. During a record review, on 01/12/23 at 10:55 A.M., showers documented between 12/14/2022 and 1/12/2023 indicated Resident 44 had recieved one shower on 12/21/2023. On 1/12/2023 at 10:57 A.M., an ADL (Activities of Daily Living) careplan was reviewed and indicated Resident 44 will receive appropriate assistance for ADL's. Intervention: will receive extensive assist x2 care in pairs only for showers on Monday and Thursday evenings. During an interview, on 1/13/2023 at 10:52 A.M., RN (registered nurse) 6 indicated Resident 44 should be receiving showers twice a week. 4. On 1/10/2022 at 2:10 P.M., Resident D's clinical records were reviewed. The resident's Admission record indicated an admission date of 3/05/2019 with diagnoses that included, but were not limited to macular degeneration, type 2 diabetes, and osteoarthritis. Resident D's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/06/2022 and indicated the resident had a Brief Interview for Mental Status of 4, indicating the resident was severely cognitively impaired. Resident D required extensive assistance of 2 persons for personal hygiene and			

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	was totally dependant on staff for bathing. Resident D's Care Plans included but were not limited to Activities of Daily Living, initiated on 3/05/2019 that indicated the resident required assistance with bathing Wednesdays and Saturdays on evening shift. Review of Resident D's Skin Check/Shower Sheets from 9/01/2022 to 11/04/2022, indicated the resident received showers at the following times: 9/05/2022 shower 2nd shift Monday 9/07/2022 bedbath 2nd shift Wednesday 9/12/2022 Shower 2nd shift Monday 9/14/2022 shower 2nd shift Wednesday 9/19/2022 shower 2nd shift Monday 9/29/2022 shower 2nd shift Thursday 10/12/2022 shower 2nd shift Wednesday 10/14/2022 Shower 2nd shift Friday 10/31/2022 bed bath 2nd shift Monday The resident did not any form of bathing on the following days: September 1,10, 17, 21, 24, 28, 2022 October 1, 5, 8, 15, 19, 21, 26, 28, 2022 November 2, 2022 5. On 1/10/2022 at 2:30 P.M., Resident L's clinical records were reviewed. The resident's Admission Record indicated the resident was most recently admitted to the facility on date of 7/01/2022, with diagnoses that included but were not limited to multisystem inflammatory syndrome, stage 4 kidney disease, urinary tract infection, cellulitis of the trunk. Resident L's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/29/2022 and indicated the resident had a Brief Interview for Mental Status of 11, indicating			

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	moderate cognitive impaired. Resident L required extensive assistance of 1 person for personal hygiene and was totally dependant on staff for bathing. Resident L's Care Plans included but were not limited to Activities of Daily Living, initiated on 1/27/2020 and most recently revised on 9/16/2021, and indicated the resident required assistance with bathing on Mondays and Thursdays on day shift. Review of Resident L's Skin Check/Shower Sheets from 12/01/2022 to 1/10/2022, indicated the resident received showers at the following times: 12/19/2022 shower 1st shift Monday 12/20/2022 bed bath 2nd shift Tuesday 12/24/2022 shower 1st shift Saturday Resident was out of the facility from 12/28/2022 to 12/31/2022 1/2/2023 shower 1st shift Monday 1/10/2023 shower 1st shift Tuesday The resident did not have any form of bathing on the following scheduled days: December 5, 8, 12, 15, 22, 26, 2022 January 5, 9, 2022 6. On 1/10/2022 at 3:30 P.M., Resident H's clinical records were reviewed. The resident's Admission Record indicated the resident was most recently admitted to the facility on date of 9/20/2021, with diagnoses that included but were not limited to chronic obstructive pulmonary disease, heart failure, stroke, need for assistance with personal care. Resident H's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 9/27/2022 and indicated the resident had a Brief Interview for M(a)ental Status			

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	of 1, indicating moderate cognitive impaired. Resident H required extensive assistance of 2 persons for personal hygiene and was totally dependant on staff for bathing. Resident H's Care Plans included but were not limited to Activities of Daily Living, initiated on 8/17/2021 and most recently revised on 2/4/2022, and indicated the resident required assistance with bathing on Tuesdays, Thursdays, and Sundays on 2nd shift. Review of Resident H's Skin Check/Shower Sheets from 11/15/2022 to 1/10/2023, indicated the resident received showers at the following times: 11/15/2022 shower 2nd shift Tuesday 12/01/2022 shower 2nd shift Thursday 12/09/2022 bedbath 1st shift Friday 12/10/2022 shower 2nd shift Saturday Resident was out of the facility from 12/13/2022 to 12/14/2022 12/27/2022 bed bath 2nd shift Tuesday 12/30/2022 bed bath 2nd shift Friday Resident was out of the facility from 1/04/23 to 1/9/2023 1/10/2023 bed bath 2nd shift Tuesday The resident did not have any form of bathing on the following scheduled days: November 17, 20, 22, 27, 29, 2022 December 4, 6, 8,19, 22, 25, 29, 2022 January 1, 3, 2023 7. During an interview, on 1/10/2023 at 2:14 P.M., Resident 180 indicated she has not had a shower or bed bath for awhile. A clinical record review was completed on, 1/13/2023 at 9:57 A.M., and indicated Resident 180's diagnoses included, but were not limited to:			

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	Necrotic bowel secondary to small obstruction, metabolic encephalopathy, anemia, neuromuscular dysfunction of the bladder, altered mental status, intestinal obstruction, dysphonia, hypertension and hypothyroidism. During a record review, on 1/13/23 at 11:28 A.M., shower documentation indicated between 12/22/2022 and 1/12/2023 Resident received one shower. An admission MDS (Minimum Data Set) assessment, dated 12/29/2022, indicated Resident 180 had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. An admission MDS (Minimum Data Set) assessment, dated 12/29/2022 indicated Resident 180 requires extensive assist of two staff for bed mobility, personal hygiene, toilet use and transfers. A current care plan, dated 12/22/2022, indicated Resident needs assistant with activities of daily living, personal hygiene: extensive with 2 staff assistance. During an interview, on 1/13/2023 11:36 A.M., RN (registered nurse) 6 indicated Resident 180 should be receiving showers every week, she also indicated she did not know if Hospice or facility staff are to do them. On 1/17/23 at 2:34 P.M., the Executive Director provided the policy titled, "Activities of Daily Living (ADL's), Supporting", dated 3/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...Residents who are unable to carry out activities of daily living independently will receive the services			

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	necessary to maintain good nutrition\, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care...." This Federal tag relates to complaints IN00393689, IN00398585, IN00399080, and IN00394527. 3.1-38(a)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to provide activities of choice for 1 of 3 residents reviewed for activities. (Resident 280) Finding includes: During an initial interview on 1/10/2023 at 11:51 A.M., Resident 280 indicated, she stays in her room all day, including meals, and would like to participate in activities.	F 0679	**F679- Activities Meet Interest/Needs Each Resident** It is the practice of this facility to ensure that all residents are provided activities of resident choice or preference. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	02/10/2023

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	On 1/11/2023 at 11:39 A.M., Resident 280 was observed lying in bed in a facility gown watching the television. An observation and interview on 1/12/2023 at 1:42 P.M., Resident 280 was observed lying in bed with a facility gown on. She indicated during an interview, she enjoys horseback riding, crocheting, listening to music and coloring. No independent activities were observed in the room. During observations on 1/13/2023 at 11:12 A.M. and 2:58 P.M., Resident 280 was observed lying in bed with a facility gown on and the television playing. A clinical record review was completed on 1/18/2023 at 10:20 A.M. Diagnoses included, but were not limited to: displaced trimalleolar fracture of left lower leg, hemiplegia and hemiparesis following a cerebral infarction affecting non-dominant side, anxiety disorder, and osteoarthritis. On 1/18/2023 at 1:31 P.M., Resident 280 was observed lying in bed. She indicated she had gone to therapy, ate in the dining room. The Activity Director was observed coming to Resident 280's room and invited her to bingo. Resident 280 did not have any visible activities in her room. An Admission MDS (Minimum Data Set) Assessment was completed on 1/3/2023. The assessment indicated that Resident 280 had moderate cognitive impairment. She required extensive assistance with one staff member for locomotion off her unit. The Interview for Daily and Activity Preferences was not assessed.		Resident 280- resident was provided materials to encourage individual activities in resident room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents reviewed to ensure that materials are provided for residents who choose to take part in individual activities within their rooms. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All activity staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Executive Director or Designee and will include a review of Individual Activities and Room Visit Program. The Activity Director/Designee will audit all resident Activity Care Plans to ensure accuracy and that facility is providing appropriate materials to residents in room as needed. **How the corrective action(s)**	

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	A Care Plan on 1/12/2023, indicated, Resident is involved in her own activity during the day, but welcomes visits from the activity staff. An intervention included, to provide materials that will help Resident 280 to be successful in her own activities during the day. During an interview on 1/18/2023 at 11:17 A.M., the Activity Director indicated that she interviews the residents about their interests and includes the questions for Section F of the MDS Assessment, Interview for Daily and Activity Preferences. She indicated she keeps the interview sheets of each resident. When asked to see Resident 280's interview sheet, the Activity Director indicated she did not have an interview for Resident 280. The Activity Director indicated she did not complete a comprehensive assessment for Resident 280. She indicated the care plans are basic and not person centered. On 1/18/2023 at 11:33 A.M., a review of Resident 280's activity participation worksheet was reviewed with the Activity Director. The worksheet indicated on 1/12/2023 at 2:19 P.M., Resident 280 had one on one active conversation. There were no further entries on the worksheet. On 11/17/2023 at 3:22 P.M., a policy was provided by the Activity Director titled, "Activity Assessment". The policy indicated, " ...1. Within 14 days of a resident's admission to the facility, an Activity Assessment will be conducted to help develop an activity plan that reflects the choices and interests of the resident ...5. Each resident's Activities Care Plan shall relate to his/her Comprehensive Assessment and should reflect his/her individual needs ...." 3.1-33(a)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Activity Director/Designee will be responsible for completing the QAPI Audit tools labeled “In-Room Activities” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to collaborate with hospice regarding the development of a comprehensive hospice care plan related to communication of resident changes i.e.: pain, nutrition, skin and end of life for 1 of 3 residents reviewed for hospice. (Resident 180) Findings include: A clinical record review was completed on, 1/13/2023 at 9:57 A.M., and indicated Resident 180's diagnoses included, but were not limited to: necrotic bowel secondary to small obstruction, metabolic encephalopathy, anemia, neuromuscular dysfunction of the bladder, altered mental status, intestinal obstruction, dysphonia, hypertension and hypothyroidism. An Admission MDS (Minimum Data Set) assessment, dated 12/29/2022, indicated Resident 180 had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. Current physician orders, dated January 2023, indicated Resident 180 was receiving Hospice Care with a local hospice.	F 0684	**F684 – Quality of Care** It is the practice of this facility to ensure that hospice and the facility collaborate to develop a comprehensive hospice care plan related to communication of resident changes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 180- hospice contacted for all up to date communication for facility records. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents receiving hospice services reviewed and hospice communication binders	02/10/2023

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	A current care plan, dated 12/23/2023, indicated Resident 180 is receiving hospice services and indicated the facility would work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. During an observation, on 1/13/2023 at 10:02 A.M., (Company name) Hospice binder was noted in nursing unit for Resident 180 and was empty. During an interview, on 1/13/2023 at 10:12 A.M., CNA (certified nursing assistant) 7 indicated there is no schedule when hospice comes in to complete showers and the nurses will let us know who is on hospice. During an interview, on 1/13/2023 at 10:20 A.M., CNA (certified nursing assistant) 5 indicated Hospice provides showers in the evening but she was not sure. During an interview on 1/13/2023 at 10:22 A.M., RN (registered nurse) 6 indicated she would communicate with hospice while they are in the facility visiting the Resident or call the hospice provider. RN (registered nurse) 6 went to the nurses station and opened the Hospice binder to look for the contact information and noted the binder was empty. During an interview on 1/13/2023 at 10:25 A.M., RN (registered nurse) 6 indicated the Hospice binder should have Resident 180's information in it, such as careplans, shower schedules and information to contact Hospice. On 1/19/2023 at 10:40 A.M., the Executive Director provided the policy titled, "Hospice Services", dated 7/2020, and indicated the policy was the one		updated with all current communications in collaboration with hospice providers. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of hospice services. The Director or Nursing/Designee will audit all current hospice residents to ensure that proper communication between facility and hospice is maintained. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Hospice Communication” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved	

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	currently used by the facility. The policy indicated"...It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinate to establish both a centered plan of care refelecting the physical, spiritual, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professionals, facility staff and resident...." 3.1-37(a)		an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review and interview, the facility failed to ensure catheter care was completed appropriately for 2 of 3 residents reviewed for catheter care. (Resident 28 and Resident L) Findings include: 1. During and observation, on 1/17/2023 at 1:55 P.M., CNA 12 was observed to provide catheter care to Resident 28. The CNA washed her hands and applied gloves. A basin of water, one with soapy water and wash cloths and towels were on the bed side table. The CNA removed the tape from the sides of the resident's brief and then with a soapy wash cloth, washed the penis from the abdomen towards the meatus (opening of the penis). She then washed the catheter, by using different parts of the wash cloth washing the tube away from the penis opening. she then washed the groin area and removed her gloves. The CNA applied new gloves and used a wet wash cloth to rinse the penis and groin area by moving towards the penis tip. Without washing her hands, she applied new gloves and then turned the resident to wash his buttocks. She removed the brief, washed the buttocks and then applied new gloves and removed the bed pad from under the resident. She applied new gloves and applied a new brief	F 0690	**F690 – Bowel, Bladder Incontinence, Catheter, UTI** It is the practice of this facility to ensure catheter care is provided appropriately for all residents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 28 – appropriate catheter care was provided with no issues noted. Resident L – appropriate catheter care was provided with no issues noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents utilizing a catheter have the potential to be affected by the deficient practice. All residents utilizing a catheter have	02/10/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on the resident. During an interview, on 1/17/2023 at 2:10 P.M., CNA 12 indicated she should not have washed towards the head of the penis and should have washed her hands between changing gloves. 2. During an interview, on 1/9/2023 at 2:49 P.M., Resident L indicated staff do not clean his catheter tubing very often. A clinical record review was completed on 1/11/2023 at 10:54 P.M., and indicated Resident L's diagnoses included, but were not limited to: multisystem inflammatory syndrome, basal cell carcinoma of skin, right ear and external auricular canal, chronic kidney disease stage 4, dysphagia, malignant neoplasm of rectum, major depressive disorder, dementia, neuromuscular dysfunction of bladder, anxiety, adjustment disorder with anxiety, anemia, metabolic encephalopathy, osteomyelitis of vertebra, sacral and sacrococcygeal region, dysphagia and muscle weakness. A Significant change MDS (Minimum Data Set) assessment, dated 12/16/2022, indicated Resident L had a BIMS (Brief Interview for Mental Status) score of 12, indicating moderately impaired. Physician orders, dated 1/12/2023, indicated Resident L had a supraubic catheter. A current care plan, dated 1/27/2020, indicated Resident L had a suprapubic catheter related to a neurogenic bladder. Interventions included, but were not limited to: cleanse supra-pubic site every shift with soap and water, change catheter/bag as scheduled and prn, cover drainage bag to promote dignity/privacy, irrigate catheter as ordered, keep catheter tubing free of kinks and keep drainage		been reviewed to ensure no negative affects as result. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of catheter care and hand hygiene policies. The Director or Nursing/Designee will observe all CNAs performing catheter care to ensure appropriate care being provided. The Director of Nursing/Designee will complete catheter care skills validation with nursing staff. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Catheter Care” and “Infection Control”	

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	155689	A. BUILDING 00 B. WING	01/18/2023

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	bag below level of bladder, labs as ordered, meds as ordered, notify nurse if catheter is leaking, notify nurse if resident is incontinent of urine, observe for/document color, clarity, odor of urine, notify charge nurse of abdominal urine, observe/document signs and symptoms of UTI (urinary tract infection), treatments as ordered. During an observation, on 1/12/2023 at 1:44 P.M., CNA 9 used an alcohol wipe to clean catheter tubing and used the same alcohol wipe to clean the stoma. During an interview on 1/12/2023 at 1:52 P.M., CNA 9 indicated she should have used a new alcohol wipe to clean area and not the used one. On 1/17/2023 at 10:31 A.M.., the Administrator provided the policy titled,"Handwashing/Hand Hygiene", dated 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...5. Employees must wash their hands for twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...d. After removing gloves...." On 1/18/2023 at 3:12 P.M., the Administrator provided the policy titled, "Policies and Practices-Infection Control". The policy indicated, "...The facilities infection prevention, and control program (ICPC) is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...." On 1/17/2023 at 11:00 A.M., the Administrator provided the policy titled, "Catheter Care, Urinary", dated September 2014, and indicated the		weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	policy was the one currently being used by the facility. The policy indicated "...16. For a male resident: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the wash cloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position...20. Discard disposal items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly...." This Federal tag relates to complaints IN00399080 and IN00398585.			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the			

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	health care provider orders a therapeutic diet. Based on interview, and record review, the facility failed to ensure a resident maintained their admission weight when not on a prescribed weight loss program for 1 of 3 residents reviewed for weight loss, (Resident G). Findings include: On 1/13/2023 at 11:00 A.M., an interview with Resident G indicated she has had unplanned weight loss since admission. The resident indicated she has not had an appetite and that no one from nursing, dietary, nor the physician have talked to her about concerns they may have regarding her weight loss. The resident indicated she had not been offered any form of supplements for her weight loss. 01/13/2033 at 11:34 A.M., an interview with the Assistant Director of Nursing indicated the Interdisciplinary Team was discussing Resident G's weight loss and was going to start the resident on a dietary supplement. On 1/13/2033 at 1:30 P.M., Resident G's clinical record was reviewed. The resident's Admission Record indicated an admission date of 12/05/22 and the most recent comprehensive Minimum Data Set dated 12/12/2022 for Admission Assessment indicated Resident G had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident required supervision and setup help for eating. Diagnoses included but were not limited to diabetes, acquired absence of parts of digestive tract, femoral fracture, kidney failure, stroke, hemiplegia, and surgical wound for femoral fracture repair.	F 0692	**F692 – Nutrition/Hydration Status Maintenance** It is the practice of this facility to ensure residents maintain their admission weight when not prescribed a weight loss program. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident G – resident added to weekly risk review and dietary interventions added. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents at risk for weight loss have the potential to be affected by the deficient practice. All residents with significant weight loss reviewed to ensure that they have been added to weekly risk review and interventions appropriately added. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced	02/10/2023

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	Review of Resident G's physician's dietary orders dated 12/05/2022, indicated a reduced carbohydrate diet regular texture, thin consistency. Review of Resident G's Care Plans included but were not limited to: At risk for fluid imbalance due to diabetes type 2, hemiplegia and hemiparesis following a stroke, kidney disease, edema. Interventions included but were not limited to, diet as ordered, document intake, weights as ordered, and to notify physician of significant weight changes. At risk for complications and symptoms of hypoglycemia or hyperglycemia due to diagnosis of diabetes. Interventions included but were not limited to document meal/snack intake. Both Initiated 12/07/2022. And a potential for nutritional risk related to potential for delayed healing process secondary to diabetes type 2, chronic kidney disease, and left femur fracture. Interventions included but were not limited to, document food/fluid intakes, which was initiated on 12/12/2022. Review of the Resident G's documented weights indicated an admission weight on 12/06/2022 of 218 lbs, and on 1/04/2023 Resident G's weight was 195 lbs which indicated a 10.55 % Loss. Review of Resident G's documented meal intake percentage record from 12/16/2022 to 1/04/2023, indicated there was no meal intake documentation on the following dates: 12/17/2022 breakfast and lunch 12/19/2022 breakfast and lunch 12/20/2022 breakfast and lunch		on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of weight monitoring program. The Director or Nursing/Designee will review all weights weekly to ensure that any resident with significant weight loss are added to risk review and interventions appropriately added. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Weight Monitoring” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	12/21/2022 breakfast lunch and dinner 12/22/2022 breakfast and lunch 12/23/22 dinner 12/24/2022 breakfast lunch and dinner 12/25/2022 breakfast and lunch 12/26/2022 breakfast and lunch 12/29/2022 breakfast and lunch 12/30/2022 breakfast and lunch 12/31/2022 breakfast and lunch 1/1/2023 breakfast and lunch 1/3/2023 breakfast and lunch 1/4/2023 breakfast On 1/13/2023 at 2:00 P.M., the policy titled, Resident Weight Monitoring, dated 10/2018, was provided by the Executive Director indicating it was the current facility policy. The policy indicated, "...A weight report will be generated monthly and reviewed by the DM [Dietary Manager], RD [Registered Dietician], DNS [Director of Nursing Services], and MDS [Minimum Data Set] for significant changes. A significant weight change is defined as 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. The resident's physician and family/guardian will be notified of any verified significant weight change...." On 1/19/2023 at 1:00 P.M. the policy titled, Nutrition Assessment, dated 2001 and revised 10/2017, was provided by the Executive Director indicating it was the current facility policy. The policy indicated, "...The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident...as indicated a change in condition that places the resident at risk for impaired nutrition...multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for			

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	the resident at risk for or with impaired nutrition..." 3.1-46(a)(1)(2)			
F 0694 Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review and interview, the facility failed to change PICC (peripherally inserted central catheter) line dressings for 1 of 1 resident reviewed for intravenous antibiotic therapy (Resident 101) During an observation on 1/10/2023 at 2:26 P.M., Resident 101's PICC line dressing had a PICC line kit dated tape adhered to the clear Tegaderm with the date of 12/4/2022. The Tegaderm was observed to be rolled on the edges and not adhered around the PICC lines. A clinical record review of Resident 101 was completed on 1/13/2023 at 9:13 A.M. Diagnoses included, but were not limited to: congestive heart failure, atrial fibrillation, chronic kidney disease, and osteomyelitis. A Significant Change MDS (Minimum Data Assessment) Assessment on 12/15/2022 indicated Resident 101 was cognitively intact. He received intravenous therapy with antibiotics for 7 of 7 days of the assessment period. There was no documented rejection of care. A Care Plan on 10/4/2022 indicated Resident 101	F 0694	**F694- Parenteral/IV Fluids** It is the practice of this facility to ensure that all PICC line dressings are changed per physicians orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 101- PICC dressing changed per physician order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with dressing change orders have the potential to be affected by the deficient practice. All residents with dressing change orders reviewed and updated as appropriate.	02/10/2023

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	required intravenous antibiotics due to diabetes mellitus type 2 with a foot ulcer and wound vac, multi-drug resistant organisms, Escherichia coli, Extended Spectrum Beta-Lactamase, and vancomycin-resistant enterococci. An intervention was to change the dressing as ordered and to keep the site dry and clean. Physician Order's on 12/8/2022, indicated, to change the PICC line dressing every seven days with a sterile CVC (central venous catheter) kit and as needed for dislodgement and soilage. A Nurse's Note on 1/12/2023 at 7:30 A.M., indicated, " ...Left upper arm PICC line dressing changed using sterile technique ...." During an observation and interview on 1/13/2023 at 10:03 A.M., the PICC line dressing had a been changed. The dressing was adhered to the skin and dated 1/12/2023. Resident 101 indicated this was the first time the dressing had been changed since returning from the hospital on 12/8/2022. During an interview on 1/18/2023 at 11:07 A.M., the Assistant Director of Nursing (ADON) indicated, the PICC line dressing was to be changed every seven days. When the observed date of the PICC line dressing was verbalized to the ADON, she replied, "That is not okay." A review of the Medication Administration Record indicated that nursing had signed the PICC line dressings were changed on 1/1/2023, 1/8/2023, 1/15/2023 and as needed on 1/12/2023. The ADON indicated the nurses had signed off on the dressing change and did not complete the dressing change. On 1/18/2023 at 3:12 P.M., the Executive Director provided a policy titled, "PICC/Midline/CVAD		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of PICC and dressing changes and following physician orders. The Director or Nursing/Designee will review all residents with orders for dressing changes to ensure that dressings are being changed per physician orders. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Dressing Change QAPI" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality	

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	[central venous access device] Dressing Change". The policy indicated, " ...It is the policy of this facility to change peripherally inserted central catheter (PICC), midline or central access device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician orders will specify type of dressing and frequency of changes ...." 3.1-47(a)(2)		Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on Observation, record review and interview, the facility failed to maintain oxygen equipment and non-invasive respiratory mechanical devices in a sanitary manner for 2 of 4 residents reviewed for oxygen use. (Resident 44 and 279) Findings include; 1. During an observation, on 1/10/2023 at 10:17 A.M., Resident 44's oxygen tubing was undated, hanging over the trash can and on the floor. During an observation, on 1/11/2023 at 9:21 A.M., Resident 44's oxygen tubing was undated, and under a pile of dirty clothes.	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** It is the practice of this facility to ensure that oxygen equipment and non-invasive respiratory mechanical devices are stored in a sanitary manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 44 – oxygen tubing	02/10/2023

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	A clinical record review was completed on 1/11/2023 at 2:40 P.M., and indicated Resident 44's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, hypoxemia, heart failure, obstructive sleep apnea, chronic atrial pulmonary edema, pleural effusion, chronic pulmonary edema, chronic atrial fibrillation, polyosteoarthritis, insomina, visual hallucinations, benign prostatic hyperplasia, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and mesothelioma. A 5 day MDS (Minium Data Set) assessment, dated 1/6/2023, indicated Resident 44 had a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition. A current careplan, dated 9/28/2022, indicated Resident 44 is at risk for respiratory distress related to chronic obstructive pulmonary disease, sleep apnea, chronic respiratory failure with hypoxia, pleural effusion, and chronic pulmonary edema. Physician's orders, dated January 12, 2023, indicated Resident 44 was receiving 02 at 2 liters via NC (nasal cannula) continuous and to change and date 02 tubing, humidifier and bag weekly every night shift on Sunday. During an interview, on 1/11/2023 at 11:18 A.M., RN 6 indicated 02 tubing should be changed weekly, dated and not be laying on the floor. 2. During an observation on 1/9/2023 at 11:11 A.M., Resident 279's BiPap (bilevel positive airway pressure) mask was observed hanging		changed and labeled/dated and stored appropriately. Resident 279 – bipap accessories changed and labeled/dated appropriately and order received and carried out for cleaning of bipap. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents utilizing respiratory devices have the potential to be affected by the deficient practice. All residents utilizing respiratory devices have been reviewed for order accuracy and observed to ensure appropriate labeling and dating of accessories and storage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of oxygen administration and cpap/bipap cleaning. The Director or Nursing/Designee will review all residents with orders for respiratory devices to ensure that all orders are accurate and	

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	over the machine on the bedside table. On 1/10/2023 at 10:16 A.M., the BiPap mask was observed lying on the bedside table. The equipment did not have any indication of a date attached to the changeable equipment (mask, headgear, or tubing). A clinical record review was completed on 1/12/2023 at 11:39 A.M. Diagnoses included, but were not limited to: urinary tract infection, chronic respiratory failure, congestive heart failure, obstructive sleep apnea, and history of MRSA (Methicillin-resistant Staphylococcus aureus) infection. An Admission MDS Assessment indicated Resident 279 did not have any special treatments. Resident 279 had moderate cognitive impairment. A review of Resident's 279's Physician's Orders indicated a BiPap order in cue, but not activated. The Physician Order's did not include cleaning of BiPap equipment or changing the BiPap equipment. A Care Plan on 1/5/2023, indicated Resident 279 as at risk for respiratory distress. An intervention included BiPap as ordered. During an interview on 1/18/2023 at 11:00 A.M., the Assistant Director of Nursing indicated the BiPap mask, tubing, headgear, and water reservoir should be cleaned daily. She indicated a contracted company comes into the facility to maintain the changing of masks, tubing, headgears, water reservoir and filters. The ADON indicated the since the BiPap order was in the cue for orders, the ancillary orders for maintenance were not completed. She indicated the mask		observe all devices to ensure all accessories are labeled/dated, stored, and cleaned approrpiately. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Respiratory” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	should be stored when not in use in a respiratory bag. On 1/17/2023 at 10:31 A.M.., the Administrator provided the policy titled,"Handwashing/Hand Hygiene", dated 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...5. Employees must wash their hands for twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...d. After removing gloves...." On 1/18/2023 at 3:12 P.M., the Administrator provided the policy titled, "Policies and Practices-Infection Control". The policy indicated, "...The facilities infection prevention, and control program (ICPC) is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...." On 1/18/2023 at 1/18/2023, The Administrator provided the policy, "CPAP/BiPap Cleaning". The policy indicated, "...6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use....7. Weekly cleaning acticity (specify day of week): a. Wash headgear/straps in warm soapy water and air dry. b. Wash tubing with warm, soapy water a nd air dry...8. Follow manufacturer instructions for the frequency of cleaning/replacing filters a nd servicing the m achine. Only the supplier may service the machine...10. Replace equipment routinely i n accordance with manufacturer recommendations. General guidelines: a. Face m ask and tubing--once every three months, b. Headgear, non-disposible filters, and			

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	humidification chamber--once every six months, c. Disposible filters--twice monthly...." 3.1-18(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a resident did not receive unnecessary antibiotics for 1 of 6 residents reviewed for urinary tract infections. (Resident 279) Finding includes: During an initial interview on 1/10/2023 at 10:22	F 0757	**F757 – Drug Regimen is Free from Unnecessary Drugs** It is the practice of this facility to ensure that residents do not receive unnecessary antibiotics. **What corrective action(s) will be accomplished for those residents found to have been**	02/10/2023

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	A.M., Resident 279 indicated she had a urinary tract infection. A clinical record review was completed on 1/12/2023 at 11:39 A.M. Diagnoses included, but were not limited to: urinary tract infection, chronic respiratory failure, congestive heart failure, obstructive sleep apnea, and history of MRSA (Methicillin-resistant Staphylococcus aureus) infection. An Admission MDS Assessment on 1/6/2023, indicated Resident 279 was frequently incontinent of bladder and always incontinent of bowel. She was dependent with two or more staff members for toileting. A Nurse's Note on 1/8/2023 at 6:07 P.M., indicated, " ...Resident has had mild confusion for two days; primarily in the morning. Urine dipstick positive for blood, leukocytes, {and} nitrite. NP [Nurse Practitioner] notified. Urine sent to [hospital name] lab for UA with C&S [urinalysis with culture and sensitivity]. New orders for oral antibiotic received ...." On 1/9/2023 at 7:29 A.M., a Nurse's Note indicated, " ...Call placed to [hospital lab name] and requested culture and sensitivity be added on to UA [urinalysis] results. New order faxed to lab ...." A Physician's Order on 1/9/2023, indicated, Macrobid 100 mg (milligrams) one capsule by mouth two times a day for urinary tract infection for ten days. On 1/10/2023, a Physician's Order indicated, ceftriaxone one gram intramuscularly daily for three days for a urinary tract infection.		**affected by the deficient practice:** Resident 279 – antibiotic has been discontinued. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All residents receiving antibiotics have been reviewed to ensure antibiotic usage meets criteria. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of antibiotic stewardship program. The Director or Nursing/Designee will review all residents with orders for antibiotics to ensure that all antibiotic usage meets criteria. **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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	A laboratory result was received on 1/12/2023. The urinalysis with culture and sensitivity indicated mixed genital flora isolated. The bacteria were not indicative of a urinary tract infection. During an interview on 1/18/2023 at 1:51 P.M., the Assistant Director of Nursing (ADON) indicated, an antibiotic should be discontinued when it is discovered an infection is not present. The ADON indicated Resident 279 was still being administered the Macrobid when the culture was received on January 12th. On 1/18/2023 at 3:12 P.M., the Executive Director provided a policy titled, "Antibiotic Stewardship". The policy indicated, " ...1. The purpose of our Antibiotic Stewardship Program I s to monitor for the use of antibiotics in our residents ...11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued ...." 3.1-48(a)(6)		**into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Antibiotic Therapy" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and			

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	(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to complete a gradual dose reduction for a	F 0758	**F758 – Free from Unnecessary Psychotropic Meds/PRN Use**	02/10/2023

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	resident receiving psychotopic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 46) Finding includes: A clinical record review was completed on, 1/11/2023 at 10:53 A.M. Resident 46's diagnoses included, but were not limited to: chronic respiratory failure, Parkinson's disease, diabetes, obesity, Schizoaffective disorder, Bipolar, anxiety, depression and dementia. A Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/2022, indicated Resident received antipsychotic, antianxiety, and antidepressant medications routinely. No GDR was documented. A Quarterly MDS, dated 9/27/2022, indicated the resident had received the same medications. No GDR was completed due clinically contraindicated, dated 8/22/22. A Quarterly MDS, dated 12/21/2022, indicated Resident 46 had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. Received antipsychotic, antianxiety, and antidepressant medications and had no GDR (gradual does reductions) completed. A current care plan, dated 5/3/2019, indicated the resident uses an antidepressant medication related to Major Depressive Disorder. Interventions included, but were not limited to: Give antidepressant medications ordered by physician. Periodically review medication for effectiveness and possible reduction, changing or dc'ing.		It is the practice of this facility to ensure all residents receiving psychotropic medications have a gradual dose reduction completed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 46 – gradual dose reduction completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents utilizing antipsychotic medications have the potential to be affected by the deficient practice. All residents utilizing antipsychotic medications have been reviewed for gradual dose reduction accuracy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Director of Nursing or Designee and will include a review of psychotropic medication management and antipsychotic	

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	A current care plan, dated 8/11/2020, indicated the resident was at risk for signs and symptoms of anxiety/depression related to anxiety, depression, bipolar, and panic. Interventions included but were not limited to: Realize the resident has had ongoing difficulty during attempts to reduce psychoactive medication, particularly Klonopin/anti-anxiety medication. Carefully consider potential risks vs. potential benefits of dose reductions/GDRs prior to implementing. A Physicians' Order, dated 8/10/2020, included Doxepin (antidepressant) 50 mg (milligram) every night for depression from, 8/10/2020 to 1/18/2023. A Physician Recommendation Form, initiated on 2/28/2022, indicated the antidepressant is due for an evaluation for continued use. Doxepin 50 mg every day (Semi Annual review). The Nurse Practitioner indicated further use of the medication due to: discontinuation likely will be harmful to resident and/or others or it will disrupt their provision of care. The clinical record lacked the documentation to show a trial dose reduction had been tried on the Doxepin since 2020. A Physicians' Order, dated 5/10/2019, indicated the resident had received Klonopin 0.5 mg three times a day for anxiety. On 9/6/2019, a Physicians' Order was to decreased the Klonopin to 0.5 mg twice a day until 9/26/2019. On 9/26/2019 a new order was written to increase the Klonopin to 0.5 mg every 8 hours and is currently being administered. The clinical record lacked the documentation to show a trial dose reduction had been tried on the		medication use. The Director or Nursing/Designee will review all residents receiving antipsychotic medications to ensure that gradual dose reductions have been completed as appropriate. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Antipsychotic Medication Care Audit" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	Klonopin since 2019. A Physicians' Order, dated 1/28/2021, indicated Resident 46 was to receive Sertraline (antidepressant) 50 mg every day for depression. The clinical record lacked the documentation to show a trial dose reduction had been tried on the Zoloft since 2021. A Physicians' Order, dated 1/21/202, indicated the resident was to receive Seroquel (antipsychotic) 100 mg every day for Bipolar and Schizoaffective disorder. A Note to Attending Physician/Prescriber, printed 8/8/2022, indicated: The resident is receiving: Quetiapine ER (Seroquel) 100 mg every evening. Doxepine 50 mg every night. Sertraline 50 mg every day and Klonopin 0.5 mg every 8 hours. Please consider reducing at this time Quetiapine ER (Seroquel) 50 mg every evening if able or document as clinically contraindicated. The form, signed on 8/22/2022 by the Nurse Practitioner, indicated the Physician/Prescriber disagreed with the recommendation and documented: reduction is likely to increase distressed behaviors. A review of Resident 46's behavior documentation showed a behavior was documented on 12/272022 at 4:24 A.M., 12/29/2022 at 5:57 A.M., 1/42023 at 5:56 A.M., 1/13/2023 at 5:59 A.M., and on 1/14/2023 at 5:59 A.M. The form did not indicate what behavior the resident had. During an interview, on 1/17/2023 at 11:53 A.M., the Administrator indicated there were no other papers from the pharmacy, and they probably kept the medications the same because he was stable:			

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	he does not have any behaviors. During an interview, on 1/17/2023 at 1:40 P.M., the ADON indicated previously the facility had completed the Behavioral Health Meeting review for residents who were on the psych med's. During an interview, on 1/19/23 at 10:14 A.M., the ADON indicated the medications should have been tried for a GDR. On 1/13/2023 at 2:47 P.M., the Administrator provided the policy titled,"Antipsychotic Medication Use", dated 2016, and indicated the policy was the one currently used by the facility. The policy indicated"...Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review...." On 1/17/2023 at 11:00 A.M., the Administrator provided the policy titled," Psychotropic Management", dated September 2020, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility will initiate a request for a Gradual Dose Reduction (GDR) at least on the following schedule for each drug: For residents who use antipsychotic medication a GDR must be initiated per the following guidelines..after the first year, a GDR must be attempted annually unless clinically contraindicated by the physician/NP... For residents who use anxiolytic medications a GDR must be initiated per the following guidelines: After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician/NP... For resident who use antidepressant medications a GDR must be initiated per the following guidelines: ...After first year, a GDR must be attempted annually unless			

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	clinically contraindicated by the physician/NP...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications/treatments were kept in locked carts when unattended, failed to ensure medication storage areas were free from loose medications; failed to have medications labeled; failed to date medications when opened; and	F 0761	**F761 – Label/Storage Drugs and Biologicals** It is the practice of this facility to ensure that all medication/treatment carts are kept locked when unattended, that	02/10/2023

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	failed to destroy medications that were discontinued /refused or the resident had been discharged and no longer being used during medication storage reviews for 1 of 2 medication rooms observed and 3 of 5 medication carts observed. (Dogwood Medication carts, Birch Medication carts and med room, and Cedar treatment cart.) Findings include: 1. During a random observation, on 1/11/2023 at 4:50 A.M., 3 of 3 medication carts on the Dogwood hall were unlocked and unattended. During an interview, on 1/11/2023 at 4:55 A.M., LPN (Licensed Practical Nurse) 13 indicated the medications carts should have been locked. 2. During a medication observation, on 1/11/2023 at 5:01 A.M., LPN 14 left the medication cart on Birch hall unlocked when going into a residents room to administer a residents medication. During an interview, on 1/11/2023 at 5:04 A.M., LPN 14 indicated the medication cart should have been locked. 3. During a random observation, on 1/11/2023 at 5:26 A.M., the treatment cart on the Cedar hall was unlocked and unattended. During an interview, on 1/11/2023 at 5:27 A.M., QMA (Qualified Medication Aide) 15 indicated the treatment cart should have been locked. 4. During a medication observation, on 1/11/2023 at 6:30 A.M., the right Birch hall medication cart was observed to have a soufflé cup with different pills in it was in the top drawer. RN 16 indicated		loose medications are properly destroyed, that all medications opened are properly dated, and that all discontinued/refused medications are properly destroyed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All medication carts, treatment carts, and medication rooms have been audited by pharmacy to ensure compliance. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All medication carts, treatment carts, and medication rooms have been audited by pharmacy to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the	

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	she had pulled them out earlier and forgot to give them to the resident. She indicated the medications should not have been in the medication cart. 5. During a medication storage observation, on 1/12/2023 at 10:58 A.M., in the med room on the Birch Hall with LPN 17, the following were observed: a plastic bin with 4 insulin pens without resident labels. One individual pill package for Resident 32, dated 7/5/2022. A box of Lice killer with no label. Ten Acetaminophen 650 mg (milligram) suppositories for a resident who expired on 7/3/2022, and for a resident who was discharged from the facility on 11/23/2022. A medication card with 28 yellow round pills with the label removed and no resident identifiers. A medication card with 29 red oblong pills with no label or resident identifiers. An opened box of Metoprolol (heart medication) for a resident who expired on 4/30/2022. In another bin was 12 bottles of different medications for Resident 46. LPN 17 indicated they were waiting on the family or the VA to either send back or pick up. An opened box with 15 Nexium packets for Resident 71, that had dc (discontinue) after 7/5/2022. An opened undated bottle of Mira lax for Resident 9. An opened vial of Aplisol (tuberculin serum) dated 9/6/2022, and another opened vial of Aplisol with no opened date. An opened bottle of Mintox (stomach acid) with the label removed. A box of Albuterol (inhalation medication) for a resident who was discharge on 2/10/2022. A bottle of Ferrous Sulfate (iron) for a resident that was discharged on 11/23/2022. Two Glucagon (insulin) pens for a resident who expired on 9/16/2022. A Glucagon (insulin) pen for a resident who expired on 8/7/2022, and 1 insulin pen for another resident		Director of Nursing or Designee and will include a review of storage of medications, labeling of medication containers, and discarding and destroying medications. The Director or Nursing/Designee will review pharmacy audit of medication carts, treatment carts, and medication rooms to ensure facility remains in compliance. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Medication/Treatment Cart & Medication Room Audit" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be**	

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	who expired on 11/11/2022. A bottle with 8 different pills in it, with the label of Cephalexin (antibiotic) 1 x 7 days discontinue on 3/29/2021 for Resident 15. An opened bottle of Stomach Relief liquid for a resident who expired on 11/8/2022, and a box of Ipratropium (inhalation medication) for a resident who was discharged on 5/30/2022. 6. During a medication storage observation, on 1/12/2023 at 11:30 A.M., on the Left med cart for Birch hall the cart had 3 loose pills in 2 drawers. During an interview, on 1/12/2023 at 11:37 A.M., RN 19 indicated the pills should not be loose in the med cart. 7. During a medication storage observation, on 1/12/2023 at 1:32 P.M., on the Dogwood middle hall cart with RN 19, the following were observed: Two (2) Doxycycline (antibiotic)100 mg (milligram) pills in individual packages with no name or resident identifiers. An opened and undated bottle of MOM (Milk of Magnesia). An opened box of Chlora-septic drops with no label or resident identifiers. An opened box of Ipratropium for a resident that was discharged on 1/2/2023. An opened and undated bottle of Docusate Sodium (laxative) for Resident 110. During an interview, on 1/12/2023 at 1:38 P.M., RN 19 indicated the individual pills should not be in the med cart, the opened medications should have a date opened, the medications should have a label and the medication for the discharged residents should be out of the medication cart. 8. During a medication storage observation, on 1/12/2023 at 2:26 P.M., with LPN 20 on the right hall Birch unit medication cart the following was observed: an opened bottle of Equate allergy relief		**completed: 02/10/2023** Compliance Date = 02/10/2023	

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	tablets with no label. An opened bottle of Hair/Nails/Skin 5000 mg Biotin with no label or resident identifiers. An opened bottle of Sentry Senior (vitamins) with no label or resident identifiers. An opened and undated bottle of MOM. A container of Hemp/Vana cream in with the oral medications. Two loose pills in 2 drawers. During an interview, on 1/12/2023 at 2:33 P.M., LPN 20 indicated the opened med's should have a date opened, the medications should be labeled, there should be no loose pills in the medication cart. On 1/13/2023 at 9:15 A.M., the Administrator provided the policy titled," Storage of Medications", dated November 2020, and indicated the policy was the one currently used by the facility. The policy indicated"...1. Drugs and biological's used in the facility are stored in locked compartments under proper temperature, light and humidity controls. ...3. The nursing staff is responsible for maintaining medication storage and preparation areas is a clean, safe, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed. ...6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's are locked when not in use. Unlocked medication carts are not left unattended...." On 1/13/2023 at 9:15 A.M., the Administrator provided the policy titled, "Labeling of Medication Containers", dated April 2019, and indicated the policy was the one currently used			

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	by the facility. The policy indicated..."1. Medication labels must be legible at all times. 2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. 3. Labels for individual resident medications include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use... 6. Labels for over-the-counter drugs include all necessary information, such as: a. The original label indicating the name, strength, and quantity of the medication; b. The expiration date when applicable: and c. Directions for use and appropriate accessory/cautionary statements. 7. Only the dispensing pharmacy can label or alter the label on a medication container or package...." On 1/13/2023 at 9:15 A.M., the Administrator provide the policy titled," Discarding and Destroying Medications", dated April 2019, and indicated the policy was the one currently used by the facility. The policy indicated"...2. Non-controlled and Schedule V (non- hazardous) controlled substance will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications...." 3.1-25(j)(m)(q)(r)			
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to provide a sanitary refrigerator and food storage for the residents' nutrition needs in 3 of 3 pantries observed. (Halls 100, 200, 300) Findings include: 1. During an observation, on 1/12/2023 at 2:30 P.M., the 100-unit nutrition pantry freezer had a dried substance in the bottom and a lower cabinet had a sticky orange spill on the bottom shelf. 2. The 200-unit freezer had a spill on the bottom. There was also a coat in the lower cabinet. 3. The microwave on the 300-unit had a dried	F 0812	**F812 – Food Procurement, Store/Prepare/Serve - Sanitary** It is the practice of this facility to provide a sanitary refrigerator and food storage for the residents nutrition needs. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 100 hall – freezer and cabinets cleaned 200 hall – freezer and cabinets cleaned 300 hall – microwave cleaned	02/10/2023

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	brown liquid spilled on the plate. During an interview, on 1/12/2023 at 2:38 P.M., the Dietician indicated the spills should have been cleaned up and coats should not be stored in the nutrition pantry. On 1/13/2023 at 2:00 P.M., the Administrator provided a policy titled, "Refrigerators and Freezers", dated November 2014. The policy indicated " ...Refrigerators and freezers will be kept clean, free of debris, and mopped with a sanitizing solution on a scheduled basis and more often as necessary ...." 3.1-21(i)(3)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All resident pantries audited and cleaned appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 1/31/23. This in-service will be conducted by the Executive Director or Designee and will include a review of resident pantries and refrigerator and freezer cleaning. The Executive Director/Designee will audit all pantries to ensure all are cleaned as appropriately. **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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance	

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			Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled "Nourishment Pantry Observation" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee stating date. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at	F 9999	**F9999 – Final Observations, Personnel** It is the practice of this facility to ensure that all employee files contain health examinations. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** RN 6 – health examination provided and in employee record RN 23 – health examination provided and in employee record CNA 24 – health examination	02/10/2023

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	least annually thereafter, employees and non pain personnel of facilities shall be screened for tuberculosis. For health care workers who have had a documented negative tuberculin skin test result during the proceeding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employee files were complete with health examinations for 5 of 10 employees whose records were reviewed. RN 6, Staff Development RN 23, CNA (Certified Nursing Assistant) 24, housekeeper 26, and CNA 27. Findings include: On 1/18/2023 at 10:30 A.M., employee files were reviewed and the following was noted: 1. RN 6's start date in the facility was 12/9/2022. The employee file lacked the documentation to show a physical exam had been completed prior to starting. A Post-Offer Physical Form indicated: date of offer: 12/1/2022, Date of Physical 12/5/2022. I {name of RN)} understand that I have received a conditional offer of employment with {name of facility} that is contingent upon receipt of the results of a post offer physical examination designed solely to determine my physical fitness to perform the essential job duties of the position that I have been offered. Accordingly, I voluntarily consent to a post offer physical examination conducted at the request of and paid		provided and in employee record Housekeeper 26 – health examination provided and in employee record CNA 27 – health examination provided and in employee record **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Human Resource Director will be in-serviced on or before 1/31/23. This in-service will be conducted by the Executive Director or Designee and will include a review of employee records and requirements. The Executive Director will review all employee records to ensure that all employees have an appropriate health examination and it is present in the employee record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	for by the company. I may also provide the examiner with additional information related to my ability to perform the duties of the position. I understand that I may ask questions of the examiner and may also stop the examination at any time. I understand that if I fail to complete the examination or do not authorize the results to be released to the company within one calendar weeks (7 days) of the date of the conditional job offer, the job offer may be withdrawn. Purpose of the post- offer physical exam is designed to safely assess your physical abilities to meet the physical demands of the position offered, as some positions require significant physical effort. The form was initialed on the Nurse Practitioner/Medical Director Signature and dated 12/5/2022, and documented Reviewed/Approved. 2. The Staff Development/RN 3's start dated was 11/28/2022. The employee file lacked the documentation to show a physical exam had been completed prior to starting. A Post-Offer Physical Form indicated: date of offer: 11/30/2022, Date of Physical 11/30/2022. I {name of RN} understand that I have received a conditional offer of employment with {name of facility} that is contingent upon receipt of the results of a post offer physical examination designed solely to determine my physical fitness to perform the essential job duties of the position that I have been offered. Accordingly, I voluntarily consent to a post offer physical examination conducted at the request of and paid for by the company. I may also provide the examiner with additional information related to my ability to perform the duties of the position. I understand that I may ask questions of the examiner and may also stop the examination at any time. I understand that if I fail to complete the examination or do not authorize the results to be released to the company within		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled "Employee Records Checklist" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 02/10/2023** Compliance Date = 02/10/2023	

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	one calendar weeks (7 days) of the date of the conditional job offer, the job offer may be withdrawn. Purpose of the post- offer physical exam is designed to safely assess your physical abilities to meet the physical demands of the position offered, as some positions require significant physical effort. The form was initialed on the Nurse Practitioner/Medical Director Signature and dated 11/30/2022, and documented Reviewed/Approved. 3. CNA 24's start date in the facility was 1/6/2015. The employee file lacked the documentation to show a physical exam had been completed prior to starting. A Post-Offer Physical Form indicated: date of offer: 10/14/2022. Date of Physical 10/24/2022. I {name of CNA} understand that I have received a conditional offer of employment with {name of facility} that is contingent upon receipt of the results of a post offer physical examination designed solely to determine my physical fitness to perform the essential job duties of the position that I have been offered. Accordingly, I voluntarily consent to a post offer physical examination conducted at the request of and paid for by the company. I may also provide the examiner with additional information related to my ability to perform the duties of the position. I understand that I may ask questions of the examiner and may also stop the examination at any time. I understand that if I fail to complete the examination or do not authorize the results to be released to the company within one calendar weeks (7 days) of the date of the conditional job offer, the job offer may be withdrawn. Purpose of the post- offer physical exam is designed to safely assess your physical abilities to meet the physical demands of the position offered, as some positions require significant physical effort. The			

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	form was initialed on the Nurse Practitioner/Medical Director Signature and dated 10/14/2022, and documented Reviewed/Approved. 4. Housekeeper 26's start date in the facility was 11/23/2022. The employee file lacked the documentation to show a physical exam had been completed prior to starting. A Post-Offer Physical Form indicated: date of offer: 11/10/2022. Date of Physical: No date was documented. I {name of housekeeper} understand that I have received a conditional offer of employment with {name of facility} that is contingent upon receipt of the results of a post offer physical examination designed solely to determine my physical fitness to perform the essential job duties of the position that I have been offered. Accordingly, I voluntarily consent to a post offer physical examination conducted at the request of and paid for by the company. I may also provide the examiner with additional information related to my ability to perform the duties of the position. I understand that I may ask questions of the examiner and may also stop the examination at any time. I understand that if I fail to complete the examination or do not authorize the results to be released to the company within one calendar weeks (7 days) of the date of the conditional job offer, the job offer may be withdrawn. Purpose of the post- offer physical exam is designed to safely assess your physical abilities to meet the physical demands of the position offered, as some positions require significant physical effort. The form was initialed on the Nurse Practitioner/Medical Director Signature and dated 11/23/2022, and documented Reviewed/Approved. 5. CNA 27's start date in the facility was 11/9/2022. The employee file lacked the documentation to show a physical exam had been			

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	completed prior to starting. A Post-Offer Physical Form indicated: date of offer: 11/11/2022. Date of Physical 11/11/2022. I {name of CNA} understand that I have received a conditional offer of employment with {name of facility} that is contingent upon receipt of the results of a post offer physical examination designed solely to determine my physical fitness to perform the essential job duties of the position that I have been offered. Accordingly, I voluntarily consent to a post offer physical examination conducted at the request of and paid for by the company. I may also provide the examiner with additional information related to my ability to perform the duties of the position. I understand that I may ask questions of the examiner and may also stop the examination at any time. I understand that if I fail to complete the examination or do not authorize the results to be released to the company within one calendar weeks (7 days) of the date of the conditional job offer, the job offer may be withdrawn. Purpose of the post- offer physical exam is designed to safely assess your physical abilities to meet the physical demands of the position offered, as some positions require significant physical effort. The form was initialed on the Nurse Practitioner/Medical Director Signature and dated 11/11/2022, and documented Reviewed/Approved. On 1/17/2023 at 10:31 A.M., the Administrator provided the policy titled,"Personnel Records", dated January 2008, and indicated the policy was the one currently used by the facility. The policy indicated"...1. Federal and state regulations require that our facility maintain an individual personnel record for each employee. However, it shall be the employee's responsibility to provide the HR director with the required data. This responsibility also entails notifying, in writing, the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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
	HR Director of any changes in the required data (i.e., the employee is responsible for keeping the required data current.). 2. Should it become necessary for an employee to furnish additional data or records, the employee will be notified in writing by the HR Director, and such data must be completed and provided to the HR Director within the time frame specified on the written notice...." During an interview on 1/17/2023 at 11:28 A.M., the Administrator indicated the Post - Offer Physical Form was the only form the facility uses for the employee physicals.			