| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155695 | A. BUILDING 00<br>B. WING | 10/05/2022 |

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| RIVERSIDE VILLAGE | 1400 W FRANKLIN ST<br>ELKHART, IN 46516 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00385789, IN00383978 and IN00387884.<br><br>Complaint IN00385789- Substantiated. Federal deficiency related to the allegations are cited at F677.<br><br>Complaint IN00383978-Unsubstantiated due to lack of evidence.<br><br>Complaint IN00387884-Unsubstantiated due to lack of evidence.<br><br>Survey dates: September 28, 29, 30 and October 3, 4 and 5, 2022<br><br>Facility number: 003075<br>Provider number: 155695<br>AIM number: 200364160<br><br>Census Bed Type:<br>SNF/NF: 73<br>Total: 73<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 52<br>Other: 17<br>Total: 73<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 10/20/2022. | 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 relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after 11/14/22. | |

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

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| F 0567<br>SS=D<br>Bldg. 00 | 483.10(f)(10(i)(ii)<br>Protection/Management of Personal Funds<br>§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.<br>(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.<br>(ii) Deposit of Funds.<br>(A) In general: Except as set out in paragraph (f)( l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do | | | |

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| | not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.<br>Based on record review and interview, the facility failed to ensure residents are able to withdrawal more than $5.00 of their money for 1 of 1 residents reviewed for personal funds. (Resident B)<br><br>Finding includes:<br><br>During an interview, on 9/29/2022 at 9:51 A.M., Resident B indicated she was only allowed to take $5.00 of her money out at a time.<br><br>A clinical record review was completed on 10/03/2022 at 9:54 A.M. Resident B's diagnoses included, but were not limited to: anemia, hypertension, cerebral vascular accident, diabetes and hemiparesis.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 8/1/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating her cognition was intact.<br><br>During an interview, on 10/04/2022 at 2:16 P.M., the Business Office Manager indicated the residents will ask at the front desk and they will direct them to the 300 hall nurse to withdrawal their money. There is a sheet that is updated every week to indicate how much money each resident has in their account. The locked box will usually have only $20.00 in it. Every resident is allowed $50.00 a month, and if that particular resident had $50.00 in their account, they should be able to take out that amount. They can take the full amount and should always have access to their fund.<br><br>On 10/5/2022 at 2:45 P.M., the Administrator | F 0567 | **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident B has been informed of the increase of funds available to access 24 hours per day, 7 days per week.<br>**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:**<br>All residents have the potential to be impacted by this deficient practice. The facility has posted information to inform on how and where to access funds. Resident Council will be educated on the increase of funds available to access 24 hours per day, 7 days per week on or before 11/14/22.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Posting has been placed in Resident common area advising of how and where to access funds. All staff will be in serviced on procedure on or before 11/14/22.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | 11/14/2022 |

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| | provided the policy titled," Resident Trust Funds Policy", dated 2/2019, and indicated the policy was the one currently used by the facility. The policy indicated"...Residents will have funds available from the resident trust account during the day and during evenings and weekends... 2. A petty each fund will be maintained at a designated nurse's station in the evening and on weekends. 3. The amount of cash will be determined by the Executive Director and Business Office Manager of each facility. Effect of Non-Compliance: Lack of compliance can result in potential negative outcomes or deficiencies cited by State or Federal Surveyors...."<br><br>3.1-6(b) | | **assurance program will be put into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Residents Rights “ weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |
| F 0636<br>SS=D<br>Bldg. 00 | 483.20(b)(1)(2)(i)(iii)<br>Comprehensive Assessments & Timing<br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§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 instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine. | | | |

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| | (iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(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.<br><br>§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.<br>(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 | | | |

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| | facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>Based on observation, record review and interview, the facility failed to ensure 1 of 2 residents reviewed for bladder incontinence was thoroughly assessed for bladder incontinence. (Resident 8)<br><br>Findings include:<br><br>During an observation of Resident 8's room, conducted on 9/29/2022 at 1:12 P.M., the resident's room was noted to have a very strong urine odor. Resident 8 indicated he toileted himself.<br><br>The clinical record for Resident 8 was reviewed on 9//28/22 at 3:00 P.M. Resident 8 was admitted with diagnoses, including but not limited to: status post intracapsular fracture of the right femur, fracture of the sacrum, end stage renal disease, hypertensive chronic kidney disease with stage 5, muscle weakness, dependence on renal dialysis and history of falling.<br><br>The Admission MDS (Minimum Data Set) assessment, completed on 9/20/2022, indicated the resident required limited assistance for wheelchair locomotion and toilet use. The assessment indicated the resident was occasionally incontinent of his bladder.<br><br>The care plan, noted on 9/28/2022, related to incontinence, indicated the resident required assistance for am/pm care, nutrition, hydration and elimination. The intervention related to elimination was to document elimination in point of care (electronic charting system) every shift. | F 0636 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident 8 no longer resides at facility.<br>**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:**<br>All residents have the potential to be affected by this finding. IDT team to conduct an audit of new admissions in the last 30 days to verify the IDT Bladder Continence Review has been completed. Any resident identified as a concern will have a IDT Bladder Continence Review.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Nursing staff will be in-serviced on or before 11/14/22. This in-service will be conducted by the DNS/Designee and will include review of the facility policy, Bowel and Bladder Program Policy. | 11/14/2022 |

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| | A bladder incontinence assessment could not be located in the clinical record for Resident 8.<br><br>Further review of the clinical record for Resident 8, conducted on 9/30/2022 at 11:00 A.M. indicated the care plan regarding bladder incontinence and toileting needs had been updated. The updated care plan indicated the resident was to be offered to toilet upon rising, before and after meals and prior to bed and as needed throughout the night. The plan also indicated the resident preferred to have an urinal at bedside.<br><br>During an interview with the Regional Director of Clinical Service, conducted on 9/30/2022 at 3:20 P.M., she indicated a bladder incontinence assessment had not been completed for Resident 8.<br><br>Resident 8 was discharged home from the facility on 9/30/2022 at 9:30 A.M.<br><br>Review of the facility policy and procedure, titled, "Bowel and Bladder Program" provided by the Regional Director of Clinical Services, on 10/5/2022 at 2:15 P.M., included the following: "...each resident will be assessed at admission regarding continence status and whenever there is a change in urinary tract function. The following areas will be considered during the assessment process: Prior history of bladder/bowel function, medications that may effect (sic) continence. patterns of fluid intake, use of urinary tract stimulants, functional and cognitive abilities, type and frequency of physical assistance needed, pertinent diagnoses that could effect (sic) function, potential complications related to incontinence, tests or studies (post-void residuals, urine cultures) and environmental factors restricting access to the | | **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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tool related to the Bladder Program for 4 weeks and weekly for at least 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.<br>**By what date the systemic changes will be completed:**<br>Compliance date: 11/14/22 | |

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| | toilet...."<br><br>3.1-31(d) | | | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for | | | |

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| | 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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>Based on observation, record review and interview, the facility failed to ensure a care plan regarding constipation was implemented for 1 of 1 residents reviewed for constipation. (Resident 38)<br><br>Finding includes:<br><br>Resident 38 was observed, on 9/28/2022 at 12:30 P.M., seated in a wheelchair in the dining room on the secured memory care unit of the facility. The resident was able to feed himself but indicated he was not very hungry. The resident was noted to be very thin.<br><br>During an interview with Resident 38's health care representative, it was disclosed the resident had issues with constipation which irritated his hemorrhoid issues.<br><br>The clinical record for Resident 38 was reviewed on 9/29/2022 at 11:30 A.M. Resident 29 had diagnoses, including but not limited to: Alzheimer's disease, late onset, emphysema, mixed incontinence, constipation, hemorrhoids and history of falling.<br><br>The most recent Minimum Data Set (MDS) assessment,, completed for a quarterly review on 8/8/2022 indicated the resident was frequently incontinent of his bowels and required extensive staff assistance of one for toileting needs. | F 0656 | What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the residents' goals and preferences. The care plans for Resident 38 have been reviewed and updated to include a care plan for constipation.<br>**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:**<br>All residents have the potential to be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans related to constipation will be completed and updated appropriately.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Comprehensive Care Plan reviews will be completed for all residents | 11/14/2022 |

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| | The current care plan addressing constipation, initiated on 10/6/202 and reviewed as current on 8/15/2022, included the following interventions: "Administer medications as ordered, document abnormal findings and notify MD, abdominal assessment if no BM (bowel movement) x 4 days: bowel sounds, abdominal distention's, hyper or hypo active bowel sounds, abdominal pain or tenderness, document and notify MD of abnormal findings, monitor bowel function and encourage fluids."<br><br>Review of the electronic bowel monitoring form for September 2022 indicated the resident had no bowel movement documented from 9/3/2022 through 9/10/2022 and no bowel movement 9/22/2022 through 9/25/2022.<br><br>Review of the September Medication Administration Record for Resident 38 indicated he had receives the routine Colace medication but was not administered any PRN suppositories at all for the entire month of September 2022. In addition, review of nursing progress notes for September 2022 indicated there was no note regarding any abnormal issues with the resident's bowels or mention of constipation.<br><br>Review of the current facility policy and procedure, titled Bowel Elimination, provided by the Regional DNS on 10/4/2022 at 2:22 P.M., included the following: "...3. Bowel assessments will be completed based upon each residents specific plan of care and documented in the EMR...4. Bowel movements will be recorded on the facility EMR and /record daily by the direct care staff...5. A resident bowel report will be completed by the assigned charge nurse of resident(s) who have not had a bowel movement | | upon Admissions and quarterly thereafter.<br>The Interdisciplinary Care Plan team and nursing staff in-service will be conducted on or before 11/14/22 This in-service will include review of the facility policy related to development and implementation of person-centered care plans for each resident including diagnosis for constipation as outlined in the comprehensive assessment. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans as outlined in the comprehensive assessment.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |

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| | for 3 consecutive days...6. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener or will be given an enema if ordered by the physician [sic]...8. If by the 4th afternoon, the resident(s) has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order...."<br><br>During an interview with the Regional DNS, on 10/5/2022 at 2:15 P.M., if a laxative or enema had been administered, it would be documented on the medication administration record. There was no explanation given as to why Resident 38 was not given any laxatives as directed by his care plan.<br><br>Review of the current facility policy and procedure, titled Bowel and Bladder Program, provided by the Regional DNS on 10/5/2022 at 2:15 P.M., included the following: "...Each resident should be assessed for potential causes of the fecal incontinence which may include the following...Constipation...The care plan must reflect the results of the resident's assessment and include specific interventions for any potential reversible causes...."<br><br>31-35(a) | | **By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/2022 | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155695 | A. BUILDING 00<br>B. WING | 10/05/2022 |

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| RIVERSIDE VILLAGE | 1400 W FRANKLIN ST<br>ELKHART, IN 46516 |

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| | (A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on observation, interview, and record review, the facility failed to update the care plan with interventions to prevent falls, and provide a care plan meeting for 1 of 2 residents reviewed for care planning. (Resident 272)<br><br>Finding includes:<br><br>During an interview on 9/28/2022 at 10:32 A.M., Resident 272 indicated she had not been informed of medications, therapies, or treatments through a care plan meeting.<br><br>A clinical record review was completed on 9/29/2022 at 2:03 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, severe protein-calorie malnutrition, generalized anxiety and alcoholic cirrhosis. | F 0657 | **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of the facility to ensure that all resident care plans are reviewed and updated timely. The care plans for Resident 272 have been reviewed and updated to prevent falls. IDT conducted a care plan meeting with Resident 272 to inform her of individual plan of care and long-term placement.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 11/14/2022 |

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| | Resident 272 admitted to the facility on 9/12/2022. An Admission MDS was completed on 9/21/22. The MDS indicated Resident 272 had moderate cognitive impairment.<br><br>A Road to Recovery Form was completed on 9/13/2022 at 12:05 P.M. The assessment indicated that the medication regimen review was not completed, and clinical concerns/questions were not asked.<br><br>During the clinical record review, an IDT (Interdisciplinary Team) Review Care Plan Summary was opened on 9/26/2022 at 4:40 P.M. The summary is blank, and it indicated it is in progress. The description indicated Care Plan Summary scheduled for 10/4/2022.<br><br>During an interview on 10/5/2022 at 10:11 A.M., the Social Service Director (SSD) indicated, a Road to Recovery meeting is completed within 24 hours of admission. During the meeting a discussion of goals, equipment the resident may need at home, interest in home health care, at home support systems, and insurance are discussed. An admission care plan meeting should occur within 7 days of Road to Recovery meeting. During the admission care plan meeting the team will review medications, current care plans, and strengths. She indicated the medication list and care plans will not be provided unless requested. The SSD indicated a care plan was to occur on 10/4/2022, but the emergency contact had not responded to phone calls. She indicated if the emergency contact did not respond, then a care plan meeting would occur today with Resident 272.<br><br>A policy was provided on 10/5/2022 at 1:25 P.M., | | **action(s) will be taken:**<br>All residents have the potential to be impacted by this deficient practice. A Comprehensive review of all resident fall care plans will be completed on or before 11/14/22 to ensure accurate. An audit of fall interventions will be completed to validate placement.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Comprehensive Care Plan reviews will be completed for all residents upon admission and quarterly thereafter.<br>SSD will ensure care plan meeting are held with the resident within 7 days-of admission.<br>ED/Designee will review new admits during IDT meeting to ensure care plan meetings are held and to ensure care plans address falls and fall interventions when applicable.<br>The Interdisciplinary Care Plan team and nursing staff in-service will be conducted on or before 11/14/22. This in-service will include review of the facility policy related to development and implementation of person-centered care plans for each resident.<br>**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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| | by the Regional Director of Nursing Services. titled "IDT Comprehensive Care Plan Policy". The policy indicated, " ...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs ...."<br><br>3.1-35(e) | | **into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |
| F 0677<br>SS=E<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on record review, observation and interview, the facility failed to ensure showers were provided timely for 8 of 10 residents reviewed for Adl care (Activities of Daily Living). (Residents B, C, 4, 12, 46, 56, 57 and 58)<br><br>Findings included:<br><br>1. During an interview, on 9/29/2022 at 9:56 A.M., Resident B indicated she had only receives 1 shower a week because the aides call in sick. Observed whiskers to the residents chin. | F 0677 | **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards, comprehensive plan of care, and residents’ choices. It is the practice of the facility to ensure all | 11/14/2022 |

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| | A Quarterly MDS (Minimum Data Set) assessment, dated 8/1/2022, indicated the resident required extensive assist of 2 staff for bed mobility, transfers, toilet use, extensive assist of 1 staff for dressing, and personal hygiene. Required total assist for bathing. ROM (range of motion) was limited on one side.<br><br>A shower schedule, undated, indicated Resident B was to receive a shower on the day shift on Mondays and Thursdays.<br><br>A current care plan, dated 9/28/2022, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, transfers related to hemiplegia to left side, left hand contracture, obesity, and chronic pain syndrome. Resident at times will refuse ADL care such as oral care, showers, toileting, and changing clothes. Interventions included, but were not limited to: assist with bathing per resident preference. Offer showers two times per week, partial bath in between, 2 person assist. Prefers to shower Mondays and Thursdays,<br><br>During an interview, on 10/4/2022 at 1:50 P.M., C.N.A 9 indicated that a resident is to have 2 showers a week, and if a resident refuses the shower, they are to document it on the shower sheet and make sure the nurse is aware so she can sign it.<br><br>A shower schedule indicated she was to receive showers on Monday and Thursdays. The shower sheets for July, August and September 2022, indicated the resident had received a shower on the following dates: 7/7, 7/14, 7/21, 7/28 in July. On 8/1, 8/4 in August, and on 9/1, 9/15, 9/19, 9/26/2022 in September. Out of 25 scheduled | | residents receive assistance with Activities of Daily Living. Resident 58 no longer resides at facility. Resident B, C, 4, 12, 46, 56, and 58 was provided shower assistance per preference.<br>**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:**<br>All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and frequency will be completed on or before 11/14/22.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will ensure Shower schedules are established. The DNS/Designee will review Shower Sheets daily to ensure showers are provided per resident preference.<br>Inservice with Nursing staff will be conducted on or before 11/14/22. This inservice will include Resident preferences.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality | |

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| | showers to be given in the 3 months reviewed, the resident did not receive 15 showers.<br><br>2. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident C indicated he does not get showers every week.<br><br>A Quarterly MDS ( Minimum Data Set) assessment, dated 7/21/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact.<br><br>A current care plan, dated 3/8/2022, indicated the resident required assistance with ADL's. Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between, 1 person assist.<br><br>A shower schedule indicated Resident C was to receive a shower on Tuesdays and Fridays.<br><br>The shower sheets for July, August and September 2022, indicated the resident had received a shower on the following dates: 7/1, 7/12, 8/26, 9/13 and 9/26/2022. Out of 27 scheduled showers to be given in the 3 months reviewed, the resident did not receive 22 showers.<br><br>3. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 4 indicated she did not get showers every week.<br><br>A Significant Change MDS ( Minimum Data Set) assessment, dated 7/12/2022, indicated Resident 4 had a BIMS score of 8, moderate cognitive impairment.<br><br>A current care plan, dated 12/21/2017, indicated Resident 4 required assistance with ADL's. | | Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Accomodation of Needs” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |

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| | Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week. partial bath in between, 1 person assist. Resident prefers showers 2 x weekly in P.M. in afternoon.<br><br>A shower schedule indicated Resident 4 was to receive showers on Tuesdays and Fridays evenings.<br><br>The shower sheets for July, August and September 2022, indicated the resident had received a shower on the following dates: 7/7, 7/12, 7/22, 7/26, 7/29, in July. On 8/2, 8/5 in August, and on 9/8, 9/20 in September. Out of 27 scheduled showers to be given in the 3 months reviewed, the resident did not receive 18 showers.<br><br>4. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 12 indicated she did not get showers.<br><br>A Quarterly MDS, dated 7/18/2022, indicated Resident 12 had a BIMS score of 6, severe cognitive impairment.<br><br>A current care plan, dated 10/27/2021, indicated Resident 12 required assistance with ADL's. Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between and 1 staff assist.<br><br>A shower schedule indicated Resident 12 was to receive showers on Monday and Thursday evenings.<br><br>The shower sheets for July, August, and September 2022, indicated the resident had received a shower on the following dates: 7/7, 7/14 | | | |

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| | in July. On 8/1, 8/4 and 8/29 in August, and no shower documentation for September. Out of 26 scheduled showers to be given in the 3 months reviewed, the resident did not receive 21 showers.<br><br>5. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 46 indicated she did not get showers.<br><br>A Quarterly MDS, dated 8/16/2022, indicated Resident 46's BIMS score was 9, moderately impaired and was totally dependant on 1 staff for bathing.<br><br>A current care plan, dated 7/31/2017, indicated Resident 46 required assistance for ADL care. Interventions included, but were not limited to: PM Cares including bathing, dressing, hair combing and oral care.<br><br>A shower schedule indicated Resident 46 was to receive showers on Sunday and Thursday evenings.<br><br>The shower sheets for July, August, and September 2022, indicated the resident had received a shower on the following dates: 7/21, 7/31 in July. On 8/18 and 8/28 in August, and 9/1 for September. Out of 26 scheduled showers to be given in the 3 months reviewed, the resident did not receive 21 showers.<br><br>6. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 56 indicated she did not get showers.<br><br>An Annual MDS, dated 8/25/2022, indicated Resident 56 had a BIMS score of 15, cognition intact and was total dependant on 1 staff for bathing. | | | |

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A current care plan, dated 2/29/2019, indicated Resident 56 required staff assistance with ADl's. Interventions include, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between, 1 person assist. Resident prefers 2 x in am weekly.

A shower schedule indicated Resident 46 was to receive showers on Wednesday and Saturday days.

The shower sheets for July, August, and September 2022, indicated the resident had received a shower on the following dates: 7/6, 7/13, 7/27 and 7/30 in July. On 8/3, 8/17, 8/10, 8/14, 8/24, 8/27 in August, and 9/7, 9/10, 9/17 and 9/24 for September. Out of 26 scheduled showers to be given in the 3 months reviewed, the resident did not receive 12 showers.

7. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 57 indicated she did not get showers.

A Quarterly MDS, dated 8/29/2022, indicated Resident 57 had a BIMS score of 15, cognition intact and required 1 staff assist with bathing.

A current care plan, dated 7/10/2016, indicated Resident 57 required staff assist with ADL's. Interventions included, but were not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Prefers showers 3 x week in the P.M., early afternoon, 1 person assist.

A shower schedule indicated Resident 57 was to receive showers on Tuesday, Friday and Sunday

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| | evenings.<br><br>The shower sheets for July, August, and September 2022, indicated the resident had received a shower on the following dates: 7/1, 7/3, 7/10, 7/12, 7/14, 7/18 and 7/26 in July. On 8/7 and 8/21 in August, and on 9/8, and 9/13 for September. Out of 40 scheduled showers to be given in the 3 months reviewed, the resident did not receive 29 showers.<br><br>8. During a Resident Council meeting, held on 10/3/2022 at 2:30 P.M., Resident 58 indicated she did not get showers.<br><br>A Quarterly MDS assessment, dated 8/29/2022, indicated Resident 58 had a BIMS score of 14, cognition intact and required staff assistance with bathing.<br><br>A shower schedule indicated Resident 58 was to receive showers on Tuesday, Wednesday, Friday and Saturday evenings.<br><br>The shower sheets for July, August, and September 2022, indicated the resident had received a shower on the following dates: 7/1, 7/6, 7/9, 7/13, 7/15, 7/22 and 7/31 in July. On 8/2, 8/5, 8/6, 8/13, 8/17, 8/24 and 8/27 in August, and on 9/1, 9/3, 9/17, and 9/23 for September. Out of 53 scheduled showers to be given in the 3 months reviewed, the resident did not receive 35 showers.<br><br>On 10/5/2022 at 11:28 A.M., the Regional Director of Clinical Services Nurse indicated they did not have a specific policy to address resident showers.<br><br>This Federal tag is related to Complaint IN00385789. | | | |

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| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on observation,, record review and interview , the facility failed to ensure bowel issues of constipation were assessed, the physician was notified and interventions were implemented to address the issues for 1 of 1 residents reviewed for constipation. (Resident 38)<br><br>Finding includes:<br><br>Resident 38 was observed, on 9/28/2022 at 12:30 P.M., seated in a wheelchair in the dining room on the secured memory care unit of the facility. The resident was able to feed himself but indicated he was not very hungry. The resident was noted to be very thin.<br><br>During an interview with Resident 38's health care representative, it was disclosed the resident had issues with constipation which irritated his hemorrhoid issues.<br><br>The clinical record for Resident 38 was reviewed on 9/29/2022 at 11:30 A.M. Resident 29 had diagnoses including, but not limited to: Alzheimer's disease, late onset, emphysema, mixed | F 0684 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards, comprehensive plan of care, and residents' choices. Resident 38 care plan has been reviewed and updated to monitor for constipation. The physician was notified of resident's constipation with no new orders received.<br><br>**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:**<br>All residents have the potential to be affected by this finding. A facility audit will be completed by | 11/14/2022 |

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| | incontinence, constipation, hemorrhoids and history of falling.<br><br>The most recent Minimum Data Set (MDS) assessment,, completed for a quarterly review on 8/8/2022 indicated the resident was frequently incontinent of his bowels and required extensive staff assistance of one for toileting needs.<br><br>The current physician's orders for Resident 38 indicated he received the medication, Colace, a a laxative that softens the stool, 100 mg (milligrams) twice a day routinely. In addition, there were orders for a bisacodyl suppository 10 mg rectally once a day as needed.<br><br>The current care plan addressing constipation, initiated on 10/6/202 and reviewed as current on 8/15/2022, included the following interventions: "...Administer medications as ordered, document abnormal findings and notify MD, abdominal assessment if no BM (bowel movements) x 4 days: bowel sounds, abdominal distensions, hyper or hypo active bowel sounds, abdominal pain or tenderness, document and notify MD of abnormal findings, monitor bowel function and encourage fluids...."<br><br>Review of the electronic bowel monitoring form for September 2022 indicated the resident had no bowel movement documented from 9/3/2022 through 9/10/2022 and no bowel movement 9/22/2022 through 9/25/2022.<br><br>Review of the September Medication Administration Record for Resident 38 indicated he did receive the routine Colace medication but was not administered any PRN suppositories at all for the entire month of September 2022. In addition, review of nursing progress notes for | | DNS/designee for all residents to validate bowel elimination in the last 3 days. All residents identified in this audit with no bowel elimination documented will be assessed for constipation, notify physician, and interventions implemented.<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service the nursing staff on or before 11/14/22 on documenting bowel elimination and implementing bowel assessment protocol when no elimination documented. The DNS/designee will review bowel activity report daily to monitor for no bowel elimination for 3 consecutive days.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Bowel” and “Bowel Activity report” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not | |

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| | September 2022 indicated there was no note regarding any abnormal issues with the resident's bowels or mention of constipation.<br><br>Although the resident had a history of hemorrhoids and constipation and had a care plan to address potential issues with constipation, the plan was not implemented and additional interventions were not initiated.<br><br>Review of the current facility policy and procedure, titled Bowel Elimination, provided by the Regional DNS on 10/4/2022 at 2:22 P.M., included the following: "...3. Bowel assessments will be completed based upon each residents specific plan of care and documented in the EMR...4. Bowel movements will be recorded on the facility EMR and /record daily by the direct care staff...5. A resident bowel report will be completed by the assigned charge nurse of resident(s) who have not had a bowel movement for 3 consecutive days...6. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener or will be given an enema if ordered by the physician [sic]...8. If by the 4th afternoon, the resident(s) has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician for further order...."<br><br>During an interview with the Regional DNS, on 10/5/2022 at 2:15 P.M., if a laxative or enema had been administered, it would be documented on the medication administration record. There was no explanation given as to why Resident 38 was not given any laxatives as directed by his care plan.<br><br>Review of the current facility policy and procedure, titled Bowel and Bladder Program, | | met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |

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| | provided by the Regional DNS on 10/5/2022 at 2:15 P.M., included the following: "...Each resident should be assessed for potential causes of the fecal incontinence which may include the following...Constipation...The care plan must reflect the results of the resident's assessment and include specific interventions for any potential reversible causes...."<br><br>3.1-37 | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, interview, and record review the facility failed to ensure physician ordered interventions where in place for pressure ulcer prevention for 1 of 1 residents reviewed for pressure ulcers. (Resident 37)<br><br>Finding includes:<br><br>During an observation on 9/28/2022 at 2:39 P.M., Resident 37 was observed lying in bed naked on an air mattress. Resident 37's Prevalon boots were | F 0686 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure residents receive skin care treatment/services to prevent/heal Pressure Ulcers in accordance with professional standards, comprehensive plan of care, and | 11/14/2022 |

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| | observed in the wheelchair, and not applied to the feet.<br><br>On 9/29/2022 at 10:13 A.M., Resident 37 was observed lying flat in bed in a facility gown and a top sheet partially covering him on his left side. A body pillow is at the foot of the bed by the wall. The Prevalon boots are in the wheelchair.<br><br>A clinical record review was completed on 9/29/2022 at 2:51 P.M. Diagnoses included, but were not limited to: hemiparesis, generalized anxiety, impulse disorder, and vascular dementia.<br><br>On 8/3/2022, a Braden Scale Assessment was completed. The assessment indicated; Resident 37 was at moderate risk for skin breakdown.<br><br>A Quarterly MDS (Minimum Data Set) Assessment on 8/8/2022 indicated severe cognitive impairment. He required extensive assistance with two or more staff members for bed mobility, dependent with two or more staff members for transfers and dependent with one staff member assist for and toileting. The MDS indicated Resident 37 had adequate vision and hearing, clear speech and was usually able to understand self and others.<br><br>A Physician's Order on 3/23/2021, indicated, " ...Offloading boots to bilateral feet at all times ...Special Instructions: May remove for care ...Every Shift ..."<br><br>A Care Plan on 11/77/2013, indicated, " ...Problem: *Resident is at risk for skin breakdown due to requires assist with bed mobility and transfers, resident prefers to lay in one position even after staff repositions, incontinence, utilizes wheelchair, non-ambulatory, very limited physical mobility, | | residents' preferences. Review and updated resident 37 care plan to ensure physician ordered pressure ulcer preventative measures in place.<br><br>**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:**<br><br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents that have physician orders for pressure ulcer preventative measure. All residents identified in this audit will be reviewed and validation of pressure ulcer preventative measures in place.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nursing staff on pressure ulcer preventative measurements on or before 11/14/22. Any resident requiring pressure ulcer preventative measures per physician ordered will be reviewed daily by the DNS/designee to ensure interventions are implemented per plan of care.<br>**How the corrective action(s) will be monitored to ensure the** | |

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| | left hemiparesis, occasionally moist skin resulting in the potential for moisture build up, very limited ability to change or control body position, slightly limited sensory perception, problem for friction and shear. Dandruff, bilateral knees, and left elbow contractures, left hemiplegia, dry skin, hx [history] Pressure ulcers and BLE abrasions, Hx of weight loss, severe protein-calorie malnutrition and toenails coming off ...." An intervention indicated, " ...Offloading boots to bilateral feet at all times, may remove for care ...."<br><br>During an observation on 9/29/2022 at 8:24 P.M., Resident 37 was lying in bed with a facility gown, and no mattress sheet. The Prevalon boots were in the wheelchair.<br><br>On 9/30/2022 at 11:01 A.M., Resident 37 was lying in bed naked, covered with a top sheet and the Prevalon boots were in wheelchair.<br><br>On 10/4/2022 at 9:32 A.M., Resident 37 was observed lying in bed sleeping. He has a facility gown on and covered by a top sheet. His Prevalon boots were in the bed, but not secured to his feet. An additional pair of Prevalon boots are observed in the wheelchair.<br><br>During an interview on 10/04/2022 at 9:53 A.M., During an interview, CNA 9 indicated, Resident 37 gets pressure sores on his feet because his feet touch the footboard. The Prevalon boots are in place to prevent pressure ulcers. She indicated he should be always wearing the boots.<br><br>A current policy was provided on 10/5/2022 at 1:25 P.M., by the Regional Director of Nursing Services. titled, "Skin Management Program". The policy indicated, " ...It is the policy of [corporations name] to ensure that each resident | | **deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Pressure Ulcer Prevention" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/2022 | |

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| | receives care, consistent with professional standards of practice, to prevent pressure ulcers ...3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors ...."<br><br>3,1-40(a)(2) | | | |
| 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-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on record review and interview, the facility failed to provide the recommended interventions to prevent a significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 33)<br><br>Finding includes: | F 0692 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 33 physician order reviewed for nutritional | 11/14/2022 |

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| | A clinical record review was completed on 10/3/2022 at 9:20 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease and severe protein-calorie malnutrition.<br><br>A 5-day MDS (Minimum Data Set) Assessment indicated Resident 33 was cognitively intact. She required supervision with one staff member assistance for eating. The MDS indicated Resident 33 had lost 5 percent or more in the past month or 10 percent or more in the last 6 months without being on a prescribed physician weight-loss regimen. She received a mechanically altered diet.<br><br>Resident 33's weights indicated the following:<br>7/26/2022 11:42 A.M. Weight: 144 pounds<br>7/19/2022 9:05 A.M. Weight: 146 pounds<br>7/7/2022 2:46 P.M. Weight: 149 pounds<br>6/28/2022 12:09 P.M. Weight: 149 pounds<br>6/20/2022 2:53 P.M. Weight: 148 pounds<br>6/8/2022 9:58 A.M. Weight: 152 pounds<br>5/16/2022 3:14 P.M. Weight: 164 pounds<br>4/19/2022 1:25 P.M. Weight: 162.1 pounds<br><br>A Registered Dietician Note, on 4/29/2022 at 7:18 A.M., indicated, " ...Resident reviewed for weight loss since admission. Wt [weight] 4/19/22 = [equals] 162# [pounds], - [minus]12# (6.8 percent) since 3/7/22. Weight loss is resulting from poor oral intakes. Resident is frequently refusing meals (32/39/68%). [Unit name] staff reporting that resident is very confused and is wandering the unit in her wheelchair often creating increased kcal [kilocalories] needs. Regular diet in place. She is offered Ensure plus supplement once daily and she accepts this well. Resident is accepting fluids better than food right now. Will recommend Mighty Shakes with lunch and dinner and will recommend increasing Ensure Plus to BID [twice | | supplements. Reviewed and updated resident 33 care plan to ensure resident nutritional interventions in place to prevent a significant weight loss.<br><br>**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:**<br><br>All residents have the potential to be affected by this finding. A facility audit will be completed by RD/designee for all residents for weight loss to ensure nutritional interventions in place to prevent a significant weight loss.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service IDT and nursing staff on weight loss identification and nutritional interventions to prevent a significant weight loss on on before 11/14/22.<br>The RD/designee will review meal trays for each meal and medical record to ensure nutritional interventions are implemented per resident plan of care.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | |

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| | daily] for increased kcal support via fluids ...."<br><br>On 6/21/2022 at1:58 P.M., an IDT (Interdisciplinary Team) Note indicated, " ...Reason for NAR [Nutritionally at Risk] review: Weight loss Current weight: 148 Weight change: 9.8% in 35 days Root cause of weight change: Decreased meal intakes Usual body eight/desired weight: unknown Current nutritional goal: maintain weight Current diet order: Mech soft, ground meat with gravy Meal intakes: 50-76% Nutrition interventions in place: Ensure 237ml daily Acceptance of nutritional interventions: 100% acceptance ... New recommendations/interventions: Increase ensure to BID ...."<br><br>A Physician's Order on 3/17/2022, indicated, " ...Ensure Plus 237ml [milliliters] once a day ...." The order was discontinued on 6/21/2022.<br><br>On 6/21/2022, a Physician's Order indicated, " ...Ensure Plus 237ml twice a day ...."<br><br>A Care Plan on 2/28/2022, indicated, " ...Resident is at risk for altered nutritional status due to varied food and fluid acceptance ...receives a mechanically altered diet ...recent history of significant weight loss, but now with slow gains following addition of supplement and consumption 76-100 % [percent] for all meals (May 2022. Resident has significant weight loss and weight had been trending down. Current weight in 140s, per family and resident DBW: 140's to 150s (Sept 2022) ...." Interventions include on 6/21/2022, " ...Nutritional supplement as ordered ...."<br><br>During an interview on 10/4/2022 at 2:10 P.M., the Director of Nursing Services indicated, she would have to look at the record to see if the Ensure | | **assurance program will be put into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Weight Loss” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |

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| | should have been implemented on 4/29/2022. She indicated items provided from nursing are documented in the medical record to provide consumption records, but items from dietary are not documented in the medical record for consumption.<br><br>On 10/5/2022 9:26 A.M., the Director of Nursing Services indicated, that Resident 33 had a weight increase in May, and Resident 33 did not trigger for a weight loss in June.<br><br>On 10/5/22 at 9:45 A.M., the Director of Nursing Services indicated, she was not here during that time of the weight loss and did not understand the full picture.<br><br>A current policy was provided on 10/5/2022 at 1:25 P.M., by the Regional Director of Nursing Services, titled "IDT Weight Review". The policy indicated, " ...It is the policy of [Corporation name] to identify resident's who are at nutritional risk or have a significant weight change and be reviewed by the IDT to initiate appropriate interventions ...Resident Recommended for IDT Weight Review ...Residents with continuous, gradual loss that has not triggered as significant ...Residents with significant weight loss/gain ...."<br><br>3.1-46(a)(1) | | | |
| F 0694<br>SS=D<br>Bldg. 00 | 483.25(h)<br>Parenteral/IV Fluids<br>§ 483.25(h) Parenteral Fluids.<br>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. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure intravenous (IV) tubing was dated, changed daily and (IV) solution labeled for 1 of 1 Residents reviewed for IV fluids. (Resident 39)<br><br>Finding includes:<br><br>A clinical review was completed on 9/30/2022 at 9:51 A.M., for Resident 39, diagnoses included but not limited to; type 2 diabetes, schizophrenia, Major depressive disorder, chronic kidney disease, stage 4 (severe), Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, and adjustment disorder with anxiety.<br><br>During an observation, on 9/28/2022 at 10:09 A.M., a 1000 milliliter (ml) intravenous (IV) bag of 0.9% sodium chloride was infusing via diaflow, the tubing was dated 9/27/22, 5 pm on the drip chamber, the bag of fluids did not have a label on it with resident name, date and time solution was hung, nurse's initials, route, and rate.<br><br>During an observation, on 9/29/2022 at 10:39 A.M., a 500 ml bag of 0.9% sodium chloride is infusing via diaflow the bag did not have a label on it and tubing is dated 9/27/22, 5 P.M.<br><br>During an observation, on 9/30/2022 at 6:15 A.M., 1000 ml bag of 5% dextrose 0.45 % sodium chloride no labeling on the bag or date on tubing.<br><br>During an interview, on 9/29/2022 at 2:16 P.M., Licensed Practical Nurse (LPN) 4 indicated the bag should have been labeled with the name, time, date, and the flow rate. The tubing is dated 9/27/2022 at 5 P.M. and indicated it should have | F 0694 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 39 no longer is receiving IV fluids<br><br>**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:**<br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents receiving PRN IV fluids to ensure proper labeling of solution, tubing dated and tubing changed daily.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nurses on proper labeling of solution, tubing dated and tubing changed daily on or before 11/14/22.<br>DNS/Designee will conduct rounds daily to ensure IC tubing is dated, changed daily and solution labeled.<br>**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:** | 11/14/2022 |

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| | been changed every 24 hours.<br><br>During an interview, on 9/30/2022 at 6:18 A.M., Licensed Practical Nurse (LPN) 2 indicated that the IV bag should have been dated, nurse's initials, drip rate, resident name and tubing should have been dated with nurses initials.<br><br>On 9/30/2022 at 10:50 A.M., the Regional Director of Clinical Services provided a policy titled, "6.3 Hypodermoclysis Licensed Nurse Providing Infusion Therapy in the LTC Facility", revised 5/1/ 2015, and indicated the policy was the one currently used by the facility. The policy indicated " ...Infusion Maintenance table appendix A.1 short peripheral, administration set changes primary 24 hours...."<br><br>On 10/3/2022 at 1:31 P.M., the Regional Director of Clinical Services provided a policy titled, "3.10 Labeling of Infusions", revised 5/1/2015, and indicated the policy was the one currently used by the facility. The policy indicated " ... 4. The licensed nurse administering non-admixed solution for infusion from a sealed manufacturer's package will label the bag with: 4.1 Patient's name, 4.2 Route and rate, 4.3 Ancillary precautions, 4.4 Date and time the solution was hung, 4.5 Nurse's initials...."<br><br>3.1-47(a)(2) | | Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Intravenous Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br><br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, | | | |

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| | 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.<br>Based on observation, interview, and record review, the facility failed to date the oxygen tubing and humidification bottles, and follow the physician's orders for oxygen administration for 1 of 2 residents reviewed for respiratory care. (Resident 33)<br><br>Finding includes:<br><br>During on observation on 9/28/2022 at 9:54 A.M., Resident 200's oxygen concentrator was at the bedside. The humidification bottle did not have a date on the bottle. Resident 200 was sitting in her wheelchair in the common area. Her oxygen tubing does not have a date on the tubing.<br><br>On 9/29/2022 at 11:13 A.M., Resident 200 was lying in bed with the nasal cannula attached to the portable oxygen on the back of the wheelchair. The oxygen is set at 0 (zero). The nasal cannula nor the humidification bottle was labeled.<br><br>On 9/29/2022 at 1:23 P.M., Resident 200 was lying in bed with the nasal cannula attached to the portable oxygen on the back of the wheelchair. The oxygen is set at 0.<br><br>On 9/29/2022 at 2:47 P.M. Resident 200 was lying in bed. The oxygen nasal cannula is hanging from the wheelchair, and the oxygen is turned off.<br><br>A clinical record review was completed on 10/03/2022 at 9:20 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease and severe protein-calorie malnutrition. | F 0695 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure residents receive respiratory care in accordance with professional standards, comprehensive plan of care, and residents' preferences. Resident 200 given dated replacement O2 tubing and a humidification bottle for concentrator. Review and updated resident 200 care plan indicating resident often removes her oxygen nasal cannula and switches her oxygen supply source from portable to cannula without requesting assistance. Resident 200 was educated on the risk of not following physician order for oxygen therapy.<br><br>**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:**<br>Any resident receiving oxygen has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit | 11/14/2022 |

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| | A 5-day MDS Assessment indicated Resident 33 had was cognitively intact and she received oxygen therapy.<br><br>A Physician's Order on 2/28/2022, indicated to change the oxygen tubing and humidity once a day on Sundays, and oxygen at 3 liters per nasal cannula every shift.<br><br>A Care Plan on 2/28/2022, indicated, " ...Resident is at risk for impaired gas exchange related to: COPD with shortness of breath while lying flat, chronic respiratory failure with hypoxia, chronic bronchitis, Hx [history] Covid. Resident has a chronic cough. Resident at times will remove O2 while in her room or in common area ..." The interventions included on 2/28/2022, " ...Administer oxygen as ordered ...."<br><br>During an interview on 10/4/2022 at 1:42 P.M., LPN 4 indicated, new tubing and humification bottles should be changed weekly and both should be dated. She also indicated that nurses are only allowed to change the oxygen from portables to concentrators or vice versa.<br><br>3.1-47(a)(6) | | will be reviewed and ensure dating of oxygen tubing and humidifier bottle replaced and dated weekly.<br>.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nurses on oxygen administration and oxygen supply dating requirements on or before 11/14/22.<br>DNS/designee will conduct rounds daily to ensure oxygen tubing and humidification bottles are dated and physician orders are followed for oxygen administration.<br>No other residents were identified to remove their oxygen<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).<br>The DNS/designee will be responsible for completing the QAPI Audit tool “Oxygen Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be | |

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| | | | submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |
| F 0697<br>SS=D<br>Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on observation, record review and interviews, the facility failed to ensure pain medication was thoroughly monitored for 1 of 5 residents reviewed for medications. (Resident 25)<br><br>Finding includes:<br><br>Resident 25 was observed on 10/3/2022 at 9:31 A.M., seated in the day room at a dining room table. Resident 25 giggled and laughed when she was greeted, but her face looked like she wanted to cry.<br><br>The clinical record for Resident 25 was reviewed on 9/29/22 at 2:27 P.M. The resident was admitted to the facility with diagnoses including, but not limited to: Alzheimer's disease, late onset, anxiety disorder, major depressive disorder and chronic pain.<br><br>The current Physician's Orders, for Resident 25 included pain medication's, Tramadol, one tablet, 50 mg (milligram); twice a day for chronic back pain and acetaminophen 325 mg give two tablets as needed for mild pain. | F 0697 | **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure that pain management is provided to residents who require such services. Reviewed and updated resident 25 care plan for monitoring resident for non-verbal signs of pain.<br>**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:**<br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents receiving PRN pain medications to ensure monitoring for non-verbal signs of pain.<br>**What measures will be put into** | 11/14/2022 |

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| | The current health care plans for Resident 25 included a plan to address the resident's risk for pain. The plan included interventions to notify the MD if pain was unrelieved and/or worsened, assist with positioning to comfort, administer meds as ordered, observe for non verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes,eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, for non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition<br><br>There was no routine, pain monitoring located in the clinical record for Resident 25.<br><br>During an interview with RN 6, conducted on 10/5/2022 at 10:35 A.M., he indicated he was to document pain issues in the progress notes and if they were on medicare, skilled charting there was a section to document pain issues. He also indicated if a resident received routine pain medication, there was a "pop up" box on the MAR (Medication Administration Record) to document the effectiveness of the resident's pain medications. After looking in Resident 25's MAR, RN 6 disclosed there was no "pop up" box for Resident 25 and any pain monitoring would be in the nursing progress notes.<br><br>Review of the nursing progress notes for Resident 25, from 8/8/2022 through 10/5/2022 indicated there was only discomfort and urinary tract infection discomfort documented in the progress notes. There was one physician note, dated 8/9/2022 which indicated the resident "looked comfortable."<br><br>Review of the facility policy and procedure, titled | | **place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nursing staff on non-verbal signs of pain on or before 11/14/22.<br>DNS/designee will review any resident receiving PRN pain medication to ensure residents are receiving pain medication as needed by 11/14/22.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).<br>The DNS/designee will be responsible for completing the QAPI Audit tool “Pain Management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/222 | |

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| | "Pain Management, provided by the regional Director of Clinical Services nurse on 10/5/2022 at 10:00 A.M.. included the following: "...7. Residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass....9. Additional information, including, but not limit to reasons for administration, and effectiveness of pain medication will be documented on the Medication<br>Administration (MAR) or on the facility specific pain management flow sheet..."<br><br>3.1-37(a) | | | |
| F 0758<br>SS=D<br>Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose | | | |

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| | reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§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<br><br>§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.<br><br>§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.<br>Based on interview and clinical record review the facility failed to ensure psychotropic medications were not prescribed for 1 of 5 residents reviewed for unnecessary medications. (Resident 37)<br><br>Finding includes:<br><br>A clinical record review was completed on 9/29/2022 at 2:51 P.M. Diagnoses included, but were not limited to: hemiparesis, generalized anxiety, impulse disorder, and vascular dementia.<br><br>A Quarterly MDS on 8/8/2022 indicated severe cognitive impairment. | F 0758 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>It is the practice of this facility to provide the resident an environment free of unnecessary psychotropic medication.<br>Reviewed and updated resident 37 care plan for non-pharmacological interventions when exhibiting behaviors.<br><br>**How other residents having the potential to be affected by the** | 11/14/2022 |

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| | A Pharmacist Recommendation Review was completed on 3/2/2022. The medication review indicated to consider a decrease in Depakote 125 milligrams every day with the end goal of discontinuation. The previous order for Depakote 125 milligrams two times daily had been in place since 7/16/2021. The facility Nurse Practitioner accepted the recommendation on 3/3/2022. The order was put in place.<br><br>The ADL (activities of daily living) documentation for 3/1/2022-3/31/2022 indicated the behavior of yelling out for help occurred on 3/6/22 five times on day shift, 3/8/2022 ten times on third shift, 3/9/2022 three times on third shift, 3/18/2022 two times on third shift, and 3/23/2022 three times on third shift, and 4/16/2022 ten or more times on third shift.<br><br>On 3/15/2022, the facility psychiatric nurse practitioner visited Resident 37. The note indicated, " ...Continue current medications. Continue current plan of care. Will accept GDR [gradual dose reduction] of Depakote and reduce dose to 125 mg [milligrams] Q [every] daily for Mood. Staff to monitor patient's mood and behavior. Call for any concerns ...."<br><br>On 4/6/2022 at 1:39 P.M., A Physician's Note indicated, " ...This is a 63 years old male seen today for routine regulatory visit. Patient is very poor historian due to underlying dementia. He is laying in bed quietly. He looks comfortable ...Nursing has not brought any other significant events to my attention ...Physical exam: Patient is laying in bed quietly. He was comfortable ...Psych: No agitation ...."<br><br>On 4/14/2022, the facility psychiatric nurse practitioner visited Resident 37. The note | | **same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents receiving psychotropic medications to ensure non-pharmacological intervention attempted with supportive documentation.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS /designee will in-service nurses on unnecessary medications with non-pharmacological invention approach when exhibiting behaviors on or before 11/14/22<br>The IDT Team will be responsible for daily review of all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as appropriate diagnosis to justify the need for the medication and that care plans are in place for medications requiring one. The DNS/designee will be responsible for daily review of orders and correcting and clarifying orders and care plans as needed.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not** | |

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| | indicated, " ...Current medications. Continue current plan of care. Staff to monitor patient's mood and behavior. Call for any concerns ...."<br><br>A Physician's Order on 4/22/2022, indicated Depakote Sprinkles 125 mg by mouth twice daily.<br><br>A Nurse's Note on 4/22/2022 at 1:20 P.M., indicated, " ...Resident seen by [psychiatric service NP] new orders received. There was not a NP note indicating a visit had occurred.<br><br>A Care Plan on 5/5/2022, indicated, " ... On occasion, resident has been noted to have shredded his brief with pieces of the brief noted to be on his face and in his hands...Approach: Resident to have brief removed prior to going to sleep ...."<br><br>On 2/6/2018, and revised on 8/16/2022, a Care Plan indicated, " ...Problem: Behavior #2: Resident will yell out for "help" loudly and repeatedly, pull his call light out of the wall, yell to have his feet covered up or re-positioned, is generally impatient with staff and care. Resident yells out, "I fell!", "I hurt," but denies pain/falling when given assurance/validation; will state that he had a BM [bowel movement] (shit my pants) but has not. Resident attention seeking and yells disruptively for staff to pay 1:1 attention. He has been observed eating his briefs. Resident has dx of anxiety d/o; impulse control disorder; Vascular dementia with behavioral disturbance & PBA. He has orders for mood stabilizer and antianxiety medication ...."<br><br>The approaches for care were as follows:<br>On 2/6/2018, Intervention #1: Re-position resident's feet or cover him up if asked. Assess for pain as needed. Provide validation and | | **recur, i.e., what quality assurance program will be put into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Unnecessary Medications” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |

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| | reassurance that resident is safe in chair and clean/dry.<br><br>On 2/6/2018, Approach: Behavior #2: Resident will yell out for "help" loudly and repeatedly, pull his call light out of the wall, yell to have his feet covered up or re-positioned, is generally impatient with staff and care. Resident yells out, "I fell!", "I hurt," but denies pain/falling when given assurance/validation; will state that he has d a BM (shit my pants) but has not. Resident attention seeking and yells disruptively for staff to pay 1:1 attention. Resident has dx of anxiety d/o; impulse control disorder; Vascular dementia with behavioral disturbance & PBA. He has orders for mood stabilizer and antianxiety medication. Intervention #1: Re-position resident's feet or cover him up if asked. Assess for pain as needed. Intervention #2: Remind/reassure resident that he is heard and staff cares about him. Remind him that staff cannot always get to him immediately but that he is not forgotten about. Provide validation & reassurance that resident is safe in his chair and clean/dry. Intervention #3: Offer to wheel resident around the facility, or lay down. Engage in activity of his interest: watching TV, visiting with peers, likes Notre Dame football and Cubs baseball, resident was an Army Veteran.<br><br>On 4/16/2018, " ...Approach: Intervention #2: Remind/reassure resident that he is heard and staff cares about him. Remind him that staff cannot always get to him immediately but that he is not forgotten about ...."<br>On 4/16/2018, " ...Approach: Intervention #3: Offer to wheel resident around the facility, or lay down. Engage in activity of his interest: watching TV, visiting with peers, likes Notre Dame football and Cubs baseball, resident was an Army Veteran ...." | | | |

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| | On 10/5/2022 at 9:53 A.M., the Social Service Director (SSD) provided a miscellaneous note from the psychiatric nurse practitioner that was not part of the electronic medical record. The note was dated 4/22/2022. The note Resident 37 is more restlessness, irritability and increasingly difficult to redirect over last several weeks.<br><br>During an interview on 10/4/2022 at 1:47 P.M., the Social Service Director (SSD) indicated, she could not find a reason for the increase or change in the Depakote order. She indicated psychotropic medications should not be increased without an indication.<br><br>On 10/4/2022 at 2:24 P.M., the SSD indicated she contacted the psychiatric nurse practitioner, and she is looking at the dates of the change of medication.<br><br>On 105/2022 11:04 A.M., the SSD indicated behavior care plans will mirror to Medication Administration Record for documentation. Interventions for the behaviors will be documented with the behavior.<br><br>On 10/5/22 at 1:33 P.M., the SSD indicated a nurse should have an intervention for the behaviors exhibited, and non-medicinal interventions should be tried prior to using psychotropic medications.<br><br>A current policy was provided on 10/5/2022 at 1:25 P.M., by the Regional Director of Nursing Services, titled "Psychotropic Management". The policy indicated, " ...It is the policy of [corporation name] to ensure that resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical, and psychosocial well-being with person centered intervention and assessment. These medications | | | |

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| | are managed in collaboration with professional services and facility staff to include non-pharmacological interventions, assessment, and reduction as applicable ..."<br><br>3.1-48(a)(4) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>Based on observation, interview, and record review, the facility failed to ensure the medication refrigerator temperature was checked every 24 hours for 1 of 1 medication room checked for | F 0761 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 11/14/2022 |

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| | storage and labeling. (Liberty Hall med room)<br><br>Finding includes:<br><br>During an observation, on 9/30/2022 at 11:20 A.M., of the medication refrigerator which contained intravenous bag of vancomycin, eye drops, insulin flex pens, suppositories and vial of apisol. The thermometer read 40 degrees. No posting of a temperature log was present.<br><br>During an interview, on 9/30/2022 at 11:25 A.M., the Unit Manager indicated it is kept in notebook on the unit.<br><br>On 9/30/2022 at 11:30 A.M., the log was reviewed, and the following dates were recorded 9/3. 9/4, 9/6, 9/7, 9/14, 9/15, 9/16, 9/27 and 9/28.<br><br>During an interview, on 9/30/2022 at 11:33 A.M., the Unit Manager indicated the medication refrigerator should have been checked every 24 hours and recorded on the log.<br><br>On 9/30/2022 at 1:30 P.M., the Regional Director of Clinical Services provided a policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles", revised 10/31/16, and indicated the policy was the one currently used by the facility. The policy indicated "...11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility Staff should monitor the temperature of vaccines twice a day 11.2 refrigeration: 36 degrees - 46 degrees F or 2 degrees - 8 degrees C...."<br><br>3.1-25(m) | | **practice:**<br>It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. All refrigerated medications stored at an appropriate temperature recorded on the log in accordance with the pharmacy policies.<br><br>**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:**<br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage refrigerators to ensure temperature logs are in place for monitoring and recording.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nurses on the log for recording Refrigerated Medication Storage on or before 11/14/22.<br>DNS/designee will round each day to ensure temperature log is in place and temperatures are recorded each day.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | |

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| | | | **assurance program will be put into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 11/14/22 | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, | | | |

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| | identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | | | |

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| | §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, record review and interviews, the facility failed to ensure transmission based precautions were maintained for 1 of 5 residents observed in droplet precautions (Resident 30). In addition, the facility failed to ensure 1 of 3 staff observed administering medications maintained infection control standards while obtaining blood glucose levels. (RN 6)<br><br>1. During the initial tour of the facility, conducted on 9/28/2022 between 10:15 A.M. - 11:00 A.M., Resident 30 and her roommate were noted to have an isolation sign on the door and a plastic cart with personal protective equipment (PPE) supplies next to the door. The signage was unclear as to the type of isolation required. During an interview with LPN 3, on 9/28/2022 at 11:00 A.M. she indicated both Resident 30 and her roommate were in "Droplet" precautions due to both residents recently having been in the hospiital and not fully vaccinated. She indicated neither resident had symptoms of COVID 19, but it was "precautionary."<br><br>On 9/28/22 at 12:48 P.M., the Activity Director | F 0880 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>It is the practice of this facility to ensure that residents are provided a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Resident 30 has the correct isolation signage on the door. Activity Director was educated by Executive Director regarding proper PPE when transporting resident 30. RN 6 was educated on infection control stands while obtaining blood glucose levels.<br><br>**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:** | 11/14/2022 |

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| | was noted in the hallway outside Resident 30's room, pushing Resident 30 in her wheelchair. The Activity Director had a regular face mask in place and Resident 30 had a regular face mask in place. When the Activity Director was quieried regarding the lack of PPE for both herself and Resident 30, she indicated she was on her way back from havving transported Resident 30 to an appointment. She indicated she thought Resident 30 was still in isolation but indicated "the Company" had put her (Resident 30) in isolation and it did not apply to the outside, it was just a precaution inside the facility. The Activity Director was observed to open Resident 30's room door, push her just inside the door, and then informed Resident 30 she could not enter her room without PPE in place.<br><br>Review of the facility policy and procedure, titled, "Resident policy for COVID-19" provided by the regional Director of Clinical Services on 10/5/2022 at 2:20 P.M. indicated the following: "...n. New admissions/re-admissions that are not up to date should be observed in TBP (transmission based precautions), yellow zone for full 10 days even if they have a negative test. (for COVID) They should be moved to red zone if confirmed positive for COVID-19. May be released to green zones after 10 days if asymptomatic...."<br><br>During an interview with the Regional Director of Clinical Services, who was filling in as the facility's Infection Preventionist, conducted on 10/3/2022 at 2:00 P.M., she confirmed Resident 30 was supposed to be in Droplet precautions, "Yellow zone" on 9/28/2022. She indicated the resident was removed from droplet precautions on 9/30/2022 due to facility policy changes.2. During an observation, on 10/3/2022 at 4:26 P.M., Registered Nurse (RN) 6 placed supplies and | | All residents have the potential to be affected by this finding. The facility will ensure the following:<br>All residents have the potential to be affected.<br>IP/Designee will ensure all residents in TBP in accordance with guidance follow PPE requirements when transporting residents.<br>IP/Designee to ensure nurses perform proper testing technique, glove change, hand hygiene and glucometer cleaning & disinfecting protocols during blood glucose checks.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The IP/designee will in-service all staff on required PPE for TBP on or before 11/14/22. IP/designee will in-service all nurses on blood glucose protocols on or before 11/14/22.<br>DNS/designee will conduct rounds daily to ensure proper signage on doors.<br>Skills validation for obtaining blood glucose levels will be completed for all licensed nurses by 11/14/22.<br><br>**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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| | glucometer on bedside table with no barrier, performed blood sugar, exited the room disposed the strip and lancet in the sharp container attached to the medication cart, opened a sani-wipe and wiped off the glucometer for less than 30 seconds using the same gloves used to obtain the blood sugar, removed the left glove and placed glucometer in the med cart drawer with no barrier. Then removed the other glove and documented in the medical record.<br><br>During an interview on, 10/3/2022 at 4:29 P.M., Registered Nurse (RN) 6 indicated that he followed their policy of the cleaning of the glucometer and indicated he should have changed his gloves and wash his hands prior to cleaning and after removal of his gloves and that they just place it back in the cart.<br><br>On 10/4/2022 at 9:00 A.M., the Director of Nursing provided a policy titled, "Blood Glucose Meter Cleaning/Disinfecting and Testing", revised on 5/2021, and indicated the policy was the one currently used by the facility. The policy indicated, "... Obtaining blood glucose results using glucometer: perform hand hygiene, gather supplies: gloves, alcohol swab, lancet, 2 x 2 gauze or cotton ball (if needed), test strip, and blood glucose monitor. (Plastic cup or clean barrier if not using paper towel from resident room), proceed to resident room with cleaned meter, testing equipment, and supplies, verify resident, place a clean paper towel, plastic cup, or clean barrier on a hard surface, place cleaned glucometer on paper towel, plastic cup, or clean barrier, Don clean gloves, cleanse resident's fingertip with alcohol wipe, allow fingertip to air dry. Insert glucometer test strip into blood glucose meter, perform skin puncture by using the lancet, obtain a single drop of blood, place glucometer with test strip near | | **into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Infection Control” and “Blood Glucose Procedures” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up<br>**By what date the systemic changes will be completed:**<br>**Compliance Date:** 11/14/22 | |

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| | blood droplet, the test strip will act as a wick and absorb blood, wait for test results, check finger for bleeding. If necessary, apply band aid. Remove gloves, gather meter, used test strip, lancet, alcohol wipes, barrier, gloves, and exit the room. May dispose of everything except lancet and test strip in waste receptacle in resident room or in medication cart trash can. Exit room, Dispose of lancet and test strip in sharps container. Dispose of alcohol wipe, test strip, paper towel or clean barrier and gloves in trash if not already done in resident room. Place glucometer on paper towel, plastic cup, or other barrier that was left on medication cart. (Note: the paper towel is not a dirty surface). Note: if blood is visibly present on the glucometer, two wipes MUST be used. One germicidal wipe to clean. The second wipe to disinfect and must be done with Clorox Germicidal Bleach wipe for a 3 -minute contact time. Cleaning blood glucose meter after use/prior to using on next resident: perform hand hygiene, place a paper towel, plastic cup, or other clean barrier on hard surface, Don gloves, obtain germicidal wipe approved for the glucometer approved for use on glucometer. DO NOT use alcohol preps to clean glucometer, as they are not effective in killing bloodborne pathogens. For Medline Evencare G3 glucometers the cleaning and disinfecting wipe is Clorox Bleach Germicidal Wipes. Wipe entire external surface of the blood glucose meter with wipes for 3 minutes. When using Clorox Bleach Germicidal Wipes in the individual packet, it is best to squeeze out excess solution into a trash container or plastic cup to be disposed of. Place cleaned meter on paper towel, in plastic cup, or on clean barrier. Allow glucometer to dry completely, Dispose of used wipe and dirty paper towel, cup, or barrier in trash. Doff gloves and dispose of in trash. Perform hand hygiene, document result of blood glucose level in the clinical record...." | | | |

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