| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155178 | A. BUILDING 00<br>B. WING | 07/12/2024 |

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| BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER | 609 W TANGLEWOOD LN<br>MISHAWAKA, IN 46545 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: July 8, 9, 10, 11 & 12, 2024<br><br>Facility number: 000094<br>Provider number: 155178<br>AIM number: 100290310<br><br>Census Bed Type:<br>SNF/NF: 82<br>Total: 82<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 53<br>Other: 19<br>Total: 82<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed on 7/28/2024 | F 0000 | This response is not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility respectfully requests paper compliance. | |
| F 0585<br>SS=E<br>Bldg. 00 | 483.10(j)(1)-(4)<br>Grievances<br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC | | | |

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

Anne Morgan | Executive Director | 08/05/2024

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

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| | facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances | | | |

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| | through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, | | | |

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| | or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>Based on record review and interview the facility failed to ensure resident grievances were responded to promptly and acted upon for 4 of 21 residents reviewed for grievances. (Residents 52, 30, 70 & 128)<br><br>Findings include:<br><br>Review of 21 resident grievance forms, on 7/12/2024 at 9:38 A.M., indicated there was no documentation of response and outcomes for 4 of the 21 grievances reviewed.<br><br>1. During an interview, on 07/12/2024 at 10:49 A.M., Resident 52 indicated he had waited about an hour on every shift to get care and he has had staff come in, turn the call light off and never came back. The grievance discussed his concerns related to having to wait an hour every shift to get the care he needed, staff turning his call light off, without meeting his care needs and never coming back to give him care. Resident 52 indicated he had not received any response, written or verbal regarding his grievances.<br><br>On 6/7/2024 Resident 52 filed a personal grievance indicating he had asked for help to use the bathroom and had to wait over 40 minutes for help. The grievance was reviewed by the Executive Director and resolved on 6/10/2024.<br><br>2. During an interview, on 7/12/2024 at 10:54 A.M., Resident 30 indicated he had waited 2 hours | F 0585 | F585 Grievances<br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Resident 52, 30 and 70 have been informed of the resolution to their grievances and have been offered a written copy of the resolution.<br>Resident 128 no longer resides at the building.<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 other residents have the potential to be affected by the deficient practice. An audit of the grievance log for the past 30 days will be reviewed, resolution will be completed if not already done, and residents will be informed of the resolution while also being offered a copy of the written resolution.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Management team will be educated on the Resident and Family Grievance Policy. All filed | 08/09/2024 |

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| | for care, he had pressed his call light and staff would turn it off and not come back to provide care. Resident 30 filed a personal grievance and had never been told the outcome of any of his grievances or received a written copy.<br><br>On 6/30/2024, Resident 30 filed a personal grievance indicating it took too long for care and was specifically complaining about the care he received on 6/29/2024. The grievance was reviewed by the Executive Director and resolved on 7/13/2024<br><br>3. During an interview, on 7/12/2024 at 11:05 A.M., Resident 70 indicated she had waited approximately 20 minutes for her call light to be answered, staff would come in and turn her call light off and then leave. She stated most of the time staff did not come back after turning off the call light. Resident 70 indicated she had filed a grievance and had never received any outcome or response to her grievances or a written copy.<br><br>On 6/8/2024 Resident 70's significant other filed a grievance indicating the resident was not receiving care as soon as she asked for help. The grievance was reviewed by the Executive Director and resolved on 6/10/2024.<br><br>During an interview, on 7/12/2024 at 1:10 P.M., the Administrator indicated the facility never provided residents with written responses to their grievances and they should have provided responses. 4. During an interview, on 7/9/2024 at 9:49 A.M., Resident 128 indicated he was missing $20.00 from his wallet. This had occurred sometime between midnight and 4 A.M. on a date near the end of June 2024. A staff member had filled out a grievance form but he had not been informed of the outcome. | | grievances will be added to a Grievance log which will include dates of filing, dates of resolution, whether or not a copy of the written resolution was offered, and if the resident accepted/declined the copy. Grievance log will be reviewed by management team 5 times weekly x 30 days, then 3 times weekly x 30 days, then 2 times weekly x 4 months.<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; and<br>Results of these audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring. | |

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| | Review of the grievance log indicated there was an entry, dated 6/27/2024, for Resident 128 regarding missing money. The report indicated he was missing $20.00 out of his wallet.<br><br>A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128.<br><br>An admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated he had no cognitive impairment.<br><br>During an interview, on 7/10/2024 at 10:55 A.M., the Administrator indicated the grievance process included the following: once the facility heard a complaint from a Resident, the concern/grievance was assigned to a department head and they were responsible to interview and resolve the complaint/grievance. She indicated the Admissions Director had been assigned Resident 128's grievance.<br><br>During an interview, on 7/10/2024 at 11:04 A.M., the Admissions Director indicated she had been assigned to Resident 128's grievance. She had spoken to the resident and asked him if he had possibly spent the money or had given it to his family. She had left a telephone message for his family but had not received a return call. The resident did have some take out food, undated from a local delivery service in the pantry refrigerator at the time of the investigation. The Admissions Director indicated she had not gone back to follow up on the grievance, nor did she inform the resident of any outcome In addition, she had not documented any resolution to the complaint/grievance. She preferred to have the forms completed within 24 hours after she received them. | | | |

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| | On 7/10/2024 at 11:10 A.M., the Administrator provided a policy titled, "Resident and Family Grievances", dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...10. Procedure: c. Forward the grievance form to the Grievance Official as soon as practicable. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concerns(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decisions was issued....."<br><br>3.1-3(2)(l) | | | |
| F 0625 SS=D Bldg. 00 | 483.15(d)(1)(2)<br>Notice of Bed Hold Policy Before/Upon Trnsfr<br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if | | | |

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| | any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>Based on interview and record review, the facility failed to ensure residents were made aware of the facility's bed hold policy upon transfer to a hospital for 2 of 2 residents reviewed for hospitalizations. (Residents 28 and 64)<br><br>Findings include:<br><br>1. A record review for Resident 28 was conducted on 7/9/2024 at 3:04 P.M., Diagnoses included, but were not limited to, type 2 diabetes mellitus and anxiety disorder.<br><br>An Annual Minimum Data Set (MDS) assessment, dated 5/8/2024, indicated Resident 28 had moderate cognitive impairment.<br><br>Nursing Progress Notes, dated 4/22/2024, indicated Resident 28 was admitted to the hospital due to a methicillin resistant staph aureus | F 0625 | **F625 Notice of bed hold policy before/upon transfer**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 28 & 64 were provided with a copy of the bed hold from the date of transfer<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 the alleged deficient practice. All residents who have transferred in the last 30 days have been reviewed by the HIM | 08/09/2024 |

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| | infection.<br><br>The record indicated her family had been notified but did not indicate the bed hold policy was explained and/or a copy given to the resident.<br><br>2. A record review for Resident 64 was conducted on 7/11/2024 at 9:32 A.M. Diagnoses included, but were no limited to, acquired absence or right and left leg below the knee and type 2 diabetes mellitus.<br><br>An Admission Minimum Data Set assessment, dated 5/9/2024, indicated Resident 64's cognition was intact.<br><br>A Nursing Progress Note, dated 5/16/2024, indicated the resident was transferred to the hospital for congestive heart failure. The family was notified of the resident's transfer but the record did not indicate the resident or the resident's family was made aware of, or given a copy of the facility's bed hold policy.<br><br>During an interview on 7/10/2024 at 1:42 P.M., LPN 11 indicated copies of the Advance Directive, face sheet, current order summary, bed hold policy, and any pertinent labs or x-rays were given to EMS personnel when residents were transferred to the emergency room. A copy of the bed hold policy given to the resident should have been placed in the medical record.<br><br>During an interview on 711/2024 at 1:40 P.M., the ED (Executive Director) indicated there was no documentation of bed hold policies being given to Residents 28 and 64 when they were transferred to the hospital.<br><br>On 7/11/2024 at 1:50 P.M., the Regional Nurse 14 | | and/or designees; all residents not provided with a bed hold notice have been provided with one.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on transfer and discharge policy. Residents transferred out will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure all bed holds are provided per policy.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |

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| | provided a current, undated, policy titled, "Transfer and Discharge (including AMA). The policy indicated, "...Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated...."<br><br>3.1-12(a)(25)(26) | | | |
| F 0677 SS=D 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 observation, record review and interview, the facility failed to provide nail care for dependent residents for 3 of 5 residents who were reviewed for activities of daily living needs. (Residents 35, 5, & 28)<br><br>Findings include:<br><br>1. During an observation on 7/8/2024 at 10:06 A.M., Resident 35's right hand was contracted and his fingernails were long and curled downward on both hands.<br><br>During an observation on 7/9/2024 at 11:30 A.M., Resident 35's right hand was contracted and his nails were long and curled downward on both hands.<br><br>During an observation on 7/11/2024 at 10:04 A.M., Resident 35's right hand was contracted and his nails were long and curled downward on both hands.<br><br>Resident 35's record review was completed on 7/11/2024 at 10:40 A.M. Diagnoses included, but | F 0677 | **F677 ADL care provided for dependent residents**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 35, 5, & 28 were provided nail care<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; All residents have the potential to be affected by the alleged deficient practice. All residents identified with long nails were provided nail care.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff educated on ADL | 08/09/2024 |

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| | were not limited to, conversion disorder with seizures and convulsions, diabetes insipidus, bipolar disorder, dysphagia, anxiety, and dementia.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated, 5/8/2024, indicated Resident 35 was severely cognitively impaired and was dependent on staff for bathing and personal hygiene needs.<br><br>A June 2024 TAR (Treatment Administration Record) indicated Resident 35 was given a full bed bath on: 6/13/2024, 6/17/2024, 6/20/2024, 6/21/2024, 6/23/2024, and 6/24/2024. Resident 35 received a shower on 6/27/2024 and 6/29/2024. He refused a shower on 6/12/2024, 6/16/2024, 6/19/224, 6/22/2024, 6/26/2024, and 6/29/2024.<br><br>A July 2025 TAR indicated Resident 35 received a partial bed bath every day from 7/1/2024 through 7/12/2024 and refused a shower on 7/3/2024 and 7/5/2024.<br><br>Resident 35's record lacked the documentation to indicate he was offered nail care after refusing baths or showers.<br><br>Resident 35 did not have a current Care Plan to address the rejection of care.<br><br>A Care Plan, dated, 2/10/2020, indicated the resident had a physical functioning deficit related to self care impairment. He had a goal of maintaining his current level of physical functioning. Interventions included, but were not limited to, personal hygiene assistance and nail care.<br><br>During an interview on 7/10/2024 at 1:09 P.M., | | policy. Residents nails will be observed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure nail care is provided routinely per policy. These observations to be random and include all units.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |

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| | CNA 2 indicated nail care was included in shower and bath care. If a resident refused care, care was to be attempted at a later time. If the resident still refused care, the nurse was notified and a third attempt was made. Refusals were to be documented in the resident's Electronic Medical Record (EMR).<br><br>During an interview on 7/11/2024 at 10:42 A.M, the Unit Manager indicated Resident 35's fingernails were too long on both hands but she was not able to provide any documentation indicating why nail care had not been provided during his baths or showers.<br>2. During an observation on 7/9/2024 at 8:59 A.M., Resident 5's fingernails were long with dark yellowish/brown matter under them and his toenails were very long.<br><br>During a record review conducted on 7/9/2024 at 1:48 P.M., a Quarterly Minimum Data Set assessment, dated 5/3/2024, indicated Resident 5's cognition was moderately impaired. No behavior issues were noted. He was dependent for bathing, transfers, and toileting. He required supervision or touch assist for personal hygiene. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus.<br><br>A record review for Resident 5 was completed on 7/9/2024 at 1:48 P.M. Diagnosis, included but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus.<br><br>A Quarterly Minimum data Set (MDS) assessment, completed on 5/3/2024, indicated Resident 5's cognition was moderately impaired, he had not exhibited any behavioral issues, was dependent on staff assistance for bathing, | | | |

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| | transferring and toileting needs and required supervision and/or touch assistance from staff for personal hygiene needs.<br><br>The current care plan and facility documentation regarding activities of daily living lacked any reference for nail care.<br><br>During an observation, on 7/10/2024 at 10:58 A.M., Resident 5's toenails had been trimmed but his fingernails remained long and had dark yellowish/brown matter under them.<br><br>During an observation and interview, on 7/10/2024 at 2:28 P.M., QMA 10 indicated that Resident 5's fingernails should have been clean and trimmed.<br><br>3. During an observation on 7/8/2024 at 11:40 A.M., Resident 28's fingernails were very long and had dark yellow matter under them.<br><br>The record for Resident 28 was reviewed on 7/9/2024 at 3:04 P.M. Diagnoses, included but were not limited to, generalized osteoarthritis, firbromyalgia and type 2 diabetes mellitus.<br><br>An Annual Minimum Data Set (MDS) assessment, completed on 5/8/2024, indicated Resident 28 had moderate cognitive impairment, had not exhibited any behavioral issues and required substantial to maximal assistance from staff for toileting, bathing and personal hygiene needs.<br><br>The current care plan and facility documentation regarding activities of daily living needs lacked any reference for nail care.<br><br>During an interview, on 7/10/2024 at 1:30 P.M., CNA 16 indicated a shower should include hair washing and nail care. If the resident was diabetic, | | | |

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| | she would soak their fingernails and clean under them with an orange stick. If their fingernails or toenails need to be trimmed she would notify the nurse. She indicated shaving was done if the resident agreed and/or requested it. If they did not want to be shaved, she would document it as a refusal on the shower sheet and in the chart and report it to the nurse.<br><br>During an observation and interview, on 7/10/2024 at 2:28 P.M., QMA 10 indicated Resident 28's fingernails should have been cleaned and trimmed.<br><br>During an interview, on 7/10/2024 at 2:35 P.M., the Unit Manager indicated fingernails should be cleaned and trimmed. Nurses provided nail care for diabetics.<br><br>On 7/11/2024 at 1:36 P.M. the ED provided a current, undated, policy titled, "Activities of Daily Living (ADLs)." The policy indicated, "...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care...."<br><br>3.1-38(a)(3) | | | |
| F 0684<br>SS=E<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. | | | |

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| | Based on interview, observation and record review, the facility failed to follow the physician's orders for 1 of 17 residents whose physician's orders were reviewed (Resident 11), and failed to accurately assess and document a wound for 1 of 7 residents reviewed for non pressure skin conditions. (Resident 5). The facility failed to obtain treatment orders for a new admission (Resident 127) and failed to transcribe and administer prescribed treatment orders from a follow-up post operative appointment. (Resident 63) for 1 of 17 residents reviewed for quality of care.<br><br>Findings include:<br><br>1. During an interview and observation, on 7/8/2024 at 2:18 P.M., Resident 11 indicated he had problems with water retention in both of his lower legs and feet, and was not on a fluid restriction and was given as much to drink as he wanted. He indicated he did not wear any devices to help with the fluid retention. The resident had a full 20 ounce cup of water,dated 7/8/2024 and his lower legs and feet were observed to be swollen.<br><br>During an observation, on 7/9/2024 at 11:05 A.M., Resident 11 had a 20 ounce cup of water, dated 7/9/2024, on his bedside table and his lower legs and feet remained swollen.<br><br>During an observation, on 7/10/2024 at 9:55 A.M., Resident 11's lower legs and feet remained swollen. He had a 20 ounce cup of water, dated 7/10/2024, that was half empty and a second 20 ounce cup full of water without a date.<br><br>A record review was completed on 7/10/2024 at 1:11 P.M. for Resident 11. Diagnoses included, but were not limited to, dementia, stage 3 chronic | F 0684 | **F684 Quality of care**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 11 plan of care updated regarding fluid restriction, resident 5 skin assessment completed and plan of care updated for identified skin issue with tx plan, resident 127 no longer a resident, resident 63 skin assessment completed and plan of care updated for appropriate tx plan per orders<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 the alleged deficient practice. All current resident's skin assessed for any new areas and plan of care updated accordingly. All new admission skin assessed for the last 7 days to ensure treatment plan is initiated/transcribed for any identified skin issues upon admission. Resident appointments reviewed for the last 7 days to ensure any new orders are transcribed timely per policy. All residents with fluid restriction orders reviewed for fluid restrictions and plan of care updated accordingly for all departments affected for communication regarding | 08/09/2024 |

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| | kidney disease, hypertension, post traumatic stress disorder, anxiety disorder, major depressive disorder, glaucoma and benign prostatic hyperplasia.<br><br>A current Physician's Order, indicated the resident was on an 1800 mL (milliliter) fluid restriction. Dietary was to offer 1080 mLs a day and nursing staff could offer 240 mL per shift.<br><br>A Quarterly MDS (Minimum Data Set), dated, 6/26/2024 indicated Resident 11's cognition was intact.<br><br>A current Care Plan, dated 6/25/2021, indicated Resident 11 had history of significant weight gain and losses throughout his stay and was on daily diuretic medication which could contribute to weight changes. The goal was to have no significant undesirable weight changes. Interventions to the Care Plan included, but were not limited to, provide fluid restriction as ordered and diet as ordered.<br><br>An interview was completed on 7/11/2024 at 9:43 A.M. CNA 2 indicated she was responsible for taking care of Resident 11. Water should be passed at the beginning of every shift and then refilled as needed. CNA 2 was not aware the resident had a fluid restriction and gave him a full cup of water. Staff typically knows a resident is on a fluid restriction because fluid restrictions were posted on a list in the kitchenette, but Resident 11 was not on the fluid restriction list. The cups that were used to pass water contained 20 ounces or 591 mL. Resident 11 should not have been given a cup of water with 591 mLs.<br><br>During an interview, on 7/11/2024 at 9:45 A.M., CNA 2 indicated she was assigned to care for | | restriction need to ensure order is followed.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on fluid restriction policy, and wound treatment management policy. DNS/Nurse Manger/designee to review skin assessment for new admissions 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure identified skin issues have an active treatment plan per policy/orders. DNS and/or nurse management team to randomly review skin assessments for current residents to ensure any identified wound has an active treatment plan per policy/order. These audits to be conducted as follows: 5 residents/week x 4 weeks, then 3 residents/week x 2 months, than 1 resident/week x 3 months. Resident appointment documents to be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure any new orders/treatment plans are transcribed timely. Resident new orders to be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure any new orders for fluid restrictions are | |

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| | Resident 11. Water was to be passed at the beginning of every shift and then refilled as needed. CNA 2 was not aware Resident 11 had a fluid restriction and had given him full cup of water. She indicated staff were notified of any fluid restrictions from a list posted in he kitchenette and Resident 11 was not on he list of residents with fluid restrictions. The water cups used to pass ice water were 591 ml and residents on fluid restrictions were not to have full cups of ice water.<br><br>On 7/11/2024 at 9:50 A.M., the Regional Nurse Consultant provided an undated policy, titled, "Fluid Restriction," and identified it as the policy currently used by the facility. The policy indicated, "...It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders... 2. The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes... 4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction...."2. During an observation of Resident 5, on 7/8/2024 at 10:11 A.M., dark reddish/brown scabs were noted on Resident 5's left foot 2nd and 3rd toes.<br><br>A record review was completed on 7/9/2024 at 1:48 P.M. for Resident 5. Diagnoses, included but were not limited to, peripheral venous insufficiency and type 2 diabetes mellitus.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 5/3/2024 indicated the resident was moderately cognitively impaired, had not exhibited any behavioral issues, was dependent on staff for bathing, transferring and toielting needs, was frequently incontinent of his bladder and always incontinent of his bowels, was at risk | | implemented/communicated according to policy and plan of care updated.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |

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| | for pressure ulcers but had none, had a pressure reducing mattress and cushion for his wheelchair and had creams and ointments applied to his skin other than his feet.<br><br>The Physician's Order Summary's included the following orders: elevate legs and float heels while in bed.<br><br>A current Care Plan problem, initiated on 8/27/2019, indicated the resident was at risk for pressure ulcers. The interventions included, but were not limited to, conduct a weekly skin inspection and check skin during bathing.<br><br>A Weekly Skin Assessment, dated 7/8/2024, indicated his skin was intact and there were no orders for wound care.<br><br>During an interview, on 7/11/2024 at 2:58 P.M., the Unit Manager indicated she did not think Resident 5 currently had any wounds. After the Unit Manager was made aware of Resident 5's wounds, she indicated the wounds should have been noted during the weekly assessment.<br><br>During an interview, on 7/11/2024 at 2:59 P.M., LPN 4 indicated he did not know about any wounds for Resident 5.<br><br>On 7/1//2024 at 8:30 A.M., the Executive Director provided a current, undated, policy titled, "Skin Integrity-Skin Tears." The policy indicated, "...a. Licensed nurses will conduct skin assessments in accordance with facility policy...."3. During an interview on 7/8/2024 at 2:56 P.M., a family member indicated Resident 63 had back surgery on 6/13/2024. On 6/26/2024 following a post-operative visit, she returned with treatment orders and the orders did not get initiated for a | | | |

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| | couple days afterwards.<br><br>A record review was completed on 7/12/2024 at 7:45 A.M. for Resident 63. Diagnoses included, but not limited to, status post lumbar decompression/discectomy tube based right L 2-3, low back pain and type 2 diabetes with chronic kidney disease.<br><br>A Physician Progress Note, dated 6/26/2024, indicated to see wound care and betadine was tot be applied daily with a light dressing.<br><br>A Treatment Administration Record (TAR), dated 6/1/2024 - 6/30/2024, indicated an order was initiated on 6/28/2024 on the evening shift to cleanse the surgical wound, pat dry and apply betadine twice a day.<br><br>During an interview on 7/11/2024 at 2:42 P.M., the Wound Nurse indicated Resident 63 had returned from her post operative appointment on 6/26/2024 with an order for betadine and a dressing.<br><br>During an interview on 7/12/2024 at 11:00 A.M., the Regional Nurse Consultant indicated she did not know why the order was not written until 6/28/2024.<br><br>On 7/12/2024 at 1:14 P.M., a policy was requested, the Regional Nurse Consultant indicated the facility did not have one.<br><br>4. During an interview and observation on 7/8/2024 at 11:23 A.M., Resident 127 indicated his right hip surgical site dressing had not been changed every day and the staff just peeked under his skin tear dressing to the right wrist and layed the dressing back down. The hip dressing had visible bloody drainage and was undated, and | | | |

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| | the right wrist dressing was undated.<br><br>A record review was completed on 7/10/2024 at 9:46 A.M., for Resident 127. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur and initial encounter for closed fracture. He was admitted to the facility on 7/3/2024.<br><br>During an observation on 7/9/2024 at 1:26 P.M., Resident 127 indicated his dressings had been changed, and he had told them to date the hip dressing, but they did not date the wrist.<br><br>A Nursing Admission General Note, dated 7/3/2024, indicated there was a skin issue to the right anterior wrist and redness and bruising to the right hip. There was no mention of the surgical wound to Resident 127's right hip.<br><br>The current Physician's Order Summary, for July 2024, indicated there were no treatment orders for the right wrist skin tear nor the right hip surgical site.<br><br>During an interview on 7/10/2024 at 1:08 P.M., the Wound Nurse indicated the treatment orders for the skin tear and the right hip surgical site should have been obtained upon admission and when a dressing was changed, it should be dated with the nurse's initial.<br><br>On 7/10/2024 at 1:44 P.M., the Wound Nurse provided a policy titled, "Wound Treatment Management," undated, and indicated the policy was the one currently used by the facility. the policy indicated, "...Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards | | | |

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| | of practice and physician orders. Policy Explanation and Compliance Guidelines: 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse....."<br><br>3.1-37(a) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>Based on observation, interview and record review the facility failed to ensure a catheter was anchored to prevent excessive tension on the catheter for 1 of 1 resident reviewed for urinary catheters. (Resident 128)<br><br>Finding includes:<br><br>During an interview, on 7/9/2024 at 9:58 A.M., Resident 128 indicated he had asked multiple times for several days on all three shifts for a catheter strap. He had an issue with blood in his catheter and was fearful of it getting pulled out.<br><br>A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128. Diagnosis included but not limited to: paraplegia, osteomyelitis of vertebra in the sacral and sacrococcygeal region, residual foreign body in soft tissue, pressure ulcer of unspecified site, unspecified stage, and unstageable pressure ulcer of sacral region.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated the resident had no cognitive impairment.<br><br>During an observation of Resident 128's urinary catheter, on 7/10/2024 at 10:23 A.M., 7/11/2024 at 1:25 P.M., there was no catheter strap in place.<br><br>A current Care Plan, dated 7/3/2024, indicated the resident had a foley catheter related to a stage 4 sacral wound. Interventions, included but were | F 0690 | **F690 Bowel/Bladder Incontinence, Catheter, UTI**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 128 no longer a resident<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 the alleged deficient practice. All residents identified with a foley catheter were provided a leg strap per plan of care.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Nursing staff educated on Indwelling catheter use and removal policy. Residents with a foley will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure leg strap is in place per plan of care.<br>• how the corrective | 08/09/2024 |

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| | not limited to, anchor catheter to avoid excessive tugging on the catheter during transfers and delivery of care.<br><br>During an interview, on 7/11/2024 at 1:27 P.M., LPN 3 indicated, to avoid excessive tugging on a urinary catheter during care and transfers, staff should make sure the urinary collection bag and tubing was unhooked from the bed and chair and fastened down with a catheter strap. If the tubing was not secured, the catheter could get pulled out and cause trauma to the urethra. LPN 3 indicated the physician's orders "batched" for the care of urinary catheters did not have a specific order regarding providing catheter straps, but it would help Resident 129 if a catheter strap was provided and applied.<br><br>On 7/11/2024 at 1:01 P.M., the Regional Nurse Consultant provided a policy titled, "Indwelling Catheter Use and Removal", undated, and indicated the policy was the on currently used by the facility. The policy indicated "...7. Additional care practices include: d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter....."<br>3.1-(2) | | 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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |
| F 0693<br>SS=D<br>Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able | | | |

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| | to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on observation, record review and interviews, the facility failed to ensure physician orders regarding tube feeding orders were followed for 1 of 1 residents with tube feeding. (Resident 53)<br><br>Finding includes:<br><br>During an observation, on 7/11/2024 at 10:45 A.M., Resident 35 had a container of Jevity 1.5 (Brand of food used in feeding tubes) with 350 mL of formula remaining in the bag. The bag was still connected to a feeding tube pump that was turned off.<br><br>Resident 35's record review was completed on 7/11/2024 at 11:40 A.M. Diagnoses included, but were not limited to, conversion disorder with seizures and convulsions, diabetes insipidus, bipolar disorder, dysphagia, anxiety, and dementia.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 5/8/2024, indicated Resident 35 was severely cognitively impaired and had a feeding tube. | F 0693 | **F693 Tube Feeding Management/restore eating skills**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; NP was notified on 7.11.24 that Resident 128 did not received full amount of Jevity from previous night. No new orders were given at this time.<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 the alleged deficient practice. All residents identified with a G-tube were reviewed/observed to ensure completion of enteral nutrition was provided per order.<br>• what measures will be | 08/09/2024 |

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| | A current Physicians Order indicated the resident was to receive 1050 mL (milliliters) of Jevity 1.5 daily.<br><br>A July 2024 Medication Administration Record (MAR) indicated the resident had received the full amount of Jevity 1.5 on 7/11/2024.<br><br>A current Care Plan, indicated Resident 35 was dependent on tube feeding. The goals of the care plan were to have no undesirable weight changes, be free from discomfort, and be free from dehydration. Interventions included, but were not limited to, enteral formula and feedings as ordered, monitor ins and outs, and water flush.<br><br>During an interview, on 7/11/2024 at 2:06 P.M., the Unit Manager indicated Resident 35 did not get all of his prescribed tube feed that day.<br><br>On 7/11/2024 at 1:36 P.M., Regional Nurse 14 provided an undated policy, titled, "Care and Treatment of Feeding Tubes", and identified it as the policy currently used by the facility. The policy indicated, "... e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders...."<br><br>3.1-44(a)(2) | | put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on care and treatment of feeding tube policy. Residents with a feeding tube will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure full nutrition via feeding tube is provided per order.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |
| 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, record review and interviews, the facility failed to ensure physician orders regarding dressing changes were followed for 1 of 1 residents reviewed for intravenous fluids. (Resident 128)<br><br>Finding includes:<br><br>During an observation and interview on 7/9/2024 at 10:14 A.M., Resident 128 indicated his peripheral inserted central catheter (PICC) line dressing had only been changed once since he was admitted. The date on the dressing was 6/29. The dressing had gauze tape applied around the edges of the dressing.<br><br>A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128. Diagnosis included but not limited to, paraplegia, osteomyelitis of vertebra, sacral and sacrococcygeal, region, residual foreign body in soft tissue pressure ulcer of unspecified site, unspecified stage, pressure ulcer of sacral region, unstageable.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated he had no cognitive impairment.<br><br>A Physician's Order, dated 6/21/2024, indicated to the PICC line dressing was to be changed upon admission, then weekly and as needed, on the night shift every Sunday.<br><br>A Medication Administration Record (MAR), dated 6/1/2024-6/30/2024, indicated the dressing was changed on 6/23/2024, and 6/30/2024.<br><br>A Medication Administration Record, dated 7/1/2024 - 7/31/2024 indicated the dressing was changed on 7/7/2024. | F 0694 | **F694 Parental/IV fluids**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 128 was assessed at the time and no ill effect r/t the deficient practice was noted, resident no longer in facility. LPN #17 was immediately educated regarding the “PICC/Midline/CVAD Dressing Change” and “Hand Hygiene” policies and observed performing a PICC line dressing change and hand hygiene utilizing the validation checklists.<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. All current residents with PICC lines were reviewed to ensure no other residents were affected; no concerns were noted.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>The Director of Clinical Education/designee will in-service all licensed nurses on the “PICC/Midline/CVAD Dressing Change” and “Hand Hygiene” policies and will perform check offs with licensed nurses utilizing the PICC/Midline/CVAD Dressing | 08/09/2024 |

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| | A Nursing Progress Note, dated 6/29/204 at 7:28 P.M., indicated the Access RN was in the building and the PICC line dressing changed was completed.<br><br>A Care Plan, dated 6/21/2024, indicated the resident had a potential risk for infection at the PICC line site with an intervention for dressings to be changed as ordered.<br><br>During an interview on 7/9/2024 at 3:30 P.M., LPN 15 indicated the date on the PICC line dressing was 6/29. She indicated it looked like someone re-enforced the dressing with tape and it was not ok to leave the dressing on that long.<br><br>During an interview on 7/12/2024 at 12:47 P.M., the Infection Preventionist (IP) Nurse indicated that the dressing was not changed and the MAR was inaccurately signed on 7/7/2024.<br><br>During an interview on 7/10/2024 at 10:16 A.M., the IP (Infection Preventionist) Nurse indicated she could not find any documentation the dressing had been changed upon the resident's admission to the facility. She could not find that it was required in the facility policy and did not know why it was ordered to be changed upon admission.<br><br>On 7/10/2024 at 8:25 A.M., the IP Nurse provided a policy titled, "PICC/Midline/CVAD Dressing Change," undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Policy: It is the policy of this facility to change peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or | | Change and the Hand Hygiene validation checklists prior to the date of compliance. The Director of Nursing/designee will audit 3 random residents with sterile dressings to ensure sterile dressings are changed according to facility policy. Audits will occur daily x 6 weeks, then 5x/week x 4 weeks, then weekly x 4 months.<br>The Director of Clinical Education/Infection Prevention Nurse/designee will audit 3 random staff to ensure hand hygiene is performed according to facility policy. Audits will occur daily x 6 weeks, then 5x/week x 4 weeks, then weekly x 4 months. Audits will include all shifts and units and weekends.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |

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| | cross-contamination. Physician's orders will specify type and frequency of changes....."<br><br>3.1-47(a)(2) | | | |
| F 0755 SS=D Bldg. 00 | 483.45(a)(b)(1)-(3)<br>Pharmacy<br>Srvcs/Procedures/Pharmacist/Records<br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and | | | |

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| | periodically reconciled.<br>Based on observation and interview the facility failed to ensure reconciliation of controlled drugs was completed for 3 of 3 carts reviewed for narcotic counts. (B-Wing Hall 1 medication cart, C-Wing Hall 1 medication cart, and C-Wing Hall 2 medication cart)<br><br>Findings include:<br><br>1. During an observation of the B-Wing Hall 1 medication cart on 7/12/2024 at 9:48 A.M., with LPN 11, the narcotic reconciliation sheets were missing signatures between 6/17/2024 and 7/11/2024.<br><br>During an interview, on 7/12/2024 at 9:58 A.M., LPN 11 indicated narcotics should be counted by the off going nurse with the oncoming nurse and the reconciliation sheet should be signed by both nurses every shift.<br><br>2. During an observation, of the C-Wing Hall 1 medication cart on 7/12/2024 at 10:34 A.M., with QMA 9, the narcotic reconciliation sheets were missing signatures between 6/13/2024 and 7/11/2024.<br><br>During an interview, on 7/12/2024 at 10:35 A.M., QMA 9 indicated the reconciliation of narcotics should be done every shift and both the off going and oncoming nurses should sign the sheet.<br><br>3. During and observation of the C-Wing Hall 2 medication cart on 7/12/2024 at 10:20 A.M., with QMA 9, the narcotic reconciliation sheets were missing signatures between 5/30/2024 and 6/12/2024.<br><br>During an interview, on 7/12/2024 at 10:21 A.M., | F 0755 | **F755 Pharmacy services/procedures/pharmacist /records**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Narcotic reconciliation sheets updated per policy<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. All narcotic reconciliation sheets reviewed and updated per policy.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on Controlled substance administration and accountability policy. DNS and/or nurse management team will review narcotic reconciliation sheets 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure signatures are present by offgoing nurse and oncoming nurse.<br>• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality | 08/09/2024 |

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| | the Infection Preventionist (IP) Nurse indicated the narcotic reconciliation sheets should be signed by both the off going and oncoming nurses after counting the narcotics.<br><br>On 7/12/2024 at 12:42 P.M., the Regional Nurse Consultant provided a current, undated policy, titled, "Controlled Substance Administration & Accountability." The policy indicated, "...The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure...." "...a. The entire amount of controlled substances obtained or dispensed is accounted for...."<br><br>3.1-25(n) | | assurance program will be put into place;<br>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |
| 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 | | | |

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| | 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 interview and observation the facility failed to properly store medications in 1 of 3 carts reviewed for storage. (C-Wing Hall 1 medication cart)<br><br>Finding includes:<br><br>1. During an observation of the C-wing Hall 1 medication cart on 7/12/2024 at 10:34 A.M. the following was noted:<br><br>A. A bottle of Lantus insulin for Resident 176 was found unopened in the cart. It had a label which indicated t was to be refrigerated until opened.<br><br>During an interview, on 7/12/2024 at 10:36 A.M., the IP nurse indicated the insulin should have been in the refrigerator until it was opened.<br><br>B. A bottle of Timolol eye drops and Brimondine eye drops, both for Resident 177, were found opened but undated.<br><br>During an interview, on 7/12/2024 at 10:34 A.M., QMA 9 indicated the eye drops should have been dated when opened.<br><br>On 7/12/2024 at 12:42 P.M., the Regional Nurse Consultant provided a current, undated, policy titled, "Medication Storage." The policy indicated, "...All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room...."<br><br>3.1-25(j) | F 0761 | **F761 Label/storage drugs and biologicals**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Lantus insulin medication, Brimondine, and timolol eye drops removed from cart and destroyed per policy<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 medication carts audited for improper labeling/storage of medications, and identified items labeled/stored improperly were removed and returned/destroyed per policy<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on medication storage policy. All medication carts will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure medications are stored/labeled according to | 08/09/2024 |

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| | | | policy.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional | | | |

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| | standards for food service safety.<br>Based on observation, record review and interview, the facility failed to dispose of leftovers timely in the walk-in cooler of the kitchen. This had the possibility to affect 2 of 2 resident with altered diets who received their meals from the kitchen.<br><br>Finding includes:<br><br>During the initial kitchen tour with the Registered Dietician (RD) on 7/8/2024 at 9:45 A.M., three tray, dated 7/2/2024, were observed in the refrigerator and held 8 glasses of milk, 2 glasses of water, 3 glasses of cranberry juice and 2 glasses of orange juice. The RD indicated the drinks were all thickened for residents who had altered liquid diet orders and the date on the tray was the date the drinks were prepared.<br><br>During an interview, on 7/8/2024 at 10:15 A.M., the Regional Certified Dietary Manager (RCDM) indicated left overs were good for three days and prepared food should containing a made on date and a discard date.<br><br>On 7/9/2024 at 1:27 P.M., the RCDM provided an undated policy, titled, "Storage of Refrigerated Foods," and identified it as the policy currently used by the facility. The policy indicated, "...The dining services department will store refrigerated foods...Foods Storage/Leftovers...All items not stored in original container must be labeled and noted with "use by" date according to storage chart, used or discarded within allowed days per manufacturer directions. Recipe prepared items should be discarded 3 days from preparation if not used...."<br><br>3.1-21(a)(3) | F 0812 | F812 Food Procurement, Store/Prepare/Serve- Sanitary<br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>All outdated leftovers have been disposed. All food items not in original containers have a “use by” date on them.<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 other residents have the potential to be affected by the deficient practice. An audit of the kitchen was completed to use all applicable food items are labeled with a “use by” date and all outdated food has been disposed.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>All dietary staff will be educated on the “Storage of Refrigerated Foods” policy. Dietary staff have a daily checklist and will audit the kitchen daily to ensure proper dating is in place and to ensure any outdated food is disposed. Checklist will be completed and reviewed by management team 5 times weekly x 30 days, then 3 times weekly x 30 days, then 2 times weekly x 4 months, to | 08/09/2024 |

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| | | | ensure all checks are completed consistently.<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; and<br>Results of these audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring. | |
| F 0868<br>SS=E<br>Bldg. 00 | 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br>QAA Committee<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to | | | |

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| | coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee.<br>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.<br>Based on interview and record review the facility failed to ensure the Medical Director or his designee attended the quarterly Quality Assurance and Performance Improvement (QAPI) meeting during the past year.<br><br>Finding includes:<br><br>During an interview on 7/12/2024 at 1:56 P.M., the Administrator indicated the Medical Director had not attended the quarterly meetings, but she reviewed them with him or sent the minutes from the meeting to the Medical Director via an e-mail. The Nurse Practitioner attended some facility meetings, such as the nutrition at risk/wound, behavior, morning meeting or stand down meetings, but the QAPI signature log did not indicate she had attended any QAPI meetings during the past year.<br><br>On 7/12/2024 at 2:00 P.M., the Administrator provided a policy titled, "Quality Assurance and Performance Improvement," undated and indicated the policy was currently the one used | F 0868 | F868 QAA Committee<br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Medical Director and his designee have been educated on the Quality Assurance and Performance Improvement policy and the requirement of at least quarterly attendance and signage to the attendance sheet. A review of the past quarter of QAPI occurred with the MD, with signature obtained.<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 the deficient practice. Medical Director and his designee have been educated on the Quality Assurance and | 08/09/2024 |

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| | by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines: 2. The QAA Committee shall be Interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services ii. The Medical Director or his/her designee iii.At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program,such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary....."<br><br>3.1-52(a) | | Performance Improvement policy and the requirement of at least quarterly attendance and signage to the attendance sheet.<br>Additional calendar invites for the QAPI meeting have been sent to the medical director and his designee.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Medical Director and Designee have calendar invites for all future QAPI meeting. ED or Designee will review QAPI minutes and attendance sheets monthly for 6 months to ensure Medical Director or Designee attendance.<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; and<br>Results of these audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring. | |
| F 0880 SS=D 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 | | | |

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| | 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, 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. | | | |

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| | (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.<br><br>§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. | | | |
| | Based on observation, interview and record review, the facility failed to ensure infection control practice was maintained regarding glove use and hand washing during a sterile procedure for 1 of 1 residents observed during a dressing change procedure. (Resident 128)<br><br>Finding includes:<br><br>During an observation of a peripheral inserted central catheter (PICC) line dressing change on 7/9/2024 from 4:03 P.M. to 4:10 P.M., LPN 15 placed the dressing kit on the Resident's nightstand without a barrier or disinfecting the surface prior to placing the kit on the nightstand. Then she opened the dressing kit, donned sterile | F 0880 | **F880 Infection prevention and control**<br><br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 128 was assessed and no ill effect r/t the deficient practice was noted. LPN #17 was immediately educated regarding the “PICC/Midline/CVAD Dressing Change” and “Hand Hygiene” policies and observed performing a PICC line dressing change and hand hygiene utilizing the | 08/09/2024 |

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| | gloves and removed the old dressing. Without changing her gloves, she took the antimicrobial sponge disk and cleaned an area below the insertion site, then did a circular motion to clean around the insertion site. She then applied skin prep on the whole area and then patted it with gauze, applied transparent dressing, removed her gloves and performed hand hygiene. The resident was not offered a mask or asked to turn his head away from the insertion site. His head was not turned away from his chest and he was talking to the nurse while the dressing was changed.<br><br>During an interview on 7/9/2-24 at 4:12 P.M., LPN 15 indicated nothing had touched the table as everything was inside the packet so she thought she did not need a barrier or needed to clean the surface prior to placing the kit on the nightstand. During the dressing change, her left gloved hand held down the tubing and used her right hand with the sterile glove to remove the dressing. She did not think she needed to remove the gloves and perform hand hygiene and donn sterile gloves to clean the site and apply new dressing. She did not feel the area she touched first with the antimicrobial sponge was contaminated since it was under the old dressing. She did indicate that she should have offered the resident a mask<br><br>On 7/10/2024 at 8:25 A.M., the Infection Preventionist Nurse provided a policy titled, "PICC/Midline/CVAD Dressing Change, undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Explanation and Compliance Guidelines: 3. Perform hand hygiene. a. Put on mask. b. Place mask on resident if they cannot keep their head turned away. c. Perform hand hygiene. d. Set up clean field on the overbed table with needed supplies for the dressing change. If the table is | | validation checklists.<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. All current residents with PICC lines were reviewed to ensure no other residents were affected; no concerns were noted.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>The Director of Clinical Education/designee will in-service all licensed nurses on the "PICC/Midline/CVAD Dressing Change" and "Hand Hygiene" policies and will perform check offs with licensed nurses utilizing the PICC/Midline/CVAD Dressing Change and the Hand Hygiene validation checklists prior to the date of compliance. The Director of Nursing/designee will audit 3 random residents with sterile dressings to ensure sterile dressings are changed according to facility policy. Audits will occur daily x 6 weeks, then 5x/week x 4 weeks, then weekly x 4 months.<br>The Director of Clinical Education/Infection Prevention Nurse/designee will audit 3 random staff to ensure hand hygiene is performed according to facility policy. Audits will occur | |

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| | soiled, wipe clean before setting up clean field. e. Place a disposable cloth or linen saver on the overbed table. 4. Wash hands and put on clean gloves. 5. Position resident with arm extended away from the body and below the heart level or if a CVAD, have resident turn head away from the insertion site or have them wear a mask. 7. Remove old dressing at the devoice beginning at the device hub and gently pull the dressing perpendicular to the skin toward the insertion site. 8. If the resident has a chlorhexidine -impregnated sponge dressing at the insertion site, remove and discard into the appropriate receptacle. 11. Remove and discard gloves. 14. Clean the insertion site with an antiseptic following manufactures' instructions. a. Apply chlorhexidine (if present in kit) with an applicator using a side-to-side motion for at least 30 seconds. Allow to dry completely....."<br><br>3.1-18(b) | | daily x 6 weeks, then 5x/week x 4 weeks, then weekly x 4 months. Audits will include all shifts and units and weekends.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | |
| F 0887<br>SS=D<br>Bldg. 00 | 483.80(d)(3)(i)-(vii)<br>COVID-19 Immunization<br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative | | | |

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| | receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the<br>benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br>Based on record review and interview, the facility failed to document declination forms for COVID immunizations for 3 of 5 residents reviewed for immunizations. (Residents 1, 3, & 24)<br><br>Finding includes:<br><br>On 7/11/2024 at 1:06 P.M., a record review was completed for Residents 1, 3 & 24. The records lacked documentation of signed declination forms for the covid vaccine.<br><br>During an interview, on 7/11/2024 at 2:55 P.M., the Infection Prevention Nurse indicated she did not have signed declination forms for residents 1, 3, or 24 and she should have had each resident sign a declination form.<br><br>On 7/12/2024 at 11:17 A.M., the Regional Nurse provided the policy titled, "COVID Vaccination," no date, and indicated it was the policy currently in use by the facility. The policy indicated, " ...The resident's medical record will include documentation of the following: If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal ...." | F 0887 | **F887 COVID-19 Immunization**<br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<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>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Licensed staff educated on COVID-19 vaccination policy.<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>DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue. | 08/09/2024 |
| F 0921 SS=D Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155178 | A. BUILDING 00<br>B. WING | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| | residents, staff and the public.<br>Based on observation, interview and record review, the facility failed to maintain a temperature log for a resident's personal refrigerator for 1 of 2 residents reviewed for personal refrigerators. (Resident 9)<br><br>Finding includes:<br><br>During an observation, on 7/11/2024 at 12:30 P.M., Resident 9's personal refrigerator did not have a thermometer or a temperature log.<br><br>During an interview, on 7/11/2024 at 3:05 P.M., the Unit Manager indicated there should have been a thermometer in the fridge and temperature log record sheet for the refrigerator.<br><br>On 7/11/2024 at 1:25 P.M., the Administrator provided the policy titled, "Resident Refrigerators," no date, and indicated it was the policy currently in use by the facility. The policy indicated, " ... 2. Staff shall record refrigerator temperatures weekly on a temperature log. a. A thermometer shall remain in the refrigerator. It shall be calibrated prior to use and periodically thereafter. 3. Nursing/housekeeping staff shall clean the refrigerator weekly and discard any foods that are out of compliance. 4. Residents and staff shall comply with safe food handling and storage principles: c. Foods with use by dates shall be discarded accordingly ...."<br><br>3.1-19(f) | F 0921 | F921<br>Safe/Functional/Sanitary/Comfortable Environment<br>• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Resident 9 has a temperature log and a thermometer for her personal refrigerator.<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>A facility-wide audit of personal refrigerators occurred. All residents with personal refrigerators have a temperature log and thermometer present.<br>• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>All staff have been educated on the “Resident Refrigerators” policy. Management team will check and record refrigerator temperatures 5 times per week. ED or designee will check the temperature logs 5 times weekly x 30 days, then 3 times weekly x 30 days, then 2 times weekly x 4 months, to ensure all checks are completed consistently.<br>• how the corrective action(s) will be monitored to ensure the deficient practice will | 08/09/2024 |

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| | | | not recur, i.e., what quality assurance program will be put into place; and<br>Results of these audits will be reviewed by the QAPI Committee for a period of at least 6 months to determine the need for further monitoring. | |