STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00388366 and IN00390225. Complaint IN00388366 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690 and F921. Complaint IN00390225 - Unsubstantiated due to lack of evidence. Survey dates: September 29, 30 and October 3, 4, 5, 6, 2022 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 83 SNF: 6 Total: 89 Census Payor Type: Medicare: 7 Medicaid: 60 Other: 22 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 18, 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. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/4/22.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Executive Director	10/31/2022

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview, the facility failed to ensure residents were assisted to eat, in the dining room, with dignity, when staff stood over them during the meal. (Resident 20 and 31) Findings include: 1. On 9/29/22 at 12:20 p.m., during a random dining observation, Resident 20 was observed as she sat in a Broda (specialized high-back) chair at the dining table, in the main dining room. On 9/29/22 at 12:25 p.m., Certified Nurse Aid (CNA) 5 was observed as she pushed a rolling stool, with her foot, beside where Resident 20 was seated. The resident's meal tray was served. CNA 5 stood beside the resident and opened the containers and prepped the tray, to assist the resident. CNA 5 then assisted the resident to eat by standing over her placing bites of food in her mouth. At 12:34 p.m., CNA 5 then sat down on the stool and finished assisting the resident with her meal. During an interview, on 10/4/22 at 2:10 p.m., the Administrator (ADM) indicated there were no policies for standing to feed a resident. During an interview, on 10/4/22 at 2:14 p.m., the Director of Nursing (DON) indicated there was no policy or procedure on how to feed a resident. She would probably sit down, but that would be her preference. It was not the policy of the facility to sit down when feeding a resident. 2. During an observation, on 10/04/22 at 12:20 p.m., CNA 23 was standing to feed Resident 31 her lunch in the	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 20 and 31 will be assisted to eat with dignity in the dining room during meals **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No other residents have been affected or voiced concerns. All residents that need assistance with eating have potential to be affected by the alleged deficient practice. - Facility to provide education to staff via staff inservicing by 11/4/22. Education to include Resident Rights related to assistance with eating during meals with dignity **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Facility to provide education to staff via staff in servicing. Education to include Resident Rights related to assistance with eating during meals with dignity	11/04/2022

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	200 hall dining room. During an interview, on 10/04/22 at 12:29 p.m., CNA 23 indicated the expectation was to sit on a chair and she was supposed to sit down when feeding the resident. During an interview, on 10/04/22 at 2:33 p.m., the DON indicated the staff should sit down when feeding the resident. A current policy, titled "Resident Rights," dated 11/16 and received from the DON on 10/06/22 at 11:00 a.m., indicated "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...." 3.1-3(t)		- CDM/designee will observe meals to ensure residents are assisted with dignity - Education to be provided, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The CDM/designee will be responsible for the completion of the Meal Observation CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure the IDT (Interdisciplinary Team)determined which medications may be self-administered and failed to ensure a physician's order to use and keep	F 0554	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	11/04/2022

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	medications at the bedside was obtained for 1 of 1 resident reviewed for self administration. (Resident 57) Finding includes: During an observation, on 09/29/22 at 11:54 a.m., a Pro Air (Albuterol Sulfate) Inhaler was observed at the bedside. During an interview, at that time, Resident 57 indicated he used the inhaler as needed for anxiety. The record for Resident 57 was reviewed on 09/30/22 at 9:56 a.m. Diagnoses included, but were not limited to, acute on chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease with (acute) exacerbation, and pain. During the record review, on 09/30/22 at 10:31 a.m., there was no assessment for the resident to self-administer an Albuterol Sulfate Inhaler (A medication to treat shortness of breath) and no physician's order for the resident to keep the medication at the bedside. During an observation, on 10/03/22 at 11:30 a.m., an Albuterol Sulfate Inhaler was at the bedside and there was no physician's order at that time. During an interview, on 10/03/22 at 11:38 am., the Unit Manager on 200 hall indicated the resident was allowed to keep and use the rescue Albuterol Inhaler at the bedside as needed for shortness of breath and he usually let the nurse know when he used the inhaler. During an interview, on 10/03/22 at 2:22 p.m., the Director of Nursing (DON) indicated the resident did not have an order to keep and use Albuterol		- Resident 57 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** -No other residents have been affected. Any resident that is deemed by the Interdisciplinary Care team (IDT) and receives a Physician's Order to use and keep medications at bedside, have the potential to be affected. -Inservice to be completed by 11/4/2022 educating staff on Storage and Expiration Dating of Medications, Biologicals. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 11/4/2022 educating staff on Storage and Expiration Dating of Medications, Biologicals. Any resident determined to self administer medications, will have a completed assessment and a physician's order -DNS/designee will do rounds to ensure medications are not left at the bedside **How the corrective action(s) will be monitored to ensure the**	

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	Inhaler at the bedside and the facility did not complete the self-administration paperwork. The expectation was to assess the resident and have the physician's order before the resident could keep and use the medication at the bedside. A current policy, titled "5.3 Storage and Expiration Dating of Medications, Biologicals," dated 07/21/22 and received from the DON on 10/06/22 at 11:00 a.m., indicated "...Facility should not administer/Provide bedside medications or biologicals without a Physician/Prescriber order and approval by the interdisciplinary Care Team and Facility administration...." 3.1-11(a)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and			

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	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview and record review, the facility failed to ensure residents had current comprehensive person-centered care plans for enhanced barrier precautions (Residents 67 and 82) and respiratory care for continuous positive pressure (CPAP) treatments (Resident 85) for 3 of 19 residents reviewed for care plans. Findings include: 1. On 9/29/22 at 11:15 a.m., during the initial tour of the facility, Resident 67's room door had a sign for "Enhanced Barrier Precautions." There was a cart with personal protective equipment (PPE)	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 67 no longer has a CPAP machine Resident 82 Care Plan has been reviewed and updated for the enhanced barrier precautions Resident 85 Care Plan has been reviewed and updated with Respiratory care for continuous positive pressure (CPAP)	11/04/2022

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	observed outside the door. On 9/30/22 at 12:40 p.m., Resident 67's medical record was reviewed. On 8/30/22, a physician's order indicated enhanced barrier precautions. There were no care plans for enhanced barrier precautions. 2. On 9/29/22 at 11:20 a.m., during the initial tour of the facility, Resident 67's room door had a sign for "Enhanced Barrier Precautions." There was a cart with personal protective equipment (PPE) observed outside the door. On 9/30/22 at 12:55 p.m., Resident 82's medical record was reviewed. On 8/30/22, a physician's order indicated enhanced barrier precautions. There were no care plans for enhanced barrier precautions. 3. On 9/30/22 at 9:55 a.m., during the initial tour of the facility, Resident 67's CPAP machine was observed on the bedside table with the nose piece laying on the bedside table surface uncovered and not bagged. On 9/30/22 at 1:00 p.m., Resident 67's medical record was reviewed. Resident 67 had no care plans for use of a CPAP machine. During an interview, on 9/30/22 at 10:15 a.m., Agency Nurse (AN) 8 indicated she did not know		treatments **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** -Any resident with enhanced barrier precautions or utilizing a CPAP machine for treatments has the potential to be affected by the alleged deficient practice -No other residents were identified who had enhance barrier precautions without a corresponding care plan -All residents with CPAP machine were reviewed to ensure care plans were updated and to ensure CPAP's and stored properly -Inservice to be completed by 11/4/2022 educating staff on Comprehensive Care Plans **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 11/4/2022 educating staff on Comprehensive Care Plans -MDS/designee will Review/update care plans when a resident starts on enhanced barrier precautions or starts utilizing a CPAP machine **How the corrective action(s) will be monitored to ensure the deficient practice**	

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	if Resident 67 had a CPAP or not as there was no order in the electronic record. A current policy, titled "Comprehensive Care Plan Policy," dated as revised on 10/19 and received from the Administrator (ADM) on 10/4/22 at 2:10 p.m., indicated "...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment...." 3.1-35(a)		**will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The MDS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADL's), related to shaving and nail care, for 1 of 1 resident reviewed for activities of daily living care. (Resident 290) Findings include: During an observation and interview, on 9/29/22 at 12:00 p.m., Resident 290's facial hair was observed to be a quarter inch long and white in color from his ear to chin. Resident 290 indicated he preferred he had a smooth face with chin hair.	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 290 no longer resides at the facility **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;**	11/04/2022

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	Resident 290's fingernails were observed to be long past the fingertips with brown colored dirt underneath. During an observation, on 9/30/22 at 2:15 p.m., Resident 290's face had not been shaved and his chin, cheeks and neck was noted to be a quarter inch long and white in color. Resident 290's fingernails were long past his fingertips, had an orange staining and were dirty. During an observation and interview, on 10/03/22 at 12:15 p.m., Resident 290 was observed to have long brown colored dirt under his fingernails which extended past his fingertips. Resident 290's family member indicated she shaved the resident on 10/1/22, because Resident 290 preferred to have a clean-shaven face. The record for Resident 290 was reviewed on 10/5/22 at 3:53 p.m. Diagnoses included, but were not limited to, fracture of patella, open reduction internal fixation (ORIF) (a type of surgery used to stabilize and heal a broken bone) of right knee, dementia and needed assistance with personal care. An admission Minimum Data Set (MDS) assessment, dated 9/28/22, indicated Resident 290 had a severe cognitive impairment and had moderately impaired vision. A care area assessment (CAA), dated 09/28/22, indicated Resident 290 required total assistance with ADL's and mobility. Resident 290's record indicated no AM cares were documented on 10/1/22, and no PM cares were documented on 9/27/22 and 9/30/22.		- All residents have the potential to be affected by the alleged deficient practice -Inservices to be completed by 11/4/2022 educating staff on Activities of daily living (ADL's) related to shaving and nail care. -All residents were observed for facial hair and nail care by DNS/designee to ensure residents received the necessary nail care and facial shaving **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - -Inservices to be completed by 11/4/2022 educating staff on Activities of daily living (ADL's) related to shaving and nail care - Facility will implement rounds by DNS/designee, to ensure residents are shaved and nails are clean. - Facility to provide on going training and skills validations for ADLs, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed**	

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	A Shower Report, dated 9/24/22, indicated Resident 290 had nail care provided and lacked indication the resident was shaven. A Shower Report, dated 9/28/22, indicated the resident had nail care provided and lacked indication the resident was shaven. During an interview, on 09/29/2022 at 12:25 p.m., Licensed Practical Nurse (LPN) 25 verified Resident 290 had long dirty fingernails, his facial hair and he did not get shaved. During an interview, on 9/29/22 at 1:00 p.m., Certified Nursing Assistant (CNA) 26 verified Resident 290 had not been shaved, his facial hair was long and his fingernails were dirty. CNA 26 indicated staff should provide care as directed as a part of his morning care. A facility policy for ADL's was requested but was not provided. A facility policy on ADL's was requested and was not received. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)		- The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and			

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	(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to assess, monitor and implement interventions to prevent pressure ulcers from developing for 1 of 1 resident reviewed for pressure ulcers. (Resident 293) Finding includes: During an observation, on 9/29/22 at 2:03 p.m., Resident 293's door was shut and she was observed lying in bed with the head of the bed up at a 75-degree angle. She was observed to be wearing only a hospital gown with her right leg hanging over the edge of the exit side of bed. Her head was resting on the wall with her hips positioned pass the middle crease in the bed and her left foot pressed into the foot board of bed. During an observation, on 9/30/22 at 12:01 p.m., Resident 293's door was shut and she was observed lying flat in the bed wearing only a hospital gown. Both of her legs were found hanging over at the end of the exit side of the bed. No discoloration, scaling, or peeling of Resident 293 bilateral heals or feet was observed. During an observation and interview, on 10/03/22 at 9:48 a.m., with Certified Nursing Assistant (CNA) 15 and Nursing Assistant (NA) 19 Resident 293's bilateral heals were found to be pressed into the foot board with no pillows under the heels. Her heels were boggy to touch, were light red in color and the skin had peeled off both heels. The side of the foot, and the second, third, and forth toes on the left foot had red	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 293 has been assessed and interventions are in place to prevent pressure ulcers from developing **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 po;** - All residents have the potential to be affected by the alleged deficient practice. -Education to be provided via inservicing by 11/4/22. Education to include the skin management program, to ensure interventions are effective. -All residents with the potential to develop wounds were assessed to ensure would interventions were in place per plan of care by DNS/Designee **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via	11/04/2022

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	155199	A. BUILDING 00 B. WING	10/06/2022

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	discoloration. Her right foot first toe was purple in color. Additionally, large pieces of skin were observed lying on at the end of bed under her feet and at the end of bed on the floor. Surveyor prompted CNA 15 to obtain a nurse to assess and evaluate Resident 293's feet. During an observation and interview, on 10/03/22 at 10:08 a.m., Registered Nurse (RN) 24 indicated Resident 293 had skin breakdown and a boggy texture to the skin on both right and left heels and feet. RN 24 indicated Resident 293's feet had been pressing down to the end of the bed and the resident could benefit from Prevalon boots and a visit from the wound nurse. During observation and interview, on 10/03/22 at 10:25 a.m., the Assistant Director of Nursing (ADON) indicated the resident had pink and purple discoloration to heels and toes, skin peeling from the bottom of the feet and a boggy texture of the tissue to both right and left heels. The record for Resident 293 was reviewed on 10/4/22 at 8:30 a.m. Diagnoses included, but were not limited to, sepsis, chronic obstructive pulmonary disease (COPD) (lung disease which block airflow and make it difficult to breathe), congestive heart failure (CHF) (condition in which the heart doesn't pump blood as well), peripheral vascular disease (PVD) (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes mellitus and difficulty in walking. An admission (Minimum Data Set) MDS assessment, dated 9/29/22, indicated Resident 293 had a moderate cognitive impairment. A Care Area Assessment (CAA), dated 9/29/22,		inservicing by 11/4/22. Education to include the skin management program, to ensure interventions are effective. - Facility will implement daily by Management, to ensure residents wound preventions are in place per care plan -Facility to provide on going training and skills validations for wound treatments, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The ADNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	indicated Resident 293 triggered for pressure ulcer injury and required total assist with bed mobility and incontinence. The CAA indicated Resident 293's skin was intact, and had a pressure relieving mattress, cushion in her wheelchair and staff were to reposition frequently. A care plan, dated 9/25/22, indicated the resident had a risk for further skin breakdown due to the history of limited sensory perception, incontinence, including friction and shearing, due to decreased mobility, sepsis, CHF, hypertension, COPD, PVD, and diabetes. The care plan directed staff to float heels when in bed utilizing pillows, gel overlay to mattress, turn and reposition at least every two hours, pressure reducing redistribution mattress on bed and incontinent care as needed. On 10/3/22, Prevalon boots to bilateral lower extremities when in bed was added. A Functional Assessment observation, dated from 9/23/22 to 9/25/22, indicated Resident 293 was dependent on staff for transfers, putting on footwear and lower body dressing. The Functional Assessment indicated Resident 293 required substantial maximal assistance with lying to sitting on side of bed, sitting to lying position, and to roll left and right. A physician's progress note, dated 9/26/22, indicated Resident 293 had fragile skin, bruises, gait instability, weakness and decreased muscle tone. A resident profile, print date of 9/30/22 at 6:30 a.m., lacked indication staff should offload Resident 293's heals or Resident 293 was at risk for developing pressure sores. A skin observation progress note, dated 9/30/22,			

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	indicated Resident 293's skin was warm and dry, with edema noted in bilateral lower extremities. Her bilateral feet were warm, dry with intact skin, with no reddened or discolored areas noted. Pillows were used for positioning, her heels were off loaded, a pressure reducing mattress was on the bed and a cushion was used in a chair. A treatment administration record, indicated on 10/3/22, staff were directed to apply Prevalon boots to bilateral lower extremities when in bed and remove for hygiene and to apply skin prep to bilateral heels every shift. A nurse progress note, dated 10/3/22 at 11:11 a.m., entered as a late entry on 10/4/22 at 11:27 a.m., indicated she was notified Resident 293 had pink boggy heels and upon assessment, her bilateral feet were found to have dry scaling to toes and tops of feet. The progress note indicated there was various toes with purple discoloration to tips, she tended to hang her legs off side of bed. A nurse progress note, dated 10/3/22 at 2:56 p.m., indicated the resident's feet were scaling and an order was placed for boots due to soft heels and redness. A nurse progress note, dated 10/03/22 at 4:29 p.m., entered as a late entry on 10/4/22 at 3:38 p.m., indicated the resident's bilateral heels remained boggy and pink. During an interview, on 10/4/22 at 1:56 p.m., the Director of Nursing (DON) and Corporate Regional Clinical Director indicated Resident 293 was at risk for skin breakdown and staff would find interventions needed to care for the resident on the Resident profile list. If Resident 293's door was opened, it would be easier for staff to observe			

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	when she needed to be repositioned and ensure appropriate interventions were used. During an interview, on 10/6/22 at 9:50 a.m., Nurse Practitioner (NP) 22 indicated Resident 293 was at risk for pressure injury related due to her diagnosis of peripheral vascular disease (PVD) and the frequent movement in her legs. NP 22 indicated pressure injury may be avoided for Resident 293 by using interventions to keep her feet off the mattress and away from the foot board of the bed. A current policy, titled "Skin Management Program," dated 5/22, indicated the purpose was to promote the prevention of pressure ulcers and injury development. The policy defined avoidable pressure ulcer or injury as the resident developed a pressure ulcer or injury and the facility did not do one or more of the following: evaluate the resident clinical condition and risk factors, define, and implement intervention consistent with resident needs, and monitor and evaluate the impact of the interventions or revise the interventions as appropriate. 3.1-40(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview and record review, the facility failed to ensure staff followed fall interventions for 2 of 2 residents reviewed for falls and sustained injuries. (Resident 290 and 293) Findings include: 1. During an observation, on 9/29/22 at 1:56 p.m., Resident 290 was observed seated in his wheelchair with the brakes unlocked and rolling his chair back and forth when he attempted to stand up. His call light was found on the floor next to the head of bed, more than 10 feet away from the resident. During an observation, on 9/30/22 at 2:16 p.m., Resident 290 was observed with his door closed, seated in his recliner wearing his right leg brace. The call light was placed on his bed, more than 10 feet away from the resident. His walker was located behind the recliner on the left side, the wheelchair was located directly behind his recliner, and a blue mattress was placed next to the wall. He attempted to reposition himself in his recliner by pushing off his arm rest. He indicated he did not recall if he had a fall. He had a large lump with bruising covered with an absorbent dressing on the left side of his forehead. A Fall Risk Assessment was completed, on 9/22/22 at 7:33 p.m., and indicated Resident 290 was a high fall risk. A care plan, dated 9/23/22, and revised on 10/3/22 at 9:51 p.m., indicated Resident 290 was at risk for falls due to a history of falls, impaired balance, fracture of right Patella with an open reduction internal fixation, dementia, age, medications and Foley catheter. Staff were directed to keep personal items within reach, therapy to screen	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 290 no longer resides in the facility -Resident 293 is receiving adequate supervision and or assistance to prevent injury related to falls. All fall interventions are implemented based on the care plan. **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;** - Education to be provided via inservicing by 11/4/22. Education to include the Fall Management program and interventions in place per the plan of care -All residents have potential to be affected by the alleged deficient practice. -All residents who are at risk for falls were observed by DNS/designee to ensure fall interventions were in place based on resident's care plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via inservicing by	11/04/2022

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	quarterly, keep pathways free of clutter, non-skid footwear on when out of bed and call light in reach. An admission Minimum Data Set (MDS) assessment, dated 9/28/22, indicated the resident had severe cognitive impairment, moderately impaired vision, and required extensive assistance of two staff for bed mobility, transfers. He was an extensive assistance with one staff for walking in the room, dressing, toilet use, and was totally dependent on staff for activities of daily living (ADL). A care area assessment (CAA), dated 9/28/22, indicated the resident had triggered for impaired balance. He had sustained a fall with a right patella fracture. Resident 290 had impaired balance with walking and transition, had both short term and long-term memory impaired and was severely impaired with decision making. Resident 290's care profile, printed date of 9/30/22 at 6:30 a.m., indicated the resident was at risk for falls, used a walker or wheelchair and required assistance with one for transfers. A Fall Event report, dated 9/27/22 at 12:58 p.m., indicated Resident 290 had an unwitnessed fall. On 9/26/22, at 8:25 p.m., the resident was found lying on the floor. When assessed by staff, the resident indicated he was trying to get out of bed to go the bathroom. He complained of pain, irritation and burning in the peri area. A nurse progress note, dated 9/26/22 at 8:25 p.m., entered as a late entry on 9/27/22 at 12:58 a.m., indicated Resident 290 was found lying on the floor. The resident reported he had attempted to get out of bed to get to the bathroom to "let his		11/4/22. Education to include the Fall Management program and interventions in place per the plan of care - Facility will implement daily rounds to ensure residents fall interventions are in place per plan of care. - Facility to provide on going training and skills validations for falls, as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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pee out". He complained of pain, irritation and burning to peri area. Upon assessment, his penis appeared mildly irritated. The nurse practitioner was notified of the fall and complaints of pain to peri area. New orders were received for urine analysis and culture, complete blood count, basic metabolic panel and encouraged fluids.

A nurse progress note, dated 9/30/22 at 5:45 a.m., indicated Resident 290 had an unwitnessed fall and had a hematoma and laceration to left forehead. Staff cleansed the area, and applied steri-streps, completed neuros checks, and an adhesive border bandage was applied. Additionally, found upon assessment the resident had frequent hiccups and nurse practitioner was notified. Resident 290's call light was placed within reach.

A nurse progress note, dated 9/30/22 at 10:30 a.m., indicated Resident 290 was found to have an abrasion to his right posterior ankle which occurred during a fall this a.m. The abrasion area measured 0.4 centimeters (cm) by 0.8 cm.

A physician's order report, dated 10/1/22 to 10/5/22, included, but were not limited to, the following orders:
a. On 9/30/22, Cleanse abrasion to right posterior ankle with normal saline, pat dry, apply xeroform to abrasion and cover with adhesive boarder dressing daily.
b. On 9/30/22, Monitor wound on forehead for signs and symptoms of infection or non-healing. Steri-strips to remain in place until they fall off.
c. On 9/30/22, a thick blue fall mat.
d. On 10/3/22, a low bed.
e. On 10/3/22, a touch pad call light.

2. During an observation, on 9/29/22 at 1:30 p.m.,

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	Resident 293's door was closed. Upon entering her room, her call light was on the floor near the head of bed, the bed was elevated to waist height, and no non-skid socks were on her feet. She was observed to have a 50 percent blood colored stain to the large white absorbent bandage on her right lower extremity. During an observation, on 9/30/22 at 8:29 a.m., Resident 293's door was closed. Her call light was found lying on the bedside table out of her reach and no non-skid socks were on the resident. During an observation, on 9/30/22 at 2:36 p.m., Resident 293's door was closed, her bed was elevated to waist height, oxygen nasal cannula (device used to deliver supplemental oxygen) was found lying on the floor next to her bed. During an observation, on 10/3/22 at 9:29 a.m., Resident 293's door was closed, her bed was in the low position, and the call light and bed remote was found on the floor near the head of bed. Resident 293 was observed not wearing gripper socks. The record for Resident 293 was reviewed on 10/4/22 at 8:30 a.m. Diagnoses included, but were not limited to, sepsis, chronic obstructive pulmonary disease (COPD) (lung disease which block airflow and make it difficult to breathe), congestive heart failure (CHF) (condition in which the heart doesn't pump blood as well), peripheral vascular disease (PVD) (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes mellitus, anxiety, cognitive communication deficit (difficulty with any aspect of communication), and difficulty in walking. An admission MDS (Minimum Data Set)			

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	assessment, dated 9/29/22, indicated Resident 293 had a moderate cognitive impairment. A care area assessment (CAA), dated 09/29/22, indicated Resident 293 required total assistance with activities of daily living (ADL's) and mobility. A care plan, with a revised date of 10/3/22 at 9:54 a.m., directed staff to put the bed in the lowest position, place the call light within reach, keep pathways free of clutter, toilet upon awaking, at bedtime, and before and after meals. The care plan directed staff to place nonskid socks on at all times, bilateral positioning rails and therapy to screen quarterly and as needed. Resident 293's care profile, printed date 9/30/22 at 6:30 a.m., indicated the resident was at risk for falls, used a wheelchair, non-skid socks on at all times and required assistance with two for transfers. A nurse progress note, dated 9/24/22 at 11:53 a.m., indicated a skin assessment was completed and Resident 293 had a left forearm skin tear and purple bruise to her right arm. A Fall Risk assessment progress note, dated 9/24/22 at 11:58 a.m., indicated Resident 293 had no history of falls and was assessed to be a high fall risk. A nurse progress note, dated 9/27/22 at 10:50 p.m., indicated the resident was not acting as usual, had increased confusion, frequency, and urgency, tried to climb out of bed and she became combative. A urine sample was collected. A nurse progress note, dated 9/28/22 at 3:03 p.m., indicated the resident had complained of			

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	shortness of breath and had yelled out incoherent statements. Her oxygen saturation (which measures the amount of oxygen in the body) was at 85 percent (normal oxygen saturation level is between 95% and 100%). Staff increased oxygen via nasal cannula to 3 liters per minute and oxygen saturations rose to 88%. A nurse progress note, dated 9/28/22 at 11:59 p.m., indicated the resident was found hanging off the side of the bed and staff had lowered the resident to the floor. She was found to have a 2 inch by 2-inch skin tear noted to her right lower extremity. An interdisciplinary team (IDT) progress note, dated 9/29/22 at 9:19 a.m., indicated the resident had a fall on 9/28/22 at 11:51 p.m., and staff heard Resident 293 yelling from her room, her legs were off the bed, and she was observed sliding. A nurse assisted the resident to the floor. She reported to staff she attempted to get out of bed. Resident 293 sustained a skin tear to her right lower extremity. The interventions which were in place at the time of the fall included the call light and personal items would be in reach, her room and pathways free of clutter, and non-skid footwear when out of bed. Interventions put into place after the fall for Resident 293 were gripper socks on at all times and bilateral assist rails. A nurse progress note, dated 9/29/22 at 4:17 p.m., indicated the resident had been confused, combative with care, and refused to wear oxygen or Bipap/Cpap mask during care. An IDT progress note, dated 9/29/22 at 6:50 p.m., indicated the resident had a skin tear to her right lateral lower leg which measured 3.7 centimeters (cm) by 4.5 cm			

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	A nurse progress note, dated 10/1/22 at 1:12 p.m., indicated Resident 293 had an unwitnessed fall and was found by a Certified Nursing Assistant (CNA), seated next to the bed on the floor with her back next to bed. An IDT progress note, dated 10/3/22 at 8:45 a.m., indicated the resident had a fall on 10/1/22 at 1:09 p.m., and was found seated on the floor with her back against the bed. A bariatric bed was ordered for an additional intervention. During an interview, on 10/4/22 at 1:40 p.m., with the Director of Nursing (DON) and Corporate Regional Director of Clinical Services indicated their expectation for staff would be to ensure call lights are within reach of the resident. Any facility staff are able to place the call light in reach of a resident. The DON indicated the door to the resident's room should be open unless it would be requested by the resident to be closed. The door may be closed if isolation was required. A review of a facility document, titled "All Falls for the facility," dated from 6/30/22 to 9/30/22, indicated the facility had a total of 69 falls, 49 falls were unwitnessed. A current facility policy, titled "Fall Management Policy," with a revision date of 8/22, indicated residents residing within the facility would receive adequate supervision and or assistance to prevent injury related to falls. 3.1-45(a)(2)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and to notify the physician with a change of condition for 2 of 2 residents reviewed for catheter care. (Resident 49 and 290) Resident 49 was not provided care to	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 49 has been	11/04/2022

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	address concerns which developed after a urinary catheter was placed which led to a hospitalization with intravenous antibiotic intervention for the development of sepsis. Findings include: 1. The record for Resident 49 was reviewed on 9/30/22 at 10:55 a.m. Diagnoses included, but were not limited to, sepsis (life-threatening response to infection), paraplegia, chronic respiratory failure, tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe), subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), gastrostomy (opening into the stomach from the abdominal wall) and paraplegia (paralysis of the legs and lower body). The facility document, titled "Admit Discharge Report," dated 8/1/22 to 10/31/22, indicated Resident 49 was discharged/transferred to the hospital on 9/10/22. A care plan, dated of 9/16/22, indicated Resident 49 was readmitted to the facility with a UTI (Urinary Tract Infection) and directed staff to report concerns for urinary tract infection such as acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine and blood in urine. The care plan further directed staff to: a. Administer antibiotic as ordered. b. Provide assistance for catheter care. c. Change catheter per MD order. d. Keep catheter system a closed system as much as possible.		reviewed and assessed to ensure that the urinary catheter has been placed properly to prevent hospitalization with intravenous antibiotic intervention for the development of sepsis - Resident 290 no longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - All residents with foley catheters have the potential to be affected by the alleged deficient practice - Education to be provided via inservicing by 11/4/22. Education to include the Resident Change of Condition and Urinary Catheter Insertion - All residents with catheters have been observed by DNS/Designee to ensure tubing is placed properly, **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** - Education to be provided via inservicing by 11/4/22. Education to include the Resident Change of Condition and Urinary Catheter Insertion	

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	e. Manipulate tubing as little as possible during care. f. Position bag below level of bladder. g. Avoid obstructions in the drainage. h. Store collection bag inside a protective dignity pouch. i. Do not allow tubing or any part of the drainage system to touch the floor. Physician's orders, dated 9/16/22, included, but were not limited to, a. Catheter orders: to change Foley catheter and urinary drainage bag as needed for dislodgement, leakage, or occlusion. b. Catheter orders to change Foley catheter monthly Size: 16 Fr (French) - 10 ml (milliliter) bulb. Once a Day on the 15th of the month. c. Catheter orders for Foley catheter care. Nurse to record output every shift. d. Catheter orders to change catheter bag weekly on Sunday. A hospital discharge summary, dated 9/16/22, indicated the resident was treated for sepsis and catheter associated urinary tract infection (occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause infection). The facility document, titled "Healthcare Associated Infection Report," dated 8/22, indicated a total of 12 types of infection with an infection rate of 4.5 percent. The facility document, titled "Surveillance Log of Resident infections and antibiotic use," indicated, on 9/17/22, Resident 49 was started on Cefepime antibiotic for sepsis and urinary tract infection. The surveillance log indicated Resident 49 had a Healthcare-Associated Infection (HAI).		-All residents with foley catheters will be assessed to ensure proper placement of the urinary catheter daily, by DNS/Designee **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 by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	A review of the nurse progress notes, from 9/9/22 at 10:42 p.m., until 9/10/22 at 2:11 p.m., indicated Resident 49 had no urine output, no bladder scan completed and no call to the provider to notify of concerns of no urine output. A nurse progress note, dated 9/10/22 at 2:11 p.m., indicated the resident had no output of urine after a Foley placement. Blood was noticed in Resident 49's catheter tube. The Nurse Practitioner was notified and directed staff to remove Foley and reinsert Foley due to possible swelling. Upon reinsertion of the Foley catheter, blood had begun to flow from penis. The NP directed staff to send Resident 49 to the emergency room for evaluation. A nurse progress note, dated 9/10/22 at 2:43 p.m., indicated Resident 49 was transferred to the hospital. A nurse progress note, dated 9/10/22 at 11:29 p.m., indicated the hospital notified the facility Resident 49 was admitted to the intensive care unit with the diagnosis of sepsis. A nurse progress note, dated 9/10/22 at 6:00 a.m., indicated Resident 49 had 16 Fr/30 cc Foley catheter inserted at the end of 2nd shift on 9/9/22. No output was noted from the resident's Foley catheter at the time of this entry. The progress note indicated a reinsertion was attempted of the Foley catheter with no effective results and staff would continue to monitor. The progress note lacked indication the provider was notified. A nurse progress note, dated 9/16/22 at 5:25 p.m., indicated Resident 49 had returned to the facility after hospitalization at 5:00 p.m.			

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	A nurse progress note, dated 9/16/22 at 1:56 a.m., entered at as a late entry on 9/17/22 at 2:03 a.m., indicated Resident 49 was on intravenous antibiotic Cefepime and had a midline placed in the left upper extremity. A nurse progress note, dated 9/23/22, indicated Resident 49 was on intravenous antibiotic for sepsis and urinary tract infection. During an interview, on 10/5/22 at 11:05 a.m., the Assistant Director of Nursing (ADON) indicated Resident 49 was hospitalized from 9/10/22 to 9/16/22 for the treatment of septic shock caused by urinary catheter related urinary tract infection. Resident 49 had Enterobacter urinary tract infection. The catheter was placed, on 9/9/22, for the treatment of a pressure ulcer. During an interview, on 10/5/22 at 12:15 p.m., the Director of Nursing (DON) indicated Resident 49 had a hospital admission due to bacteremia related to catheter associated infection. The DON and Corporate Regional Director of Clinical Services indicated a nurse made insertion of a catheter attempt twice and left it in place with no urine output. At around 2:00 p.m., a nurse found blood in the catheter tube and notified the Nurse Practitioner (NP). The RN had no documentation of the output of urine after Foley placement and later noticed blood in urine tube of the Foley catheter. When the catheter was originally placed and the staff did not get urine return, the nurse should have notified the provider and completed a bladder scan. The DON and Corporate Regional Director of Clinical Services indicated no documentation was completed until after 2:00 p.m., and the staff should have checked within 6 to 8 hours for urine return. A resident could be at risk each time a catheter was attempted or placed.			

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During an interview, on 10/6/22 at 9:50 a.m., Nurse Practitioner (NP) 22 indicated staff should notify the provider if there was no urine output for an 8-hour shift and complete a bladder scan if available, straight catheterization, or insert a Foley catheter. She was not notified until after 2:00 p.m., with the concern about blood in the catheter tubing and the resident was at risk for hospitalization due to repeat catheterizations and no urine output for more than 16 hours.

During an interview, on 10/6/22 at 11:18 a.m. the Infection Preventionist (IP) indicated the facility did have residents who had recurrent UTI's, who had catheters. He had provided education to staff on Hand Hygiene and Peri care, also staff were provided with skills validation regarding catheter insertion and catheter cares. He found no trends related to urinary tract infections within the facility. When Resident 49 was admitted to the hospital or readmitted to the facility, he would review the diagnoses and follow up as indicated related to infections. During the review of the surveillance records, no trends were found for UTI. No formal audits were completed on catheters and infections. At least one resident in the last month developed a UTI with a catheter. Nursing staff were given skills validation for catheter insertion upon hire and nursing assistants are given education on peri care.

During an interview, on 10/6/22 at 1:30 p.m., the Executive Director (ED) indicated nursing staff could look on the Electronic Medical Record (EMR) for information on how to perform a procedure.

2. During an observation, on 9/29/22 at 12:03 p.m., Resident 290's catheter was in place and the Foley

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	catheter bag hung on the right side of the wheelchair, at waist level. The urine was dark yellow in color and no dignity bag covered the catheter bag. During an interview, on 9/29/22 at 12:03 p.m., a family member indicated Resident 290 had a catheter placed while in the hospital because he had urinary retention after surgery. Resident 290 had a trial for the catheter removal but required staff to reinsert it because Resident 290 was suffering from significant abdominal pain. She had observed on multiple occasions the catheter bag was hung too high to drain. During an observation, on 9/30/22 at 2:10 p.m., Resident 290's Foley catheter tubing was located under the brace of the right leg with the Foley catheter bag hung on the right side of the recliner chair. The record for Resident 290 was reviewed on 10/3/22 at 8:30 a.m. Diagnoses included, but were not limited to, retention of urine, dementia, right patella fracture, open reduction internal fixation (ORIF) (surgery used to stabilize and heal a broken bone) of right knee and difficulty walking. An admission Minimum Data Set (MDS) assessment, dated 9/28/22, indicated Resident 290 had a severe cognitive impairment, moderately impaired vision, and required a total assist with activities of daily living (ADL's) and mobility. A care area assessment (CAA), dated 09/28/22, indicated Resident 290 triggered for an indwelling catheter related to post-op urinary retention. Resident 290 had a failed trial of a catheter removal and had the catheter reinserted.			

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	A care plan, dated 9/25/22, indicated Resident 290 was admitted with an indwelling urinary catheter related to post-op urinary retention and was at risk for infection. The care plan directed staff to use approaches to avoid obstructions in the drainage, change the catheter per MD order and do not allow tubing or any part of the drainage system to touch the floor. The care plan directed staff to keep catheter system a closed system as much as possible and manipulate tubing as little as possible during care. Resident 290's care profile, printed on 9/30/22 at 6:30 a.m., indicated he had a Foley catheter and denuded skin to the groin and penile area. A physician's orders report, dated 10/1/22 to 10/5/22, included, but were not limited to, the following orders: a. On 9/22/22, change Foley catheter monthly, size 16 French (Fr) with 10 ml balloon on the 21st of each month. b. On 9/22/22, change Foley catheter and urinary drainage bag as needed for dislodgement, leakage, or occlusions. c. On 9/22/22, Foley Catheter care, nurse to record output every shift. d. Change Foley catheter drainage bag weekly. A nurse progress note, dated 9/23/22 at 1:07 a.m., indicated Resident 290 had a 16 Fr 10 cc Foley catheter upon admission. A nurse progress note, dated 9/24/22 at 12:43 p.m., indicated Resident 290 had an 18 Fr Foley catheter. A nurse progress note, dated 9/25/22 at 10:39 p.m., indicated Resident 290 had an 18 Fr Foley catheter.			

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A nurse progress note, dated 9/27/22 at 7:28 p.m., indicated Resident 290 did not have urinary output and an 18 Fr Foley catheter was re-anchored. Obtained 600 cc of clear urine.

A nurse progress note, dated 9/28/22 at 1:01 p.m., indicated Resident 290's tip of penis was red and swollen and night staff saw him tugging and pulling on the Foley.

A nurse progress note, dated 9/28/22 at 4:00 p.m., indicated Resident 290 passed a small amount of urine, complained of abdominal discomfort, irritation of penis and groin.

A nurse progress note, dated 9/28/22 at 4:10 p.m., indicated Resident 290 had a new intervention initiated with discontinue of Foley catheter.

A nurse progress note, dated 9/28/22 at 7:03 p.m., indicated Resident 290 had abdominal distention and no urine output, an 18 Fr Foley catheter re-anchored.

A nurse progress note, dated 9/28/22 at 9:22 p.m., indicated Resident 290 upon assessment at the beginning of the shift was complaining of severe abdomen pain. The abdomen was very distended and hard to touch. Resident 290 indicated he could not urinate. A bladder scan was done and read 800 cc of urine in the bladder. The resident's groin area was very red, swollen and painful to touch. A Foley catheter 18 Fr/10 cc was inserted. Urine return noted of 1200 cc of bloody urine return. The procedure was painful to Resident 290.

A Treatment Administration History, dated from 9/22/22 to 10/5/22, indicated Resident 290:
a. Had no urine output on 9/26/22, from 10:30 p.m.,

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	to 6:30 a.m. b. A small amount of urine output, on 9/27/22, for the shift from 6:30 a.m. to 2:30 p.m. c. On 9/27/22, for 2:30 p.m. to 10:30 p.m., indicated discontinued, and no urine output was documented. d. On 9/28/22 at 10:57 p.m., indicated 600 ml urine output. An acute care visit physician progress note, dated 9/28/22, indicated Resident 290 had a Foley catheter for urinary retention and had periods of pulling and manipulating on the Foley catheter due to his cognitive impairment. The progress note further indicated new orders were given to remove Foley and monitor for urine output. A progress note indicated Resident 290 was scheduled for an appointment with Urology on 9/28/22 and had been rescheduled for 10/5/22. During an interview, on 10/5/22 at 12:34 p.m., the Director of Nursing (DON) indicated Resident 290 had a catheter in place for urinary retention. On 9/27/22 at 10:30 a.m., an order was placed to remove the catheter and reinsert/re-anchor if no urine output. The physician's order did not indicate a time frame for notification of no urine output. She had concerns about the lack of documentation of the removal of Resident 290's catheter and amount of urine output. Resident 290's progress note, on 9/27/22 at 7:28 p.m., indicated the resident had no urine output and a catheter was reinserted with 600 cc of urine returned. During an interview, on 10/5/22 at 1:50 p.m., the Medical Records staff and Director of Nursing (DON) indicated Resident 290 had a conflict with having an orthopedic and urology appointment			

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	on the same date and time. Medical Records staff spoke to the Nurse Practitioner, on 9/27/22 at 10:30 a.m., and entered the order for the removal of the catheter and notified the nurse on duty to remove the catheter and monitor urine output. The DON indicated the staff should have used nursing judgement and used a nursing assessment. During an interview, on 10/6/22 at 9:50 a.m., Nurse Practitioner (NP) 22 indicated her expectation for staff would be to notify the provider if there was no urine output after removing a catheter in an eight-hour shift. Staff did not notify her of concerns for no urine output. Her expectation would be for staff to notify the provider, complete a bladder scan if available, attempt a straight catheterization or reinsert a Foley catheter if needed. A current policy, titled "Resident Change of Condition Policy," dated as revised 11/18, indicated all changes in resident condition will be communicated to the physician and family, timely and effective intervention takes place. The policy directed staff to communicate any sudden or serious change in condition manifested by a marked change in physical or mental behavior. The policy directed staff to document in the medical record all nursing actions and interventions. A current policy, titled " Urinary Catheter Insertion," with a review date of 12/12, directed staff to confirm physician order, including catheter and balloon size. The policy further directed staff to check the catheter and tubing for drainage. The policy lacked indication of monitoring for urinary output and reporting concerns to provider.			

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	A current policy, titled "Indwelling Urinary Catheter Care, Emptying Drainage Bag, and Catheter Removal," with a review date of 12/12, lacked indication of monitoring for urinary output and reporting concerns to provider. This Federal tag relates to Complaint IN00388366. 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §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- §483.25(g)(4) A resident who has been able 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 §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. Based on observation, interview and record review, the facility failed to ensure the head of bed (HOB) was properly elevated during an infusion of a Gastrostomy tube (GT) feeding and the syringe and tube feeding bag were labeled and	F 0693	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	11/04/2022

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	dated for 1 of 1 resident reviewed for tube feeding. (Resident 49) Finding includes: During an observation, on 9/29/22 at 10:18 a.m., Resident 49 was observed in his room lying in bed on a low air loss mattress. The foot of the bed and the head of the bed were elevated to less than a 30 degree angle. His upper body was positioned to the right side of the bed with his head off the pillows lying on the mattress. He had a tube feeding being administered during this time. Surveyor prompted staff to reposition Resident 49 and elevate the head of the bed. The formula bag was dated 9/28/22, but had no indication of what was infusing. During an observation, on 9/29/22 at 12:20 p.m., to 12:25 p.m., the power to Resident 49's room went off and on. He was found in his room, lying in bed on a deflated low air mattress. His head was tucked down to his chest with his head resting on the wall. His legs appeared higher than his abdomen. During an observation and interview, on 9/29/22 at 12:35 p.m., to 12:42 p.m., the power in the facility went out at 12:35 p.m., and turned back on within 30 seconds. Resident 49's tube feeding pump, humidified air compressor had shut off and came back on after the power turned back on. His air mattress pump had shut off and the air loss mattress deflated while he was still in bed. At 12:39 p.m., surveyor prompted the Nursing Assistant (NA) 26 to reposition the resident. NA 26 indicated the resident was in a flat position and the syringe used for flushing his G-tube was not dated. The NA requested assistance from Licensed Practical Nurse (LPN) 25. LPN 25		- Resident 49 bed was elevated to the required 30 degrees during an infusion of Gastrostomy tube (GT) feeding and the syringe and tube feeding bag are labeled and dated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - All residents with GT's have the potential to be affected by the alleged deficient practice - All future residents with order for tube feeding have the potential to be affected by the alleged deficient practice - An Inservice will be completed by 11/4/22 educating staff on proper elevation of the head of bed for residents that are receiving tube feeding. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** - An Inservice will be completed by 11/4/22 educating staff on proper elevation of the head of bed to 30 degrees, the syringe and tube feeding bags are labeled - All tube feeding orders will	

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	indicated the resident was positioned below a 30 degree angle and the position was not ideal. Surveyor prompted LPN 25 the air loss mattress had deflated, and the pump was not working. LPN 25 reset the low air loss mattress pump and the mattress begun to inflate. During this observation, Resident 49's tube feeding was running. During an observation and interview, on 10/04/22 at 8:20 a.m., Registered Nurse (RN) 14 indicated she had not checked on Resident 49 since she started her shift and the head of his bed was elevated to a 10 degree angle and his feet were elevated the same height as his head. RN 14 indicated the syringe for the tube feeding was not dated and was laid on top of the bed side table not covered. All Resident 49's tube feeding equipment and supplies should be properly labeled and stored. The record for Resident 49 was reviewed. Diagnoses included, but were not limited to, nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), gastrostomy (opening into the stomach from the abdominal wall), paraplegia (paralysis of the legs and lower body) and dysphagia (swallowing difficulties). A significant change Minimum Data Set (MDS) assessment, dated 9/22/22, indicated the resident received a Gastrotomy tube (GT) - (a medical device used to provide liquid nourishment, fluids, and medications by passing the oral intake) feeding. A Care Area Assessment (CAA), dated 9/22/22, indicated Resident 49 was a risk for altered nutrition status, was a total assist of two staff for bed mobility and transfers and received 100		be reviewed in the daily clinical meeting to ensure nursing staff and IDT are aware of the need to properly elevate the head of bed 30 degrees, the syringe and tube feeding bags are labeled - Facility will implement daily rounds by DNS/designee, to ensure the care plan is follow for GT feeding **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 by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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percent of his calories and 2054 milliliters (ml) or more a day of fluids from tube feedings.

A Care Profile, with a printed date of 9/30/22 at 6:30 a.m., directed staff to elevate the head of bed to at least 30 degrees at all times.

An Enteral Administration History, dated 9/22, included, but were not limited to, the following:
a. Nothing by mouth.
b. G-tube size 20-Fr (French)
c. Flush G-tube with at least 30 ml of water before and after medication administration.
d. Change irrigation set once a day (10:30 p.m. to 6:30 a.m.).
e. To check for placement of tube, check residual and hold if residual was greater than 60 ml.
f. Elevate head of bed 30-45 degrees at all times.
g. Flush tube with 40 ml an hour of water.
h. Continuous feeding formula Jevity 1.5 at 60 ml.

During an interview, on 10/03/22 at 11:17 a.m., the Director of Nursing (DON) indicated she expected staff to position Resident 49 with the head of the bed elevated to a 30-45 degree angle while the tube feeding was running. She expected staff to ensure equipment and supplies we labeled and when the power went out staff were to reset Resident 49's equipment to ensure everything was working.

During an interview, on 10/04/22 at 8:55 a.m., the Speech Language Therapist (SLP) indicated her concerns with poor positioning or positioning the resident less than 30 degrees could put the resident at risk for regurgitation and cause aspiration. When Resident 49 had therapy, he was placed in his chair for positioning and did well.

During an interview, on 10/04/22 at 2:23 p.m., the

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	Maintenance Supervisor indicated the community had problems with power outages on 9/29/22. The facility did a scheduled weekly generator check on 10/3/22. When the power went out the diesel generator would kick in, but staff should go around the facility to check equipment to ensure it was working. A current policy, titled "Enteral Therapy," with a revised date of 1/16, indicated the licensed nurse with other healthcare team members must carefully monitor the resident's response to the enteral feedings and feeding techniques. The facility policy directed staff to observe closely for any adverse effects to the feeding procedures but lacked direction for positioning of the resident during tube feeding. 3.1-44(a)(2)			
F 0695 SS=G Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to thoroughly assess and document a resident's change in respiratory status, to notify the physician of signs of respiratory distress and when a BIPAP/CPAP (machine used to help with breathing) was not available for a resident who was at risk for	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 49 Humidification	11/04/2022

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	respiratory complications and required a hospitalization (Resident 293), and to ensure the humidification was used and wore correctly, infection control measures were in place by labeling and storing equipment appropriately for tracheostomy care (a tube surgically placed in the throat to assist with receiving air into the lungs) (Resident 49) and failed to obtain a physician's order to provide care and treatment and machine maintenance for a continuous positive pressure (CPAP) machine (Resident 67) for 3 of 4 residents reviewed for respiratory care. Findings include: 1. During an observation and interview, on 9/29/22 at 1:53 p.m., Resident 293's door was closed. The resident was found lying in bed with the head of the bed at a 75 degree angle. The resident's eyes were closed and she was positioned with her hips past the crease in bed, head on the wall, and right leg hanging over the side of the bed. An oxygen concentrator was on at 4 liters per minute (LPM), there was no label on the tubing or the BIPAP/CPAP. She was observed to have abdominal retractions and audible grunting was heard with breathing. Staff were requested to come to the room. The Infection Preventionist (IP) indicated the oxygen concentrator was on at 4 LPM, no label was on the oxygen tubing and the resident was in a "poor position". During observation and interview, on 9/29/22 at 03:49 p.m., Resident 293's door was closed, and resident was observed lying in bed with nasal cannula on the bedside table and out of reach of the resident. Oxygen concentrator was set at 1.5 LPM. Resident was attempting to communicate but the words were nonsensical, abdominal retractions were noted. IP verified oxygen		is in place and worn correctly, infection control measure are in place by labeling and storing equipment appropriately for the tracheostomy care - Resident 67 no longer has a CPAP machine - Resident 293 has a BIPAP/CPAP available for her respiratory condition and her humidification is in place correctly and MD is notified of any change of condition **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - All residents with BIPAP/CPAP machines have the potential to be affected by the alleged deficient practice - All residents with BIPAP/CPAP machines were reviewed by DNS/Designee per the plan of care is being followed - All residents with BIPAP/CPAP machines were reviewed by DNS/Designee per the plan of care is being followed - An Inservice will be completed by 11/4/22 educating staff on BIPAP/CPAP Therapy to include procedure to verify doctor's orders, and cleaning the machine **What measures will be put into place and what systemic changes will be made to**	

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	concentrator settings and nasal cannula was not on, he indicated Resident 293 must have taken the oxygen off. During an observation, on 9/30/22 at 8:26 a.m., the resident's door was closed and she was observed to be seated at the side of the bed. Her nasal cannula and tubing were on the dirty floor. The oxygen concentrator was set at 2.5 LPM. The resident had a deep moist cough, mouth breathing and bilateral lower extremity edema from her toes to her knees. The resident seemed to be confused and tried to communicate but words were nonsensical. During an observation, on 9/30/22 at 2:36 p.m., the resident was observed lying in bed with head of bed at a 30 degree angle. Her head was positioned on the wall, her hips pass the crease in bed and her legs were dangling over the exit side of bed. The oxygen was set on 2.5 liters via nasal cannula. The BIPAP/CPAP mask and tubing were lying under the bed on the dirty floor. During an observation, on 10/3/22 at 9:32 a.m., Resident 293's door was closed. She was found lying in bed with the head of bed up at an 80 degree angle, her eyes were closed and a loud grunting noise was heard with each breath with expiratory wheeze. The resident had oxygen on via nasal cannula at 2.5 LPM. The oxygen tubing was not labeled. During an observation, on 10/3/22 at 12:33 p.m., with Registered Nurse (RN) 24, Resident 293's door was observed to be shut. She was found to be hallucinating and was nonsensical, moving her arms and legs up and down. The resident was moving her hands up and down and appeared to be sewing her gown. Her BIPAP mask was on the		**ensure that the deficient practice does not recur;** - An Inservice will be completed by 11/4/22 educating staff on BIPAP/CPAP Therapy to include procedure to verify doctor's orders, and cleaning the machine - Facility will implement daily rounds, to ensure residents humidification is in place and that trach equipment is labeled correctly and that equipment is clean **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 by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	floor, audible wheezes with retractions were observed with an elevated respiratory rate over 30. The nasal cannula was found lying on the bed. The record for Resident 293 was reviewed on 10/4/22 at 8:30 a.m. Diagnoses included, but were not limited to, sepsis, chronic obstructive pulmonary disease (COPD) (lung disease which block airflow and make it difficult to breathe), obstructive sleep apnea and congestive heart failure (CHF) (condition in which the heart doesn't pump blood as well). An admission MDS (Minimum Data Set) assessment, dated 9/29/22, indicated Resident 293 had a moderate cognitive impairment. A Care Area Assessment (CAA), dated 9/29/22, indicated the resident triggered for required total assist with activities of daily living (ADL's) and had diagnoses which could impact ADL's and mobility which included sepsis, COPD and heart failure. A care plan, dated 9/25/22, indicated the resident had a risk for impaired gas exchange related to COPD with shortness of breath while lying flat and obstructive sleep apnea (OSA). The Care Plan directed staff to assess vital signs and lung sounds as needed, BIPAP as ordered, elevate the head of the bed to alleviate shortness of breath while lying flat, monitor oxygen saturations as needed, nebulizer treatments as ordered, observe for nonverbal signs of anxiety such as furrowed brows, pacing, change in mental status, and behaviors, to observe for verbal signs of stress and anxiety, the resident used oxygen at 2 LPM. A resident profile, printed on 9/30/22 at 6:30 a.m., indicated the resident used oxygen at 2 LPM via			

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	nasal cannula, but lacked direction for staff to elevate head of bed. A hospital discharge summary, dated 9/23/22 at 12:09 p.m., indicated Resident 293 had discharge diagnoses of severe sepsis, OSA treated with BIPAP/CPAP, diabetes, urinary tract infection, atrial fibrillation, and acute kidney injury. The summary indicated for the resident to wear her BIPAP/CPAP at nighttime. A Respiratory Administration History Report, dated 9/23/22 to 10/3/22, indicated Resident 293 was admitted to the facility, on 9/23/22, and orders included, but were not limited to, the following: a. Elevate head while in bed to alleviate shortness of breath while lying flat related to COPD diagnosis. b. A BIPAP. A review of the administration history indicated Resident 293 did not have an available BIPAP to use from 9/24/22 to 9/28/22. c. Oxygen continuously at 2 liters per minute (LPM). On 9/28/22, the history indicated Resident 293 was given oxygen at 4 LPM. d. Oxygen continuously at 4 liters per minute (LPM) per nasal cannula to keep oxygen saturations greater than 90 percent started on 10/3/22. A progress note, on 9/24/22 at 11:38 a.m., indicated a respiratory company was contacted with a new admission, BIPAP order and information given. The facility was waiting for a return call. A nurse progress note, dated 9/27/22 at 10:50 p.m., indicated the resident was not acting as usual, had increased confusion, frequency, urgency, tried to climb out of bed and she became combative. A urine sample was collected.			

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	A nurse progress note, dated 9/28/22 at 3:03 p.m., indicated the resident was complaining of shortness of breath and was yelling out incoherent statements. Oxygen saturation (measures the amount of oxygen in the body) were 85 percent (normal oxygen saturation level is between 95% and 100%). Increased oxygen via nasal cannula to 3 liters per minute and oxygen saturations rose to 88%. The staff worked with the resident on remaining calm and saturations were at 94%. The oxygen was decreased to 2 liters per minute (LPM) and oxygen saturations remained at 91 to 92%. A nurse progress note, dated 9/28/22 at 11:59 p.m., indicated the resident was found hanging off the side of the bed and staff lowered the resident to the floor. She was found to have a 2 inch by 2-inch skin tear noted to her right lower extremity. The physician and family were notified and the call light was placed within reach. A progress note, dated 9/28/22 at 12:28 p.m., indicated a respiratory company was contacted regarding BIPAP delivery and was still working on it. A nurse progress note, dated 9/29/22 at 4:17 p.m., indicated the resident had been combative during the shift, refused to wear oxygen or BIPAP mask and the resident remained confused and combative with care. A nurse progress note, dated 10/3/22 at 2:56 p.m., indicated the resident had been confused and combative with staff. The Nurse Practitioner was notified oxygen saturations were 88-91% and new order to utilize oxygen titration and BIPAP/CPAP as needed in addition to the nightly order. A new			

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order of prednisone (oral steroid) was also written.

A nurse progress note, dated 10/3/22 at 7:01 p.m., entered as a late entry on 10/4/22 at 2:34 a.m., indicated Resident 293 had trouble responding to verbal stimuli, was wheezing, and used extreme effort to breath. Respirations were short and labored with oxygen saturations 94% on 2 LPM, heart rate was 113. The nurse practitioner was notified and the resident was sent to hospital for evaluation.

A Hospital History and Physical Report, dated 10/4/22 at 2:11 a.m., indicated Resident 293 was brought to the Emergency Department by Emergency Medical Services for altered mental status and hypoxia with oxygen saturations at 80 percent. Labs taken revealed a B-type natriuretic peptide BNP (hormone produced by your heart to indicate heart failure) of 800, Lactate of 8, and chest X-ray revealed low long volumes with diffuse opacities concerning for pulmonary edema. Resident 293 was admitted for Respiratory distress.

The record review lacked indication the physician was notified Resident 293 did not have her CPAP to wear until 9/28/22, as ordered on 9/23/22, when discharged from the hospital.

2. During an observation and interview, on 9/29/22 at 12:25 p.m., Resident 49 was found lying in his bed with his head facing the wall. The mask of the humidified air was positioned onto the side of his neck. His humidified air, water canister, tubing, mask, yankauer suction tube and suction canister was not labeled. The water canister for the humidified air was empty with water pooled in the tubing. Licensed Practical Nurse (LPN) 25 indicated the mask was not on Resident 49's

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	tracheostomy opening and his equipment was not labeled. During an observation and interview, on 9/29/22 at 12:39 p.m., Nursing Assistant (NA) 26 indicated the resident's humidified air mask was not on Resident 49 and it was the nurse's responsibility to ensure it was in place. During an observation and interview, on 9/29/22 at 2:19 p.m., LPN 25 indicated the resident was poorly positioned with his chin tucked to his chest and humidified air mask on his neck. All equipment should be labeled when opened. During an observation, on 9/30/22 at 10:15 a.m., Resident 49's respiratory equipment which included yankauer suction tube was dated 9/28/22. The humidified water bottle was not dated. The suction canister was not labeled or dated. During an observation, on 10/3/22 at 11:11 a.m., Resident 49's equipment which included suction tubing, water canister and nebulizer tubing was found to be not dated. The yankauer suction tube was dated 9/30/22. The canister for suctioning had roughly 60 cc of green, yellow colored liquid. The resident was lying in bed with his head facing the wall and humidifier air mask positioned on the side of his neck. During an observation and interview, on 10/3/22 at 11:17 a.m., the Director of Nursing (DON) indicated Resident 49's respiratory equipment was undated and not labeled. Her expectation would be for staff to ensure equipment was changed as directed and labeled appropriately. The humidified air was not over the Trach and the nursing staff and the NA could reposition as needed. Agency			

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	staff was working last night and could be the reason for items not being taken care of. The record for Resident 49 was reviewed on 9/30/22 at 10:55 a.m. Diagnoses included, but were not limited to, sepsis (life-threatening response to infection), paraplegia, chronic respiratory failure, tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe), subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), gastrostomy (opening into the stomach from the abdominal wall), paraplegia (paralysis of the legs and lower body). A care plan, dated 9/25/22, indicated Resident 49 was readmitted and had a problem with Pseudomonas in his trach. The care plan directed staff to document and notify MD of any abnormal findings, observe for continued or worsening symptoms of trach infection (increased secretion's, increased odor from trach site, increased temp), observe for adverse side effects of antibiotic (GI upset, nausea, diarrhea, rash) and to administer antibiotic as ordered. Physician's orders included, but were not limited to, per standard of practice with sterile water and normal saline assess trach site every shift for redness, swelling, drainage and warmth, change yankauer suction tip, change trach ties and change trach inner cannula (Size 8XLT) During an interview, on 10/3/22 at 12:02 p.m., the Infection Preventionist (IP) indicated Resident 49 had a hospitalization recently related to Tracheitis (bacterial infection of the windpipe). The resident's equipment had dates from the previous week. There was a concern if staff were not			

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	changing the equipment which could cause a spread of infections or cause an infection in Resident 49. Nursing staff are responsible for changing equipment. During an interview, on 10/4/22 at 8:20 a.m., Registered Nurse (RN) 14 indicated it was hard to tell whether a resident was raised to a 30-45 degree angle. His legs were elevated, his middle was creased and his head was elevated the same as his feet, more like a 10 degree angle. A thick air loss mattress was used. She had not checked on the resident yet this morning. There were concerns his trach had yellow/green colored dried mucous on the cannula with water pooling in the tube and the filter appeared dirty. All equipment should be labeled. During an interview, on 10/4/22 at 1:35 p.m., the DON indicated nursing staff should be labeling patient equipment items as needed. Resident 49 was to be properly positioned with his humidified air mask positioned over his tracheostomy. Not having the humidified air on could dry up secretions for Resident 49 and he could be at risk for of infection if the resident equipment was not stored, changed and labeled. 3. During the initial tour of the facility, on 9/30/22 at 9:55 a.m., Resident 67's CPAP machine was observed on the bedside table with the nose piece laying on the bedside table surface uncovered and not bagged. During a random observation, on 10/3/22 at 10:34 a.m., Resident 67's CPAP machine was observed on the bedside table. The nose piece was not bagged or covered. The record for Resident 67 was reviewed on			

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	10/3/22 at 10:21 a.m. Diagnoses included, but were not limited to asthma, chronic obstructive pulmonary disease and obstructive sleep apnea. A progress note, dated 10/2/22 at 4:30 p.m. indicated "Resident uses Bi-Pap or C-Pap." Resident 67 had no care plans for the use of a CPAP machine. There was no order for a CPAP or any orders for cleaning or maintenance for the machine. There was no documentation of times the CPAP was applied or removed. During an interview, on 9/30/22 at 10:15 a.m., Agency Nurse (AN) 8 indicated she did not know if Resident 67 used a CPAP or not, there was no order in the electronic record. A current policy, titled "CPAP Therapy," undated and provided by the Director of Nursing on 10/4/22 at 2:21 p.m., indicated "...Procedure: Verify doctor's orders...Cleaning the Machine: gently wash...rinse...air dry...clean and inspect...Filter maintenance...two filters...." 3.1-47(a)(6)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview and record review, the facility failed to ensure a medication error rate was less than 5%, by making 6 errors out of 30 attempts with an error rate of 26.67%. (Resident 49 and 294)	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident 49 is receiving	11/04/2022

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	Findings include: 1. On 9/29/22 at 2:15 p.m., Agency Licensed Practical Nurse (LPN) 25 was observed setting up medications for administration for Resident 49. LPN 25 had four medication cups set up labeled Baclofen (a muscle relaxant), sodium (a supplement), guaifenesin (a cold medicine) and acetaminophen (a pain reliever/fever reducer). All medications were crushed. LPN 25 stopped the resident's feeding, checked for placement and flushed the tube with water. LPN 25 first administered Baclofen and then sodium chloride with water flushes in between each medication. LPN 25 than grabbed the medication cup labeled guaifenesin with a chunky white material in it and indicated it was guaifenesin, proceeded to add water to the crushed medication and administer it in the G-tube when the G-tube became clogged. The medication would not administer. LPN 25 indicated the guaifenesin would not administer and he would not be able to administer the acetaminophen. The record for Resident 49 was reviewed on 9/29/22 at 2:40 p.m. Physician's orders, dated 10/2/22, indicated Resident 49 was to receive by gastric tube (G-tube): a. Baclofen tablet; 10 mg (milligram); Amount to Administer: 10 mg; gastric tube b. Sodium chloride [OTC] tablet; 1 gram; Amount to Administer: 1 gram; gastric tube Other Test: c. Guaifenesin [OTC] liquid; 100 mg/5 ml (milliliter); Amount to Administer: 20 ml; gastric tube d. Acetaminophen [OTC] tablet; 500 mg; Amount to Administer: 1000 mg; gastric tube		medications as ordered -Resident 294 no longer resides at the facility **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 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -Facility to provide on going training and skills validations for GT feedings, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - -The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not	

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	A nurse progress note, dated 9/29/22, indicated during medication pass the syringe neck became clogged while Tylenol was administered. The nurse was unable to clear the clog and notified the nurse practitioner. 2. On 10/03/22 at 9:03 a.m., Registered Nurse (RN) 24 was observed preparing medications for Resident 294. RN 24 indicated Resident 294 only had one medication available in the medication cart and she would need to go to the emergency kit to pull the other medications. At 10/3/22 at 9:03 a.m., RN 24 was unable to obtain and administer the following medications: a. Miralax (polyethylene glycol 3350) powder, (laxative which provides relief from occasional constipation). b. Venelex (balsam peru/castor oil) (an ointment which is used on the skin to cover wounds). c. Cyanocobalamin (vitamin B-12) tablet (vitamin B - 12 used to treat vitamin B-12 deficiency). d. Fluticasone Propionate nasal spray (used to relieve seasonal and year-round allergic and non-allergic nasal symptoms). e. Dakin's Solution (used to prevent and treat skin and tissue infections). f. Pantoprazole DR 40 mg one tablet was given two hours past scheduled time at 7:00 a.m. The record for Resident 294 was reviewed on 10/3/22 at 2:00 p.m. Physician's orders, dated 10/2/22, indicated: a. Miralax (polyethylene glycol 3350) powder; 17 gram/dose; amt: 17 grams. b. Venelex (balsam peru/castor oil) apply to affected area. c. Cyanocobalamin (vitamin B-12) tablet; 1,000 mcg; amt: 1,000 mcg; oral d. Fluticasone propionate nasal spray		achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	e. Dakin's Solution (sodium hypochlorite) solution; 0.125 %; Apply to affected area. f. Pantoprazole DR 40 milligrams (mg) one tablet at 7:00 a.m. Resident 294's Proof of Delivery, dated 9/29/22 to 10/5/22, indicated the following medications were delivered on: a. Dakin's Solution delivered on 10/3/22 at 8:18 p.m. b. Venelex ointment had not been delivered. c. Vitamin B-12 was delivered on 10/3/22 at 8:18 p.m. d. Fluticasone propionate nasal spray had not been delivered. e. Miralax (polyethylene glycol 3350) powder had not been delivered. During an interview, on 10/3/22 at 9:08 a.m., RN 24 indicated Resident 294 was not given Miralax, Venelex, Cyanocobalamin, Fluticasone propionate and Dakin's. Resident 294 had an order for Pantoprazole which was to be given at 7:00 a.m., and had the resident received the medication after breakfast it would have been two hours late. During an interview, on 10/4/22 at 1:05 p.m., the Regional Director of Clinical Services indicated staff should follow the physician's orders as directed. Staff should notify the physician and the pharmacy if medications were not available to administer. During an interview, on 10/4/22 at 1:05 p.m., the Director of Nursing (DON) indicated her expectation for staff would be to administer as directed by physician and by route indicated. She had a concern with a medication which was administered in a G-tube which should not be crushed and then clogged the G-tube.			

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	A current policy, titled "LTC Facilities Receiving Pharmacy Products and Services from Pharmacy," dated as revised 1/1/22, indicated staff should verify each time a medication administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time for the correct resident, as set forth in the facility's medication administration schedule. 3.1-48(c)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure insulin, an antibiotic tablet, and 2 of 2 medication carts were secured for medication storage. (Hall Two south cart and Moving Forward hall cart) Findings include: 1. During a random continuous observation of a medication cart, on 9/29/22 at 10:00 a.m., the medication cart located at the nurse station near the Hall Two South was found unlocked with no staff around. At 10:15 a.m., Registered Nurse (RN) 20 walked backed to the nurse's station and indicated the medication cart should be locked and secured before walking away. 2. During a random observation of a medication cart, on 10/03/22 at 3:01 p.m., the medication cart was found unlocked located at the nurse station near the Moving Forward Hall with staff seated behind the desk facing away from the medication cart. 3. During a continuous observation, on 10/4/22 at 11:25 a.m., a medication cart located on the Moving Forward Hallway located near Room 309 had one tablet of Amoxicillin (a medication used to treat infections) lying on top of the cart visible to staff and residents who walked by. At 11:28 a.m., a Nursing Assistant was observed to walk pass the medication cart. At 11:32 a.m., RN 14 indicated one tablet of Amoxicillin was left on top of the medication cart and no medications should be left on top of the medication cart unsecured. 4. During observation and interview of a medication administration of insulin, on 10/4/22 at 11:47 a.m., Licensed Practical Nurse (LPN) 13	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** -All residents have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** -DNS/Designee will round each business day to ensure Medication Carts are secured **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	11/04/2022

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	placed a diabetic supply box which contained lancets, a meter, a Humalog Kwik Pen insulin and a glargine-insulin pen on top of the medication cart. LPN 13 gathered the supplies to administer the insulin for a resident and left the diabetic supply box on top of the cart. The diabetic supply box contained the glargine-insulin pen. LPN 13 indicated she should not have left the diabetic box unsecured and should have placed it into the medication cart before she walked away. During an interview, on 10/4/22 at 1:13 p.m., the Director of Nursing (DON) indicated medications should be secured in the medication cart and all medication carts should be locked up before staff walk away due to the concern of residents could get in the carts. A current policy, titled "Storage and Expiration Dating of Medications, and Biologicals," with a revision date of 7/21/22, indicated the facility should ensure that all medications and biologicals, including treatment items are securely stored in a locked cabinet or cart, or a locked medication cart that is inaccessible by residents and visitors. A current policy, titled "General Dose Preparation and Medication Administration," with a revision date of 1/1/22, indicated the staff should not leave medications or chemicals unattended. 3.1-25(m)		After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure drinking cups were free of lime build up, to ensure meals served to residents were covered and protected during transport from the kitchen, through a common hall, to the dining room and failed to ensure staff assisting residents with meals did not touch the mouth piece of straws with their bare hands when placing them in drinks. These deficient practices had the potential to effect 87 of 87 residents who were served meals from the kitchen. Findings include: 1. During the initial tour of the kitchen, on 9/29/22 at 10:40 a.m., plastic drinking cups were observed stored on tray racks in the kitchen. The inverted cups had a thick coating of white limescale deposits. The cups, which were once clear now seemed opaque.	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** -All residents have the potential to be affected by the alleged deficient practice -An Inservice will be completed by 11/4/22 educating staff on Meal Service and distribution to include, **What measures will be put into place or what systemic changes you will make to**	11/04/2022

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	During an interview, on 9/29/22 10:45 a.m., the Kitchen Manager indicated the packaged drink mixes they used (Crystal Lite Strawberry drink and low sugar lemonade mix) caused the build up on the glasses. Both drink mixes were artificially sweetened. Corporate wanted them to use the powdered mixes. They only had certain options they could order. They had tried de-liming the glasses but it was still built up. During an observation of the dishwasher and interview, on 9/29/22 at 10:55 a.m., the digital reading was flashing "de-lime." The Kitchen Manager indicated she did not know why the dishwasher flashed de-lime. She couldn't get it to come off of the screen. They de-limed weekly. During an interview, on 10/4/22 at 2:10 p.m., the Administrator (ADM) indicated there were no policies for lime on dishes or de-liming procedures for the dishwasher. The dishwasher was fairly new. 2. During a random dining observation, on 9/29/22 at 12:12 p.m., staff were observed as they served meals to 13 residents in the main dining room. The main common hallway, from the front entrance door to the back of the building, passed between the kitchen and the dining room entrance. The hallway was approximately 10 feet across. Multiple unidentified visitors were observed entering from the front of the building and passing through the hallway to access other areas of the building, during the meal service. Visitors also exited the building by passing through the same hallway. Staff members, not involved in meal service, came and went up and down the hallway, during meal service.		**ensure that the deficient practice does not recur?** -An Inservice will be completed by 11/4/22 educating staff on Meal Service and distribution to include, -CDM/Designee to observe meal service to ensure the following items are in compliance with, **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** - The CDM/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. - If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	During the continuous meal service and dining observation, on 9/29/22 from 12:12 p.m., through 12:45 p.m., meal trays were passed through an opened kitchen window to staff waiting in the common hallway. Drinks and fruit bowls had individual covers on them. The plates were not covered. Staff carried the meal trays across the common hall, weaving through the foot traffic, to serve the residents. During an interview, on 10/4/22 at 2:10 p.m., the Administrator (ADM) indicated there were no policies for transporting food uncovered through the hallway. During an interview, on 10/4/22 at 2:14 p.m., the Director of Nursing indicated there was no policy food could not be transported, to a resident, uncovered. She spoke to corporate who advised her carrying uncovered plates from the kitchen window to the dining room was not a problem. 3. During an interview, on 9/29/22 at 12:43 p.m., Certified Nursing Assistant (CNA) 6 was observed in the main dining room as she served a meal to Resident 67. CNA 6 opened three (3) straws by touching the top (portion which comes in contact with the residents' mouth) with her bare fingers. She placed the straws in Resident 67's milk, water and Crystal Lite drinks. During an interview, on 9/29/22 at 12:40 p.m., CNA 6 indicated she should not have touched/made contact with the top of the straw which went into the residents mouth. A current policy, titled "Meal Service and Distribution," dated as revised on 6/21 and provided by the Administrator (ADM) on 10/3/22 at 2:35 p.m., indicated "...Residents are			

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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
	encouraged to eat in the dining rooms...Residents will be assisted in the dining room as needed...." 3.1-21(i)(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a safe, clean, and comfortable interior environment for 1 of 1 resident room. (Resident 293) Findings include: During an observation and interview, on 9/29/22 at 1:56 p.m., Resident 293's floor was visibly dirty with two streaks of red blood color stains and a large 12-inch dry black colored stain next to the head of bed to the center of Resident 293's exit side of the bed. Two opened alcohol wipes and crinkled up paper were also found on the floor near the head of bed. The bedside table was visibly soiled with dry brown liquid stains which was sticky to the touch. The garbage can was found to be overflowing and paper garbage was on the floor next to the garbage can. The Infection Preventionist (IP) indicated the floor was dirty and it was the responsibility of housekeeping staff to clean the floor. During an observation, on 09/29/22 at 3:49 p.m., Resident 293's nasal cannula was found lying on the visibly dirty bedside table. On the left side of the bed near the head of the bed, the wall had a two and half inches by three-inch gouge which exposed the white sheet rock.	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident 293 room has been cleaned **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 alleged deficient practice. -An Inservice will be completed by 11/4/22 educating staff on daily cleaning procedures, to include sweeping under beds, mopping floors to include under beds, chairs and equipment and to pick up any debris on the floor **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING 00 B. WING	10/06/2022

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	During an observation, on 9/30/22 at 2:36 p.m., the resident's oxygen nasal cannula (device used to deliver supplemental oxygen) was found lying on a brown dried liquid-stained floor next to the bed. During an observation, on 10/3/22 at 9:32 a.m., Resident 293's BIPAP/CPAP (a device which helps with breathing) mask and tubing was found next to the bed, lying on the floor with dry black colored dirt. During an observation and interview, on 10/3/22 at 12:33 p.m., Registered Nurse (RN) 24 indicated the floor was visibly dirty with black colored dirt and multiple pieces of dry skin and the BIPAP mask was found lying on the floor in the dirt. The record for Resident 293 was reviewed. Diagnoses included, but were not limited to, sepsis (overwhelming and life-threatening response to infection), chronic obstructive pulmonary disease (lung diseases that block airflow and make it difficult to breathe), and heart failure (occurs when the heart muscle doesn't pump blood as well). A care area assessment (CAA), completed on 9/29/22, indicated the resident had moderately impaired cognition and required total assistance with activities of daily living (ADL's) and mobility. During an interview, on 10/3/22 at 1:25 p.m., the Director of Housekeeping (DOH) indicated she was the only housekeeper working in the facility because the other housekeeping staff was out ill. Her daily cleaning consisted of common areas of the facility and she tried to deep clean five residents' room each week. It was hard because she was only one person. The staff should send		**practice does not recur;** -An Inservice will be completed by 11/4/22 educating staff on daily cleaning procedures, to include sweeping under beds, mopping floors to include under beds, chairs and equipment and to pick up any debris on the floor - Facility will implement daily rounds by Housekeeping Supervisor/Designee, to ensure resident rooms are safe, clean and have a comfortable interior environment. Work orders will be completed as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** -The Housekeeping Supervisor/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee. -If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	an email to her if a resident's room needed to be cleaned and confirmed she had not received a request to clean Resident 293's room. Staff should pick up the trash off the floor and empty the garbage when it was full as needed. During an interview, on 10/4/22 at 1:28 p.m., the Executive Director indicated staff should try to clean up in the room and pick up the garbage on floor when they see it. The housekeeping department had a housekeeping staff call in sick on a couple days, leaving only one fulltime housekeeper. Her expectation for staff, if you see something on the floor, they should clean it up. The facility housekeeping scheduled, dated 9/22, indicated one staff person worked on 9/29/22 and 9/30/22. A current policy, titled "Daily cleaning procedure," with a revised date of 12/21, directed staff to sweep under beds, mop flooring to include under beds, chairs, and equipment. This Federal tag relates to Complaint IN00388366. 3.1-19(f)(5)			