STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE VILLAGE	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 28, 29, 2022 and December 1 & 2, 2022 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 12 Medicaid: 43 Other: 15 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 12/13/22.	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. The facility is requesting a desk review in lieu of post survey revisit on or after 1/5/23.**	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's			

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

Erin Ginter | Executive Director | 01/04/2023

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	needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in			

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	§413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on observation, record review, and interview, the facility failed to ensure the bowel and bladder incontinence assessment was accurate for 1 of 2 residents reviewed for incontinence.(Resident 23) Finding includes: During an interview with alert and oriented Resident 23, conducted on 11/29/2022 at 11:00 A.M., she indicated she sometimes had incontinent bowel episodes in the morning because the nursing staff did not bring the bed pan early enough. The clinical record for Resident 23 was reviewed on 11/29/2022 at 11:00 A.M. Resident 23 was admitted to the facility with diagnoses, including but not limited to: chronic obstructive pulmonary disease, asthma, weakness, essential (primary) hypertension, rheumatoid arthritis, major depressive disorder, diverticulosis of intestine, non-infective gastroenteritis and colitis, age-related osteoporosis, hypothyroidism, iron deficiency anemia, anxiety disorder, and muscle weakness. . The current Minimum Data Set assessment, completed on 9/26/2022 indicated the resident required extensive assistance of one to two staff	F 0636	**F636- Comprehensive Assessment and Timing** It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 23 did have a new and accurate Bowel and Bladder assessment completed and the care plan was updated with specific interventions related to toileting needs. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. MDS Coordinator/designee will review the Bowel and Bladder assessments for the past 14 days to check for accuracy and timely	01/05/2023

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	for transfers and toileting needs. The resident was assessed to be occasionally incontinent of urine and frequently incontinent of her bowels. The current functional assessment for Resident 23, completed on 9/22/2022, indicated the resident was dependent for toileting needs. A bowel and bladder incontinence assessment, completed on 9/10/2022 indicated the resident was continent of her bowel and bladder. The current care plans related to incontinence needs indicated the following: "...Problem: Resident has inflammatory bowel disease: HX (history) of diverticulosis," and "Problem: Resident has hx of bowel and bladder incontinent episodes and requires assistance with toilet use. At risk for incontinence r/t (related to) impaired mobility, advanced age. She will notify staff when she needs to use the bathroom." The interventions included: Approach: Offer to toilet upon rising, before or after meals, at bedtime, and every 2 hours at night as needed, Care Needs Sign Off, Include on Profile, Chartable Task in POC (Point of Care- electronic charting system), House moisture barrier cream prn (as needed) incontinent episodes, Assist to toilet as needed, Assist with elimination as needed, Assist with incontinent care as needed, Document any abnormal findings and notify MD, Assess and document skin condition weekly and as needed, Observe for signs of urinary tract infection: decreased output, concentrated urine, abdominal/flank pain, difficult/painful urination, frequency, change in mental status, fever, increase in incontinence...." The current care plan related to providing assistance with daily care needs indicated the		completion and ensure they match the care plan. Any concerns identified will be addressed at that time. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for the interdisciplinary team will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policy titled Bowel and Bladder Program. IDT will review bowel and bladder assessments to ensure accuracy during morning meeting. **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:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tool titled, “Bowel and Bladder Program” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and	

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	resident utilized a sit to stand lift for transfers and was to be provided incontinence and toileting care as needed. The care plan related to the resident's diagnosis of colitis focused on ensuring the resident drank plenty of fluids so she did not develop dehydration and there were no specific intervention related to toileting needs. During an interview with the MDS coordinator, conducted on 12/02/22 at 2:06 P.M., she indicated she was not sure why the bowel and bladder assessment, which indicated the resident was continent of both her bowels and bladder, did not match the MDS assessment, completed on 9/26/2022. She also did not seem aware of the resident's need for a bed pan early in the mornings due to her apparent bowel pattern and colitis issues. There was also no reasoning given as to why the bowel and bladder assessment, completed as a result of the 9/26/2022 MDS assessment was completed on 9/10/2022 prior to the MDS assessment review dates. Review of the facility's police titled "Bowel and Bladder Program" provided by the Administrator on 12/02/2022 at 2:45 P.M. included the following: "...Each resident will be assessed at admission and whenever there is a change in urinary tract function...a new 3 day voiding/elimination pattern will only be completed when there is a change in the level of continence, including when a catheter is removed...each resident will be assessed at admission and with any change in bowel continence...the MDS coordinator/Unit Manager should review the voiding/elimination patterns on a daily basis to determine pattern, compliance and continence status....the care plan must reflect the results of the resident's assessment and include		follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	resident specific interventions for any potential reversible cause, and if irreversible, appropriate interventions for management of fecal incontinence...." 3.1-31(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to ensure a care plan was developed related to the specific use for an antipsychotic medication for 1 of 5 resisdents reviewed for medication use. (Resident 123) In addition, the facility failed to ensure a comprehensive care plan was developed regarding PTSD (post traumatic stress disorder) for 2 of 2 residents reviewed for the diagnosis. (Resident 123, 19 and 28) Findings include: 1. Resident 123 was observed during the initial tour of the facility, conducted on 11/28/2022 between 10:15 A.M. - 11:30 A.M., lying in her bed awake. The resident was noted to have repetative movements of her mouth and lips and her the skin just above her upper lip was noted to be chapped from licking the area repetatively. The cllinical record for Resident 123 was reviewed on 11/30/2022 at 3:01 P.M. Resident 123 was	F 0656	**F656- Develop/Implement Comprehensive Care Plan** It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the residents' goals and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 123 has discharged from the facility. A comprehensive care plan for PTSD have been added for residents 19 and 28. **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 receiving antipsychotic medications have	01/05/2023

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	admitted to the facility on with diagnosis including, but not limited to: hydronephrosis with renal and ureteral calculous obstruciton, obstructive and reflux uropathy, metabolic encephalopathy, sepsis, acute kidney failure, UTI with ESBL, protein calorie malnutrition, diabetes, atrial fibrillation, unspecified dementia without behavioral disturbance, psychotic disturbance and mood disturbance and anxiety, COPD, depressive disorders, osteoarthritis, cerebral infarction, GERD, seizures, hyperlipidemia, HTN and hypothyroidism The current physician orders for medications, included an order for the antipsychotic medication, Pimozide 4 mg at bedtime for other depressive disorders. The Admission MDS (Minimum Data Set) assessment, which was supposed to have been completed on 11/21/2022 was still listed as "In process" and was incomplete when the clinical record for Residenet 123 was reviewed again on 12/01/2022. The current care plan for Resident 123 included plans to address the resident's risk for depression, insominia, and risk for adverse side effects related to the use of psychotropic medication (antidepressant, antipsychotic) but there was not care plan regarding the medical symptom requiring the use of the antipsychotic medication for the resident. The Hospice documentation indicated the Prmozide was utilized for "Mood." During an interview wth the SSD, employee , conducted on 12/01/2022 at 10:18 A.M., she indicated she had recently returned from a medical		the potential to be affected by this finding. Additionally, any resident with a PTSD diagnosis also has the potential to be affected by this finding. DNS/ designee will complete an audit of all residents receiving antipsychotic medications to ensure a care plan is in place. Additionally, an audit of all residents will be completed to identify any resident with a PTSD diagnosis. Any resident identified will have a care plan put in place identifying personal triggers for potential trauma. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for interdisciplinary team will be held on or before 1/5/23 by the DNS or designee and will address the policy for Psychotropic Medication Policy. An in-service for all nursing will be held on or before 1/5/23 and will include the policy titled and Trauma Informed Care. IDT will review orders during morning meeting to ensure any antipsychotic medication will have a corresponding care plan. IDT will review new admission on next business day to ensure any new PTSD diagnosis will have a care plan in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	leave and was not very familiar with Resident 123. She looked through her medications and was unable to identify the antipsychotic medication. After the specific medication use was brought to her attention, Employee indicated there was no specific diagnosis associated with the medication use and she would have to "do some digging" to figure out the medication use. A prescription order form, undated and provided by the facility on 12/01/2022 at 11:54 A.M., indicated the resident was receiving the Primozide antipsychotic medication for a diagnoses of Tourette's disorder. A copy of an Acute care center emergency department visit, dated 10/24/2022 did have Tourette's disorder listed under the resident's diagnoses list. During an interview with the MDS Coordinator, conducted on 12/01/2022 at 2:45 P.M., she indicated she deffered any care plan related to mood/behavioral issues to the Social Services department. It was unclear why the resident's facility record did not include the Tourette's disorder diagnosis on the initial diagnosis list and did not identify and care plan the resident's Tourette's disorder. 2. During the initial tour of the facility, conducted on 11/28/2022 between 10:15 A.M. - 11:30 A.M., Resident 19 was observed lying in her bed watching television and looking at an electronic tablet. She was alert and indicated she was doing pretty good. The cinical record for Resident 19 was reviewed on 11/29/2022 at 9:50 A.M. Resident 19 was admitted to the facility with diangoses, including but not limited to: Type 2 diabetes mellitus with		**recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, "Antipsychotic and PTSD care plan Audit" weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	diabetic nephropathy, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Chronic obstructive pulmonary disease, Morbid (severe) obesity, hypertension, Chronic kidney disease, stage 4 (severe), Heart failure, Sleep apnea, Anoxic brain damage, Neuromuscular dysfunction of bladder, Anxiety disorder, Major depressive disorder, recurrent, unspecified, Post-traumatic stress disorder and left lower quadrant abdominal swelling, mass and lump. The most recent Minimum Data Set assessment for Resident 19, indicated she did not display any mood and/or behavioral issues during the assessment reference time frame. The current care plans for Resident 19, reviewed on 11/29/2022 indicated there was no plan to address the resident's diagnosis of PTSD. (Post Traumatic Stress Disorder). The current plans to address behaviors and/or mood did not provide any specific information regarding the PTSD diagnosis or "triggers." The most recent care plan summary, completed by the SSD, Employee, on 9/27/2022, indicated the resident had not exhibited any behavioral issues and had diagnoses of anxiety and depressive disorder. The summary note indicated the resident did express feeling of sadness and feeling "down" at times. The summary note indicated the resident was seen by the psychiatric services in the facility. There was no specific mention of PTSD in the care plan summary. During an interview with the MDS Nurse, conducted on 12/01/22 at 3:39 P.M., she indicated she usually defers behavioral care plans to the social service designee. When asked if residents			

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	should have had a care plan for PTSD. the MDS coordinator indicated a plan had been initiated for Resident 19 on 12/01/2022 by the Social wellness and enrichment consultant, Emplloyee . During an interview with Employee conducted on 12/01/22 at 3:41 P.M., she indicated she had intiated care plans regarding PTSD for Resident 19. When asked why the resident did not have a plan intiiated earlier she indicated the "new" corportate policy and education had been "rolled out 11/03/2022 and the social service staff were directed to conduct an audit to identify residents in the building with a PTSD diagnosis. She indicated the audits were to be completed by "the end of the month (November) and so she had indiated the care plans for those resident on 12/01/2022. Review of the PTSD care plan for Resident 19 indicated it did not idenitfy specific triggers and was not individualized. Employee indicated the plan was to speak with the facility psychiatric services provider regarding "triggers" and then further individualize the care plans.3. A clinical record review was completed, on 11/30/2022 at 11:48 A.M., for Resident 28, diagnoses included, but not limited to: atrial fibrillation, post traumatic stress disorder, major depression, anxiety disorder, schizoaffective disorder and neuroliptic Parkinson. No care plan was found for PTSD. During an interview, on 12/1/2022 at 3:39 P.M., MDS Nurse indicated she usually defers behavioral care plans to the Social Service Director. A care plan was put in today 12/1/2022. During an interview, on 12/1/2022 at 3:41 P.M., the Regional Social Wellness Enrichment indicated they recently rolled out a new policy on 11/3/22. Social Service is completing audits and she put in			

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	the care plan today. Reviewed the plan of care and she agreed the it is not individualized regarding triggers. On 12/1/2022 at 3:54 P.M., the Regional Social Wellness Enrichment provided a policy titled," Trauma Informed Care", revised 10/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the policy of this facility to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Procedure: 4. The plan of care will routinely be evaluated whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. If interventions do not appear effective, behavioral health and the IDT will collaborate on revised approaches...." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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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
	(D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to invite a resident to the care plan conference for 1 of 25 residents reviewed for care plans. (Resident 51) Finding includes: During an interview with alert and oriented Resident 51, conducted on 11/29/2022 at 9:58 AM., he indicated he did not recall being invited to and/or participating in a care plan meeting. The clinical record for Resident 51 was reviewed on 11/29/2022 at 11:30 A.M. Resident 51 was admitted to the facility with diagnoses, including but not limited to: dementia, osteoarthritis, benign prostatic hyperplasis , chronic atrial fibrillation, hypertension, chronic kidney disease stage 4, atherosclerotic heart disease, type 2 diabetes mellitus, mobid obesity, constipation, urinary tract infections and difficulty walking.	F 0657	**F657- Care Plan Timing and Revision** It is the practice of the facility to ensure all residents are invited to attend care plans and that all care plans are updated per policy. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 51 has had a care plan, was invited and in attendance and it is documented in his medical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. DNS/ designee will complete an audit of	01/05/2023

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	155784	A. BUILDING 00 B. WING	12/02/2022

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	The most recent Quarterly MDS assessment for Resident 51, dated 11/23/2022 indicated the resident scored a 15 on the BIMS (Brief Interview for Mental Status) indicated the resident was alert and oriented. During an interview with the Social Service Designee for the unit on which Resident 51 resided, conducted on 11/30/2022 at 1:43 P.M. she indicated the other SSD handled and tracked all of the care plan meeting invitations. During an interview with SSD, conducted on 11/30/2022 at 2:00 P.M., she indicated she kept copies of mailed invitations to family members regarding care plan meetings. She indicated Resident 51's most recent care plan meeting was conducted on 11/16/2022. She indicated she did not document an invitation to the care plan meeting given to the residents themselves, but presented a blank, scripted post card which was given to residents with the date and time of their care plan meetings . She indicated "if the resident responded" or the family responded to the mailed invitations, then the care plan meeting would be held in the resident room. She indicated the other SSD, employee would have recorded who attended the care plan meetings in the care plan summary note in the clinical record. There was no care plan summary note in the clinical record for Resident 51 regarding the 9/22/2022 care plan meeting. . During an interview with SSD, employee on 11/30/2022 at 2:15 P.M. she indicated she had recently returned to work after an extended leave and had not yet put the care plan summary meeting note in the record for Resident 51 regarding the 11/16/2022 care plan meeting. She provided handwritten documentation which indicated the care plan		all care plan invites for last 14 days to ensure residents were included and care plan is documented in medical record. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for the IDT team will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policies titled Comprehensive Care Plan Policy. IDT will review the schedule for upcoming care plan meetings and ensure resident was invited and is aware of the date and time of the meeting. **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:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Care Plan invite and updating” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and	

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	meeting only involved herself, the MDS coordinator, the dietary supervisor and the activity director. The note indicated the resident was not involved in the care plan meeting. Resident 51 was again interviewed on 11/30/2022 at 2:07 P.M. regarding an invitation to the care plan meeting and he indicated he did not recall receiving a post card, nor did he recall anyone personally inviting him to a care plan meeting in the last few weeks. The facility policy and procedure, titled IDT Comprehensive Care Plan Policy, provided by the Administrator on 12/02/2022 at 9:50 A.M. included the following: "...Procedure: ...Resident, resident's representative, or others as designated by resident will be invited to care plan review...2. During the meeting: all IDT members promptly meet with resident and/or representative at the bedside, or resident's desired location, at the time mutually agreed upon by SS (social services), IDT (inter-departmental team), resident and/or representative....Resident's representative reserves the right not to attend, but the IDT should still attempt to meet with the resident and complete the Care Plan Summary as indicated...." 3.1-35(c)(2)		follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on record review, observation and interview, the facility failed to provide treatment for worsening skin integrity, proper physician ordered treatment for skin integrity, and lack of investigation and documentation for bruises with an improper transfer. (Residents 6, 5 & 28) Findings include: 1. During an initial interview with Resident 6, she indicated she had dry skin and picks at her skin especially when it is dry. She indicated her legs are dry, she had picked at her legs causing scabbing to both legs. Resident 6 indicated she had requested for lotion to be applied. A clinical record review was completed on 11/20/2022 at 3:16 P.M. for Resident 6. Diagnoses included, but were not limited to: Parkinson's disease, bipolar disorder, dementia, and obstructive sleep apnea. A Quarterly MDS (Minimum Data Set) Assessment was completed on 8/25/2022. The assessment indicated Resident 6 had no skin issues. Residen6 6 was cognitively intact and had no documented behaviors. A review of the Physician Order's indicated no lotions or treatments were indicated. A Care Plan revised on 8/18/2022, indicated, " ...Resident is at risk for skin breakdown r/t limited sensory perception, limited/impaired mobility, skin moisture r/t episodes of bowel and bladder incontinence, impaired/decreased mobility, potential for shearing and friction, Parkinson's disease, dementia, dermatitis, Hx [history of] CVA	F 0684	**F684- Quality of Care** It is the practice of the facility to ensure all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 6 did receive an order for her impaired skin integrity. Resident 5 had a completed head to toe assessment done by Nurse Manager; new skin events were noted and physician and family notified. Additionally, the Administrator did a full investigation of incident immediately. Resident 28 had head to toe assessment to ensure no new areas were identified. **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 have the potential to be affected by this finding. DNS/ designee will complete a full facility a full facility skin sweep before 1/5/23. Weekly Skin Assessments will be audited for past 14 days to check for completion and accuracy and that	01/05/2023

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	[cerebral vascular accident] with right hemiparesis, heart disease, hypothyroidism, PVD [peripheral vascular disease]. She has a hx of picking at skin and causing scabbed areas. Has stasis dermatitis to bilateral lower legs with scabbed areas present. Prefers to wear shoes without socks ...." The interventions included, "...Assess and document skin condition weekly and as needed. Notify MD [medical doctor] of abnormal, House moisture barrier cream prn incontinent episodes, no towels on lap tray under arm, Pressure reducing/redistribution mattress on bed, and Incontinent care as needed using peri wash and moisture barrier ...." Weekly Skin Assessment on 11/15/2022, indicated, "...Redness to buttock-blanchable ...." On 11/22/2022, the Weekly Skin Assessment indicated, "...Redness to groin and abdomen ...." During an observation on 12/1/2022 at 11:46 A.M., Resident 6 indicated a treatment has not been ordered this time. She was observed to have more than 20 scabbed areas to the left lower extremity from the ankle to the knee. Resident 6 had more than 12 scabbed area, with one scabbed area actively bleeding to the right lower extremity from the ankle to mid-calf. Erythema is observed around all the scabbed areas. Resident 6 indicated she would appreciate some lotion to combat the dryness on her legs. During an interview on 12/1/2022 at 4:17 P.M., LPN 18 indicated she completed the Weekly Skin Assessment on 11/29/2022 and identified redness on Resident 6's buttocks, under the breast and abdomen. She indicated Resident 6 received house moisture barrier to her buttocks. LPN 18 indicated Resident 6 will tell the staff what		any new skin issue identified in those assessments has a new skin event completed and treatment in place if necessary. All nursing staff will be educated on following physician orders specifically related to transfers and wound prevention measures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policies and procedures related to Skin Management Program and Following physician orders specifically related to transfers and wound prevention. DNS/designee will ensure that treatments are implemented for worsening skin integrity by reviewing the new skin events and ensuring treatments are in place per physician orders. DNS/Designee will routinely round to ensure pressure reducing devices are in place per physician order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility	

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	treatment she wants with her skin issues. She indicated Resident 6 had not indicated she needed a treatment to her legs. LPN 18 indicated Resident 6 does not receive a treatment to her legs, rubs her legs a lot due to dry skin, received scabbed skin from itching, and should have lotion applied daily to the legs. LPN 18 observed the scabbed areas to Resident 6's legs. She indicated since the areas were scabbed; a treatment was not indicated. LPN 18 indicated these scabbed areas should have been identified on the Weekly Skin Assessment. On 12/2/2022 at 8:58 A.M., an interview with LPN 18 indicated the physician had been notified of the scabbed areas. She indicated when Resident 6's legs get this bad we le the physician know. She indicated communication was completed 12/1/2022 by means of the triage sheet (written communication log). During an interview on 12/2/2022 with Nurse Practitioner 19, she indicated she had never seen Resident 6. She indicated she had not received notification of Resident 6's legs and the issue was identified on the triage sheets. She indicated another Nurse Practitioner had seen Resident 6 on 11/23/2022, and did not make any notation of skin issues to the legs. On 12/2/2022 at 12:59 P.M., Resident 6 indicated no staff members had applied lotion to her legs. She indicated she was seen by the Nurse Practitioner today and Eucerin lotion was ordered. On 12/2/2022 at 1:58 P.M., the Administrator indicated the Nurse Practitioner's Note was not available at this time from the visit today. 2. A clinical review was completed, on 11/30/2022 at 9:37 A.M., for Resident 5, diagnosis included but not limited to: primary osteoarthritis, difficulty in		Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Skin and Wound Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	walking, malaise, age related physical debility, and artificial hip joint. During an interview, on 11/28/2022 at 2:49 P.M., the resident indicated she got bruises and a knot on her right knee from being toileted by three staff when she is a hoyer transfer. She told them her legs were not strong enough. The transfer occurred before Thanksgiving. The resident showed the bruise on her right arm, right elbow, top of left and right hand, left hand middle finger and lifted her right pant leg to show the knot. No discoloration noted to the right leg. A Physician Order, dated 4/26/2022, indicated patient to use hoyer lift during transfers. A Care Plan, titled, "ADL Functional/Rehabilitation Potential", approach dated 4/26/2022, indicated hoyer lift x 2 assist for transfers. A Care Plan, dated 4/5/2022 indicated Resident requires assistance with toileting due to decreased mobility r/t fx of left great toe, osteoarthritis, weakness, malaise, difficulty in walking, bowel and bladder incontinence. Approach: Check and change every 2 hours while awake and prn. During an interview, on 11/30/2022 at 10:00 A.M., the Certified Nurse Aide (CNA) 5 indicated Resident 5 is a hoyer lift. The transfer information is on our assignment sheets and charting. The resident had stomach cramps, so he offered a bed pan or the toilet. It took three people to do the transfer two to lift and one to manage the clothing. The transfer was extensive, she did not bare much weight when they got her off the toilet and does not recall her hitting anything during the			

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	transfer. He indicated they should not have transferred her to the toilet. During an interview, on 11/30/2022 at 10:17 A.M., the Certified Nurse Aide (CNA) 2 indicated she did assist with managing resident 5's clothing during the transfer. The transfer was shaky, and she was scared getting off the toilet. It was difficult because she did not bare any weight. She is a hoyer and probably should have used the sit to stand lift. During an interview, on 11/302022 at 1:32 P.M., the Registered Nurse (RN) 4 indicated that she was aware of the transfer and the staff did not follow the plan of care to transfer by hoyer lift. On 12/1/2022 at 2:15 P.M., the Administrator provided a policy titled, "Telephone Orders/Physician Orders," dated 11/15, and indicated the policy was the one currently used by the facility. The policy indicated "...Orders from physicians are used to communicate instruction required to supervise and maintain a resident's health. Physician orders may also include, but are not limited to, medication orders, diagnosis, vital signs, precautions, laboratory/diagnostic order, transfer/discharge orders...." 3. A clinical review was completed, on 11/30/2022 at 9:37 A.M., for Resident 5, diagnosis included but not limited to: primary osteoarthritis, difficulty in walking, malaise, age related physical debility, and artificial hip joint. On 11/26/2022, the weekly skin documentation indicated scattered bruises without indication of where they are located or sizes. No new Event noted under the Event tab in the electronic			

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	medical record. During an interview, on 11/28/2022 at 2:49 P.M., the resident indicated she got bruises from being toileted. The resident showed the bruise on her right arm, right elbow, top of left and right hand, left hand middle finger and lifted her pant leg to show the knot. No discoloration noted to the right leg. During an interview, on 11/30/2022 at 1:32 P.M., the Registered Nurse (RN) 4 indicated when a bruise is noted on a resident they do a skin event, measure, and report it to the Director of Nursing or Administrator. She indicated she did not do a skin event, measure, or report Resident 5's bruises on 11/26/2022 and she should have had. During an interview, on 12/1/2022 at 2:15 P.M., the Administrator indicated she does not have an investigation on the bruises because she was not aware of them. On 12/1/2022 at 2:15 P.M., the Administrator provided a policy titled, "SKIN MANAGEMENT PROGRAM," revised on 5/22, and indicated the policy was the one currently used by the facility. The policy indicated "...PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY - PRESSURE AND NON-PRESSURE 1. Alterations in skin integrity will be reported to the MD/NP, the resident and/or resident representative as well as to the direct care staff. 4. All newly identified areas after admission will be documented on the New Skin Event...." 4. A clinical record review was completed, on 11/30/2022 at 11:48 A.M., for Resident 28, diagnoses include but not limited to: atrial fibrillation, post- traumatic stress disorder, major			

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	depression, anxiety disorder, schizoaffective disorder and neuroleptic Parkinson. During an observation, on 11/30/2022 at 2:44 P.M., resident was sleeping in bed, both prevalon boots were sitting on the other side of the closet on top of a folded walker, pillows under her heels. During an observation, on 12/1/2022 at 10:15 A.M., resident was sleeping in bed, both prevalon boots were sitting on the other side of the closet on top of a folded walker, pillows under her heels. During an observation, on 12/1/2022 at 4::15 P.M., the resident was in bed and prevalon boots were sitting on the other side of the closet on top of a folded walker, pillow under her heels. During an observation, on 12/2/2022 at 8:45 A.M., the resident was in bed, heels resting on top of the pillows, and prevalon boots on the other side of the closet on top of a folded walker. A Physician Order, dated 7/25/2022, indicated offer to float heels while in bed or recliner Every Shift. A Physician Order, dated 7/25/2022, indicated Prevalon boots to BLE while in bed as preventative Every Shift. A Care Plan, titled Pressure Ulcer, with approaches: Offer to float heel while in bed or recliner, and Prevalon boots to bilateral feet while in bed. During an interview, on 12/2/2022 at 9:02 A.M., the License Practical Nurse (LPN) 15 indicated she does have an order for prevalon boots and they are not on and should be. And she does have her			

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	heels on the pillows incorrectly because they are resting on top of the pillows and not floating. On 12/1/2022 at 2:15 P.M., the Administrator provided a policy titled, "Telephone Orders/Physician Orders," dated 11/15, and indicated the policy was the one currently used by the facility. The policy indicated "...Orders from physicians are used to communicate instruction required to supervise and maintain a resident's health. Physician orders may also include, but are not limited to, medication orders, diagnosis, vital signs, precautions, laboratory/diagnostic order, transfer/discharge orders...." 3.1-3.7(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, observation, and interview, the facility failed to identify a pressure ulcer on admission and provide a treatment for the pressure for 1 of 2 residents reviewed for pressure	F 0686	**F686- Treatment and Services to Prevent/Heal Pressure Ulcers** It is the practice of the facility to	01/05/2023

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	ulcers. (Resident 224) Finding includes: A clinical record review of Resident 224 was completed on 11/30/2022 at 8:34 A.M. Diagnoses included, but were not limited to: acute cystitis, dementia, diabetes mellitus type 2, and peripheral vascular disease. A Clinical Hospital Rehabilitation Record on 10/27/2022 at 1:44 P.M., indicated, an unstageable pressure ulcer to the sacrum. The measurements were 1.6 centimeters by 0.8 centimeters by 0.1 centimeters. The pressure ulcer was not staged due to necrotic tissue with 100 percent adherent yellow slough. There was a small amount of serosanguineous drainage. The surrounding pressure ulcer tissue had erythema. The Hospital initiated Medi-Honey treatment with surrounding Skin Prep with an Allevyn dressing. Resident 224 was admitted to the facility on 11/1/2022. A Care Plan on 11/1/2022, indicated, " ...Resident is at risk for skin breakdown due to: limited sensory perception, skin moisture, impaired mobility, potential friction/shear while in bed, peripheral vascular disease and a goal of resident will be free from skin breakdown ...." An Admission MDS (Minimum Data Set) Assessment was completed on 11/7/2022. The assessment indicated Resident 224 was at risk for pressure ulcer development, and had a stage 2 pressure ulcer present on admission. Resident 224 was always incontinent of bladder and bowel. She was severely cognitively impaired. Resident 224 required extensive assistance with two or		ensure all residents will receive a comprehensive skin assessment upon admission and to receive treatment for any areas identified. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 224 is receiving care for pressure ulcer per physician's orders. **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 impaired skin integrity have the potential to be affected by this finding. DNS/ designee will complete a full facility skin sweep before 1/5/23. Weekly Skin Assessments will be audited for past 14 days to check for completion and accuracy. Additionally, an audit of all new admissions/readmissions from last 30 days will be done to ensure skin assessments were completed on next business day by wound nurse/designee and any identified areas have a treatment in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/02/2022

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	more staff members for bed mobility, transfers, and toileting. She required extensive assistance with one staff member for eating. A Nurse's Note on 11/01/2022 at 8:09 A.M., recorded as a late entry on 11/17/2022 08:09 A.M., indicated, " ...Admission Skin Assessment: Resident has some redness to buttock and coccyx. Redness remains blanchable. House barrier cream applied ..." A Braden Scale Evaluation on 11/1/2022, indicated a score of high risk for skin breakdown. On 11/2/2022, a Braden Scale indicated, a score of moderate risk for skin breakdown. A Weekly Skin Assessment on 11/6/2022, indicated " ... areas of skin integrity alteration: Discoloration/Rashes BUE [bilateral upper extremity]-some redness ...." On 11/12/2022 at 5:29 A.M., a Nurse's Note indicated, " ...Resident noted with open skin to the coccyx. Perimeter is red and the central area is covered with some creamy slough. Area cleaned and secured with opt-foam ...." On 11/13/2022, a Weekly Skin Assessment indicated, " ...areas of skin integrity alteration: Open Areas Coccyx ...." A Physician's Order 11/13/2022, indicated, " ...Cleanse area to the Coccyx with wound cleanser and pat dry. Secure with the Optfoam dressing every day and as needed ...." This order was discontinued on 11/14/2022. A Wound Management Note on 11/14/2022 and documented on 11/17/2022 08:14 A.M., indicated a		DNS or designee. This in-service will include review the policy titled Skin Management Program. All new admissions and any resident with new skin issues will be observed to ensure physician notification and treatment are in place. DNS/designee will round routinely to ensure skin treatments are being completed per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Skin and Wound Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	stage 2 pressure ulcer measuring 3 cm (centimeters) by 5 centimeters with an unmeasurable depth. The pressure ulcer had a light bloody drainage with no odor. There was no undermining or tunneling. The pressure ulcer had 85 percent of granulation tissue, 10 percent slough tissue and 5 percent eschar tissue. The surrounding tissue had blanchable erythema. The wound is indicated as stable with no signs and symptoms of infection and has a history of an open area to the coccyx. N unstageable A Physician's Order on 11/14/2022, indicated, " ...Cleanse coccyx with wound cleanser and pat dry. Apply collagen and cover with dry dressing daily ...." The order was discontinued on 11/17/2022. A Care Plan on 11/14/2022, indicated, " ...Problem: Resident has impaired skin integrity: Pressure area noted to the coccyx. Dx: acute cystitis without hematuria, mixed hyperlipidemia, dementia with psychotic disturbance, COPD, chronic diastolic heart failure, insomnia, osteoporosis, peripheral vascular disease, diabetes, depression, repeated falls, encephalopathy, chronic respiratory failure, obstructive sleep apnea, atrial fib [fibrillation], hypokalemia, hypertension, osteoarthritis, CKD 3 [Chronic Kidney Disease Stage 3]. Contributing factors: limited sensory perception, skin moisture, impaired mobility, potential friction/shear while in bed, peripheral vascular disease ...Goal: Wound will heal without complications ...." A Nurse's Note on 11/15/2022 5:22 A.M., indicated, " ....Dressing to the coccyx changed, some scant amount of drainage noted from the wound perimeter. The central part noted with some creamy slough. Procedure well tolerated ...." A Wound Management Note on 11/16/2022, and			

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	documented on 11/17/2022 at 8:20 A.M., indicated, " ...an unstageable pressure ulcer due to slough and eschar. The pressure ulcer measured 3.7 centimeters by 7.1 centimeters by 0.1 centimeters. The pressure ulcer had a bloody drainage and no odor. There was no undermining or tunneling. There was no undermining or tunneling. The pressure ulcer had 85 percent granulation tissue, 10 percent slough tissue, and 5 percent eschar tissue. The surrounding tissue had blanchable erythema. The surrounding tissue had blanchable erythema. The wound is indicated as stable with area of new eschar. The treatment was changed, and there was no signs or symptoms of infection...." A Physician's Order on 11/17/2022, indicated " ...Cleanse coccyx with wound cleanser and pat dry. Apply Medi-honey to eschar, cover Medi-honey with calcium alginate, apply collagen to right and left buttock and cover with dry dressing daily and as needed. This order was discontinued on 11/30/2022. An order for an air mattress was placed on 11/17/2022, and indicated, " ...[Mattress brand] settings per resident comfort Every Shift ...." On 11/18/2022 03:06 P.M., A Nurse's Note indicated, " ...Wound culture obtained at this time. Dressing change completed as ordered and tolerated well. Edges remain intact, no odor, drainage or s/sx [signs/symptoms] of infection observed. Foley cath [catheter] placed using sterile technique. 16fr [French] cath with 15mL [milliliter] balloon intact. Yellow urine draining to gravity at this time. Tolerated procedure well. No c/o [complaints of] pain or discomfort noted during placement or after procedure. Resting comfortably on left side to offload pressure area with call light in reach. POA [Power of Attorney]			

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	notified via voicemail ...." On 11/21/2022 at 5:53 A.M., a Nurse's Note indicated, " ...Changed dressing to the coccyx. Zero bleeding/odor noted. However, the central area is covered with some creamy slough. Treatment administered as ordered ...." On 11/21/2022 at 3:23 P.M., a Nurse's Note indicated, " ...Lab report for wound culture in and shows MRSA [Methicillin Resistant Staphylococcus Aureus}, NP [Nurse Practitioner] notified. Have a Picc [peripheral inserted central catheter] line placed and start Vancomycin IV [intravenously] with Pharmacy to dose for wound infection, Moxifloxacin 400 mg po daily x [times] 10 days for wound infection. [Company Name] was called for Picc line placement and will call back the facility when in route. Dressing to coccyx intact and no drainage or foul odor noted. Several attempts were made to notify dtr [daughter] [Daughter's name] but could not answer the phone, left message to call facility ...." A Physician's Order on 11/22/2022, indicated, " ....vancomycin 1,000 mg [milligrams] intravenously, infuse 1g [gram] @ 167[milliliter]/hr [hour] once a day ...." On 11/28/2022 at 11:23 P.M., a Nurse's Note indicated, " ...Post NP [Nurse Practitioner] New orders received and noted: Referral Consultation wound clinic - MD [Medical Doctor]: Dx [Diagnosis]- Wound Coccyx: D/C PRN Norco Start Norco 7.5-325 po q 8 hrs [hours] scheduled ...." A Wound Management Note on 11/30/2022 at 9:37 A.M., indicated, " ...a stage 4 pressure ulcer. The pressure ulcer measures were 5.1 centimeters			

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	by 4 centimeters with a depth of 2.2 centimeters. The pressure ulcer had a moderate amount of seropurulent drainage with no odor present. The pressure ulcer had 50 percent granulation tissue and 50 percent slough tissue. The wound margins were irregular. The surrounding tissue had erythema that was blanchable. New interventions were placed. A Physician's Order on 11/30/2022, indicated, " ...Cleanse coccyx with wound cleanser and pat dry. Apply Medi-honey to slough, cover Medi-honey with calcium alginate, apply collagen to granulated wound margins and cover with dry dressing daily ...." On 12/2/2022 at 9:56 A.M., an observation of the pressure ulcer was completed with LPN 12. LPN 12 indicated the pressure ulcer was found on admission and was covered with eschar and slough at that time. He indicated the treatment on the pressure ulcer was Medi-honey and calcium alginate. The pressure ulcer was noted to have a foul odor and serosanguinous drainage when the dressing was removed. On 12/2/2022 at 10:18 A.M., CNA 14 indicated Resident 224 received bed baths. She indicated the wound was present upon admission and a dressing was applied to the wound. She indicated that the staff position Resident 224 side-to-side, get her out bed, and keep the resident clean and dry. During an interview on 12/2/2022 at 1:23 P.M., the Director of Nursing (DON) indicated, she could not say exactly when the pressure ulcer occurred. She indicated she was notified on 11/12/2022, and treatments began at that time. The DON indicated when the daughter was updated on the pressure			

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	ulcer, the daughter indicated Resident 224 had a pressure ulcer prior to admitting to the facility. The DON indicated, "We knew this was going to be an issue." A policy was provided on 12/2/2022 at 12:49 P.M. by the Administrator. The policy titled, "Skin Management Program" indicated, " ...Avoidable Pressure Ulcer/injury: means that the resident developed a pressure ulcer/injury abs that the facility did not do one or m ore of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice, monitor and evaluate the impact of the interventions, or revise the interventions as appropriate ...Procedure For Wound Prevention 1. All residents will be assessed at admission using a skin risk (Braden) assessment to determine risk for pressure ulcer/injury with initiation of a plan of care. 2. The admission skin assessment will include but not limited to: Interview of resident or family about history of skin alterations, Head-to-toe skin assessment, bed mobility, continence, signs/symptoms of peripheral vascular disease, skin alterations present on admission, skin discoloration and any evidence of scarring on pressure points, recent surgical procedures, complications such as infection and pain, nutritional status ...." 3.1-40(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who			

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	needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen was administered by a nurse and continuous positive airway pressure (CPAP) equipment was cleaned/changed for 2 out of 2 residents reviewed for respiratory services. (Resident 173 & 6) Findings include: 1. A clinical review was completed, on 11/30/2022 at 2:14 P.M., for Resident 173, diagnoses included but were not limited to: acute systolic (congestive) heart failure, venous insufficiency (chronic) (peripheral), atrial fibrillation, acute kidney failure, type 2 diabetes mellitus and atherosclerotic heart disease of native coronary artery with unstable angina pectoris. During an interview, on 11/29/2022 at 9:29 A.M., the resident was sitting in his wheelchair without his oxygen. He indicated he was going to a doctor appointment, and they went to get some tubing for the portable. During an observation, on 11/29/2022 at 9:30 A.M., a man in blue scrubs entered the room with long tubing connected it and proceeded to turn on the oxygen. He turned the dial to 2 liters. This surveyor asked if he was the nurse and he indicated he was a bus driver and not a nurse. He indicated he put the oxygen on 2 liters. A Physician Order, dated 11/29/2022, indicated	F 0695	**F695- Respiratory/Tracheostomy Care and Suctioning** It is the practice of the facility to ensure any resident requiring respiratory care have a comprehensive person-centered care plan consistent with the residents' goals and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 173 has discharged from the facility. Immediate education was provided to the bus driver at the time of incident. An order to clean and change CPAP and equipment was added to Resident 6 orders. **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 residents receiving oxygen therapy and those that utilize CPAP/Bi-Paps have the potential to be affected by this finding. DNS/ designee will complete an audit of all residents with orders for oxygen therapy to ensure	01/05/2023

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	Oxygen at 4 liters per nasal cannula. Every Shift. During an interview, on 11/30/2022 at 11:51 A.M., the bus driver indicated that he has changed the tubing over to the portable and turned on the oxygen for other residents. It is not in his job description or in his scope of practice to administer oxygen and should not have. On 12/1/2022 at 2:15 P.M., the Administrator indicated she could not find a policy but provided a procedure steps, titled "Filling Portable Oxygen Canister", revised 12/2012, and indicated the procedure is the one currently used by the facility. The procedure indicated "... 3. Ask nurse to disconnect oxygen from resident. 18. Ask the nurse to reconnect the oxygen to the resident...." On 12/1/2022 at 2:15 P.M., the Administrator provided a job description titled, "Bus Driver Position Description", revised 6/2014, and indicated the job description is the one currently used by the facility. The job description indicated "...SUMMARY OF POSITION FUNCTIONS: The Bus Driver has a primary responsibility with ensuring the health, safety and welfare of the resident while transporting to and from activities outside the community...."2. During an initial interview on 11/28/2022 at 1:51 P.M., Resident 6 indicated she wears a C-Pap (continuous positive airway pressure) at night. Resident 6 indicated there is problem with sanitation and cleaning of the C-Pap system. She indicated the mask, tubing, filtration, and humidification reservoir have not been cleaned in a long time. She indicated it had been some time since the mask, tubing, filtration, and humidification reservoir had been changed. A clinical record review was completed on 11/20/2022 at 3:16 P.M. for Resident 6. Diagnoses		orders are in place and resident's oxygen is set on correct liter flow. Additionally, an audit of all residents with orders for CPAP/Bi-Pap will be done to ensure orders are in place for cleaning and changing of equipment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policy titled CPAP Therapy and the procedure for filling portable oxygen. DNS/ designee will round routinely to ensure residents are receiving oxygen per physician order and CPAP/Bipap is being cleaned per policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, "Respiratory Therapy Audit" weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an	

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	included, but were not limited to: Parkinson's disease, bipolar disorder, dementia, and obstructive sleep apnea. A Quarterly MDS (Minimum Data Set) Assessment was completed on 8/25/2022. The assessment indicated Resident 6 was cognitively intact. A Care Plan on 8/18/2015, indicated, " ...Problem: Resident has potential for impaired gas exchange related to: Chronic obstructive pulmonary disease, Obstructive sleep apnea. Has an order for CPAP at night, which she often refuses to wear or will remove in bed after wearing for a short time. Becomes short of breath when lying flat. Uses supplemental oxygen, refuses to keep it in place at times. PRN [as needed] nebulizer treatment. Hx [History] COVID-19 ...." A Physician's Order on 9/16/2018, indicated, "...CPAP Set 4-20 cm H2O Twice A Day ...." The orders indicated a service provider for the C-Pap equipment. During an interview with the Director of Nursing (DON) on 12/02/22 at 1:16 P.M., the DON indicated residents should have orders to wash the mask out with soap and water daily, orders to place at night and take off in the morning when they wake up, and orders to change the mask and tubing every 6-12 months. The DON reviewed Resident 6's orders and could not identify any maintenance or cleaning orders. On 12/2/2022 at 12:49 P.M., a policy titled, "CPAP Therapy" was provided by the Administrator. The policy indicated, " ...Cleaning and Maintenance 4) Follow these steps for cleaning your CPAP patient circuit]: i. Remove the headgear from the		action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	mask or nasal pillow shell. Disconnect the mask pr shell, swivel, and tubing. j. With a soft cloth, gently wash the mask or pillows with a solution of warm water, and a clear liquid detergent. k. Rinse thoroughly. If the mask still feels oily, repeat step c. l. Allow the mask or pillows to air dry. Do not place any supplies in the dryer. m. Wash tubing as necessary with a solution of warm water, and a mild clear liquid detergent. Rinse thoroughly, and allow to air dry. n. Clean and inspect all components regularly. The mask, tubing, and headgear should last approximately 6-12 months, but the actual life of the equipment can vary greatly ...6) Filter maintenance 6. Will depend on the model of the unit you have. 7. There may be two filters on some models. 8. The first filter is usually disposable and the second is reusable. 9. Disposable filters should be replaced per manufacturer's' recommendations. 10. Reusable filters should be rinsed of dust and allowed to air dry. Never put a damp filter in your CPAP unit ...." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure a resident receiving dialysis was assessed before and after dialysis for 1 out of 1 reviewed for dialysis services. (Resident 58) Finding includes:	F 0698	**F698- Dialysis** It is the practice of the facility to ensure all residents receiving dialysis will be assessed before and after dialysis **What corrective action(s) will be accomplished for those**	01/05/2023

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	155784	A. BUILDING 00 B. WING	12/02/2022

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	A clinical review was completed, on 11/30/2022 at 3:57 P.M., for Resident 58, diagnoses included but not limited to: hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, peripheral vascular disease, atrial fibrillation, and osteoarthritis. A Physician Order, dated 10/29/2022, indicated Dialysis Tuesday, Thursday, Saturday at 12:30 P.M.. During an interview, on 12/2/2022 at 9:37 A.M., the Unit Manager 2 indicated that Resident 58 goes to dialysis on Tuesday, Thursday and Saturday and when he goes out to dialysis the nurse opens an event and fills out the questions prior to dialysis, when he returns the nurse on duty finishes the event. The unit manager found events dated 11/1/2022, 11/3/2022. 11/5/2022 and 11/8/2022. She indicated there was no event filled out for 11/10/2022 11/12/2022, 11/15/2022, 11/17/2022 11/19/2022, 11/21/2022, 11/23/2022, 11/26/2022, 11/29/2022 and 12/1/2022 and there should have been. The Event is titled, "Dialysis/Other Outpatient Event - ASC Dialysis Appointment Assessment". On 12/2/2022 at 10:51 A.M., the Administrator provided a policy titled, " Dialysis Care", revised 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated, "...POLICY Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. PROCEDURE 3. A dialysis event will be initiated in EMR to include time of transfer and completed on return to the unit...."		**residents found to have been affected by the deficient practice:** Resident 58 is being assessed before and after dialysis. **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 receiving dialysis have the potential to be affected by this finding. DNS/ designee will complete an audit of all residents receiving dialysis to ensure dialysis events are completed per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policy titled Dialysis Care. Dialysis events will be reviewed in morning meeting to ensure event are completed per policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement	

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	155784	A. BUILDING 00 B. WING	12/02/2022

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	3.1-37(a)		Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Dialysis Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of			

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	1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled appropriately in 2 of 2 medication carts reviewed and failed to ensure non-pharmalogicals were stored appropriately for 1 of 1 medication carts and refrigerators reviewed. Findings include: 1. During an observation of the medication cart for the 400 unit, conducted on 12/01/2022 at 2:21 P.M., the following was noted: There was an opened bottle of refresh tears eye drops for Resident 31 with an open date of 4/30/2022, there was an opened inhaler for Resident 23 with an open date of 6/22/2022. During an interview with LPN 15 indicated she thought the eye drops and the inhaler medications expired after 45 days. The following opened insulin pens had no open date on them: Novolog insulin pen for Resident 36, Glargine insulin pen for Resident 58 and Levemir insulin pen for Resident 33. During an interview with LPN 15 she confirmed there was no opened date on the insulin pens. 2. During an observation of the medication cart for the 200 unit, conducted on 12/01/2022 at 2:40 P.M., the following was noted: An opened bottle of Timopol eye drops for Resident 24 had no date to indicate when it was opened and an opened inhaler for Resident 54 had no date to indicate when it had been opened. During an interview with LPN 12 he indicated he was going to "fix" the issue immediately.	F 0761	**F698- Dialysis** It is the practice of the facility to ensure all residents receiving dialysis will be assessed before and after dialysis **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 58 is being assessed before and after dialysis. **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 receiving dialysis have the potential to be affected by this finding. DNS/ designee will complete an audit of all residents receiving dialysis to ensure dialysis events are completed per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policy titled Dialysis Care. Dialysis events will be reviewed in morning meeting to	01/05/2023

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	3. During an observation of the medication cart on the 300 unit, conducted on 12/01/2022 at 2:21 P.M., with LPN 15, an opened bottle of soda was noted to be stored inside the medication cart next to the narcotic drawer. The nurse removed the soda and indicated it should not have been in the cart. 4. During an observation of the medication refrigerator on the 300 unit, conducted on 12/01/2022 at 2:25 P.M., an opened, unlabeled bottle of soda was noted to be stored in the refrigerator door of the medication refrigerator. When queried as to why there was a soda in the medication refrigerator, LPN 15 indicated it belonged to Resident 123 and was being stored in the medication refrigerator because sometimes items came up missing when they were stored in the nutrition pantry refrigerator. Review of the facility policy and procedure, titled " Storage and Expiration of Medications, Biological's, Syringes and Needles:, provided by the Administrator on 12/02/2022 at 9:50 A.M., indicated the following: "...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..." The policy did not specify specific medication expiration dates once opened...." According to the Consumer Medication Storage organization, regardless of where it is stored, OPEN insulin will only last 28 days before it must be thrown away. In addition, according to the		ensure event are completed per policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Dialysis Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	

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	manufacturer's instructions for Timopol eye drops, once opened the eye drops should not be used longer than 4 weeks. Finally, the manufacturer's instructions for the inhaler for Resident 23 indicated it was only good for 3 months after the foil packaging was opened and the inhaler for Resident 54 was good for 12 months after it had been opened. 3.1-25(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must			

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	include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.			

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	The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure 1 of 5 nursing staff observed administering medications followed infection control policies regarding cleaning of a glucometer. (LPN 15) Finding includes: During an observation of a medication administration pass, conducted on 12/01/2022 at 10:02 A.M., LPN 15 gathered items to obtain the blood glucose level for Resident 53. She gathered a glucometer, a large packet containing a disinfectant wipe, a few smaller packets containing alcohol wipes, and a cardboard box which contained several unused lancets. After entering Resident 53's room, the LPN placed a paper towel on his over bed table, washed her hands and donned gloves. Next, she opened an individual packet containing a disinfectant wipe and cleaned and disinfected the glucometer. After allowing the glucometer to dry for a few minutes, the nurse then opened an alcohol swab and cleaned Resident 53's finger with alcohol. After placing a new test strip into the glucometer machine, LPN 15 then pricked Resident 53's cleaned finger with a lancet and obtained a drop of blood. She placed the drop of blood onto the test strip and obtained the blood glucose reading. After removing her gloves, LPN then walked back to the medication cart and placed the uncleaned glucometer back on top of the remainder of testing supplies, directly on top of the remaining lancets and alcohol swab packets. Review of the facility policy and procedures, titled: "Storage and expiration of Medications,	F 0880	**F880 – Infection Prevention and Control** It is the practice of the facility to establish and maintain an infection prevention and control program designed to provide a safe, comfortable environment and to help prevent the transmission of communicable diseases and infections. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All licensed nurses received a skills check-off on Blood Glucose cleaning procedure. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. All licensed nurses and QMAs will receive skills check off on Glucose Cleaning procedure. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 1/5/23 by the DNS or designee. This in-service will include review the policy titled	01/05/2023

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	Biological, Syringes and Needles, provided by the Administrator on 12/02/2022 at 9:50 A.M. indicated the following: "...Facility should ensure that food is not to be stored in the refrigerator, freezer or general storage areas where mediations and biological's are stored...." Review of the facility policy and procedures, titled, Blood Glucose Meter Cleaning/Disinfecting and testing policy, provided by the Administrator on 12/02/2022 at 9:50 A.M. included the following instructions after exiting the resident's room with the used, gathered supplies: "...Exit room, Dispose of lancet and test strip in sharps container, Dispose of alcohol wipe, test strip, paper towel or clean barrier and gloves in trash if not already done in resident room. Place glucometer on paper towel, plastic cup or other barrier that was left on medication cart. (Note: the paper towel is not a dirty surface) (Note is blood is visibly present on the glucometer, two wipes must be used. One germicidal wipe to clean (i.e. remove visible blood or soiling, it does not need to be done per contact time); The second wipe is to disinfect and must be done with (name of germicidal wipe); wipe for a 3 minute contact time. ..." 3.1-18(a)		Blood Glucose Meter Cleaning/Disinfecting and testing policy. . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Infection Control Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 1/5/23	