STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00413914 and IN00416767. Complaint IN00413914 - No deficiencies related to the allegations are cited. Complaint IN00416767 - No deficiencies related to the allegations are cited. Survey dates: September 5, 6, 7, 8, 11, 12, and 13, 2023 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 5 Medicaid: 62 Other: 33 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 21, 2023.	F 0000		
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination.			

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

Jerod Williams | HFA | 10/06/2023

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

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	The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure a resident was provided showers as preferred for 1 of 2 residents reviewed for choices (Resident 13). Finding includes: During an interview, on 9/6/23 at 1:45 p.m., Resident 13 indicated she had requested to receive two showers a week during evening shift, but she could not remember the last time she had	F 0561	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	10/16/2023

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	received a shower. Resident 13's record was reviewed on 9/8/23 at 2:08 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated the resident had a moderate cognitive impairment and required a one-person physical assistance with bathing. A care plan, dated, 7/2/20, indicated the resident requires assistance with Activities of Daily Living (ADL's) related to decreased mobility, weakness, dementia, and depression. Interventions included, but were not limited to, bathe per resident preference 2 times per week and as needed. A choice for resident care document, dated 3/17/23, indicated Resident 13 preferred showers for bathing and requested the showers to be given on Tuesday and Thursday in the afternoon or evening time. Review of resident council minutes, dated 8/25/23, indicated the residents had concerns about not receiving the showers routinely as requested. Review of point of care documentation, dated July 2023, indicated Resident 13 did not receive a shower during the month of July. The record lacked any documentation of a shower for the month. Review of point of care documentation, dated August 2023, indicated Resident 13 received one shower on 8/8/23. The record lacked any other showers documented for the month. Review of point of care documentation, dated September 2023, indicated Resident 13 received one shower on 9/5/23. The record lacked any other showers documented for the month.		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of the facility to promote and facilitate resident self-determination through support of resident choices. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 13 received a shower at the time of survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents that prefer showers have the potential to be affected by the cited practice, therefore, this plan of correction applies to those residents who have indicated showers to be their preference. The Choice for Resident Care questionnaires have been audited to identify residents with showers as a preference, these preferences have been updated in the care plans, as necessary. Admissions conducted an audit on 9/14/23 of all resident	

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	During an interview on 9/8/23 at 11:15 a.m., the Administrator indicated he had received complaints from residents and families regarding residents not getting their showers routinely. He was aware that showers were not being provided routinely and was working on the issue. He had started an audit tool to help facilitate the issue. On 9/12/23, at 2:05 p.m., the Director of Nursing (DON) provided an undated document, titled, "Resident Preferences,", and indicated it was the policy currently used by the facility. The policy indicated, "Policy: It is the policy of the facility to ensure that as a part of a "person centered" approach to care, the resident receives care as to their preference and choice ...It is upholding their Resident Rights ...." 3.1-3(u)(1) 3.1-3(u)(3)		hygiene preference forms done during the admission process. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff has been re-educated by the DON/Designee relative to Self-determination, including but not limited to, provision of bathing assistance according to residents' preferences. Education was conducted on 9/14/2023. Any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. 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? DON/Designee will audit a minimum of 10 shower sheets at least 3 times weekly for 4 weeks to ensure proper hygiene is maintained for residents according to their preferences. Thereafter, these audits will be conducted for a minimum of 5 shower sheets at least 2 times weekly for 8 weeks, and then a minimum of 5 shower sheets bi-weekly for 12 weeks. If the facility is within 95% compliance at the end of the 6	

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			months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
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 ensure a resident who was unable to carry out activities of daily living (ADL) (daily self-care activities) received assistance with removal of facial hairs for 1 of 3 residents reviewed for ADL care (Resident 96). Finding includes: During an observation, on 9/6/23 at 11:53 a.m., Resident 96 was observed lying in bed with multiple chin hairs and indicated she wished staff would get rid of her chin hairs, but most of the time staff do not even ask when they are bathing her. On 9/7/23 at 10:57 a.m., Resident 96's multiple chin hairs were observed, while the resident was lying in bed with her eyes closed.	F 0677	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to	10/16/2023

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	On 9/8/23 at 12:21 p.m., Resident 96 was observed seated at a table in the dining room with multiple chin hairs. On 9/8/23 at 1:30 p.m., Resident 96 was observed lying in bed with multiple chin hairs. On 9/11/23 at 11:13 a.m., Resident 96 was observed lying in bed and watching television with multiple chin hairs. On 9/11/23 at 2:55 p.m., Regional Nurse Consultant 9 observed Resident 96 with multiple chin hairs and indicated Resident 96 should have her facial hairs removed daily or during bathing by the staff. Resident 96's record was reviewed, on 9/8/23. An admission Minimum Data Set (MDS) assessment, dated 7/8/23, indicated the resident was cognitively intact and required extensive assistance of two persons for bed mobility, transfers, toileting, personal hygiene, and bathing. A care plan, dated 7/3/23, indicated the resident required assistance with ADLs related to generalized weakness with interventions included, but were not limited to, assist resident, as needed, so resident was per the resident's preference with the care plan goal of Resident 96 will have all ADLs met by staff through the next review. On 9/11/23 at 3:05 p.m., Regional Nurse Consultant 9 indicated Resident 96's facial hairs should have been removed when staff had provided the resident with ADL care, during bathing the resident. The Regional Nurse Consultant 9 provided and identified an undated document as a current facility policy, titled,		maintain good nutrition, grooming and personal and oral hygiene for residents that are unbale to carry out the activity. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 96 was shaved at the time of survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Dependent residents who require assistance with ADL completion have the potential to be affected. An audit was conducted on 9/19/23 to identify those residents. This plan of correction applies to those residents identified. Care plans have been reviewed and revised, as necessary, to reflect current ADL status. RNC conducted audit on 9/14/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff was re-educated by the DON/Designee on ADL Care	

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	"Activities of Daily Living (Routine Care). The policy indicated, "...Policy: Residents are given routine daily care and HS (bedtime) care by a Certified Nursing Assistant or a Nurse to promote hygiene, provide comfort and provided a homelike environment. ADL care is provided throughout the day, evening and night as care planned and/or as needed. ADL care is coordinated between the resident and the care givers with emphasis on resident preference as much as possible ...ADL care of the resident includes: ...Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care (as indicated and as per care plan)...." 3.1-38(a)(3)		Provided for Dependent Residents, including but not limited to, providing ADL care for residents unable to carry out activities of daily living and ensuring removal of facial hair, as necessary. Education was conducted on __9/14/23_____. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. 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 DON/Designee will monitor 10 random residents for facial hair 5 times weekly for 4 weeks, the 5 random residents a week x 8 weeks, then 3 random residents a week x 12 weeks. Any identified concerns will be promptly addressed with the responsible individual(s). Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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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 (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 and interview, the facility failed to ensure that a resident received daily dressing changes to an unstageable pressure ulcer to his left heel for 1 of 3 residents reviewed for pressure ulcers (Resident 94). Findings include: Resident 94's record was reviewed on 9/12/23 at 1:56 p.m. The profile indicated the resident's diagnosis included, but were not limited to, pressure ulcer to left heel, unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough or eschar in the wound bed). A weekly wound evaluation document, dated 8/28/23, indicated the resident had developed an unstageable pressure ulcer to his left heel on 7/4/23. The wound measures 1 x 1 cm and is 100% necrotic (dead cells) tissue in wound bed.	F 0686	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to ensure residents with pressure ulcers receive necessary	10/16/2023

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	A care plan, dated 7/19/23, indicated the resident had developed impaired skin integrity left heel pressure ulcer, unstageable. Interventions included but were not limited to apply the treatment per physician orders. A physician order, dated 7/6/23, indicated cleanse with wound cleanser, apply skin prep and cover with boarded foam every dayshift to unstageable wound on the left heel. Review of Treatment Administration Record (TAR), dated July 2023, lacked documentation the resident received a dressing change to his left heel on 7/6, 7/13, 7/14, 7/16, 7/18, 7/19, and 7/22. Review of TAR, dated August 2023, lacked documentation the resident received a dressing change to his left heel on 8/26 and 8/30. Review of TAR, dated September 2023, lacked documentation the resident received a dressing change to his left heel on 9/4, 9/5, and 9/11. During an interview, on 9/13/23 at 10:53 a.m., Assistant Director of Nursing (ADON) indicated Resident 94 had holes on his TAR for the left heel dressing change and the staff should have documented the dressing change or refusal if not done. On 9/13/23 at 11:00 a.m., the ADON provided an undated document, titled, "Skin and Weight Assessment Team," and indicated it was the policy currently being used by the facility. The policy indicated, " ... Record on treatment sheet: Open area treatments need to be recorded on treatment sheet ...." On 9/13/23 at 11:00 a.m., the ADON provided an		treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers for developing. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 94's dressing was applied during the survey, per physician order. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents with pressure ulcers, and ordered treatments, have the potential to be affected by the cited practice. An audit was conducted to identify those residents with pressure ulcers and ordered treatments. Treatment orders and treatment sheets have been reviewed to ensure treatments are documented as administered. Any identified concerns were promptly addressed with the responsible individual(s). DON conducted audit on 10/5/23 of all residents with pressure ulcers and their ordered treatments.	

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	undated document, titled, "Physician Orders (Following Physician Orders)", and indicated it was the policy currently used by the facility. The policy indicated, "Policy: It is the policy of the facility to follow the orders of the physician ...." 3.1-40(a)(2)		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses have been in serviced relative to Treatment/Svcs to Prevent/Heal Pressure Ulcer, including but not limited to, the importance of ensuring physician ordered treatments are applied, and application of treatments is signed out on the Treatment Record upon completion. Education was conducted on 9/14/2023. DON/Designee completed this in-service. Any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. 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? DON/Designee will audit residents with pressure ulcers for treatment orders, treatment in place and signed on TAR weekly x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However,	

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			any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure insulin medication was administered within 15 minutes of meal service for 2 of 2 residents reviewed for significant medication error in a sample of 26 residents (Resident's 2 and 48). Findings include: 1. During an observation on 9/7/23 at 11: 20 a.m., Registered Nurse (RN) 14 assessed Resident 2 and prepared for insulin administration. The resident's blood glucose reading was 356. Humalog insulin 5 Units and 10 units of Humalog insulin according to the sliding scale administration order, was prepped to be administered. On 9/7/23 at 11:24 a.m., RN 14 administered 15 units of Humalog insulin to Resident 2. The resident was then assisted to the main dining room by a Certified Nurse Aide (CNA). During an observation on 9/07/23 at 11:39 a.m., Resident 2 was sitting at a table in the main dining room. Meal service had not begun, and there was no indication of food being served to the resident.	F 0760	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to ensure residents are free of any significant medication error. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	10/16/2023

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	During an observation on 9/07/23 at 12:00 p.m., Resident 2 was in the main dining room sitting at a table. The noon meal service had not begun and no indication the resident had been served food. During an observation on 9/7/23 at 12:21 pm, the lunch meal was served to the Resident 2. Insulin was administered 57 minutes prior to meal. On 9/8/23 at 9:00 a.m., the medical record of Resident 2 was reviewed. The resident had diagnosis including but not limited to, Diabetes mellitus, (a disease that occurs when your blood glucose, also called blood sugar, is too high), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). Physician Orders included but were not limited to: a. Insulin Detemir Solution 100 unit/ml, inject 30 unit subcutaneously two times a day for diabetes. b. Insulin Aspart Solution, inject as per sliding scale 3 times a day with meals; if blood sugar level is 0 - 149 = 0 units; 150 - 190 = 2 units; 191 - 230 = 4 units; 231 - 270 = 6 units; 271 - 310 = 8 units; 311 - 350 = 10 units. Call MD if Blood glucose greater than 350. A quarterly Minimum Data Set (MDS) assessment, dated 8/8/23, indicated the resident received insulin injections during the assessment period. A care plan, dated 9/27/2019, indicated resident was at risk for hypoglycemia and or hyperglycemia related to diagnosis of diabetes mellitus. Interventions included but were not limited to, observe for signs and symptoms of hypoglycemia and or hyperglycemia and		1. & 2. RN #14 was re-educated at the time of survey relative to insulin administration guidelines. Neither Resident 2 nor Resident 48 were negatively affected by the insulin administration. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents receiving sliding scale coverage insulin have the potential to be affected. An audit has been conducted to identify those residents. Audit conducted on 10/2/23 by DON. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were re-educated by the DON/Designee relative to Free of Significant Med Errors, including but not limited to insulin administration guidelines. Education was conducted on 9/14/23. Any staff member that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. How the corrective action(s)	

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	administer medications as ordered by the physician. 2. During an observation on 9/07/23 at 11:26 a.m., Resident 48 was lying in bed. A breakfast tray was on the overbed table. All food except for dry cereal had been consumed. RN 14 assessed the blood sugar of Resident 48. The blood sugar reading was 240. On 9/7/23 at 11:35 a.m., RN 14 administered 6 units of Novolog insulin to Resident 48. During an observation on 9/07/23 at 12:29 p.m., Resident 48 was lying in bed. The breakfast meal tray was on the overbed table. Dry cereal was not consumed. The resident indicated she had not been given a snack after insulin was administered. During an observation on 9/7/23 at 1:50 p.m., Resident 48 was sitting up in bed and eating lunch meal. On 9/8/23 at 10:00 a.m., the medical record of Resident 48 was reviewed. The resident had diagnosis including but not limited to, Diabetes mellitus, (a disease that occurs when your blood glucose, also called blood sugar, is too high), supraventricular tachycardia (an irregularly fast or erratic heartbeat (arrhythmia) that affects the heart's upper chambers), hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. This makes your metabolism slow down. Also called underactive thyroid), hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). Physicians Orders included but were not limited		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON/Designee will audit 10 random residents' insulin administration weekly x 4 weeks then 5 random residents insulin administrations week x 8 weeks then 3 random residents weekly x 12 weeks. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	to: a. Humalog Solution 100 UNIT/ML (Insulin Lispro), inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units On 9/8/23 at 9:00 a.m., the medical record of Resident 2 was reviewed. The resident has diagnosis including but not limited to, Diabetes mellitus, (a disease that occurs when your blood glucose, also called blood sugar, is too high), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). Physician Orders included but were not limited to, a. Insulin Detemir Solution 100 unit/ml, Inject 30 unit subcutaneously two times a day for diabetes. b. Insulin Aspart Solution, inject 3 times a day with meals as per sliding scale: if blood glucose (sugar) level is 0 - 149 = 0 units, 150 - 190 = 2 units; 191 - 230 = 4 units; 231 - 270 = 6 units; 271 - 310 = 8 units; 311 - 350 = 10 units. Call physician if Blood glucose greater than 350. A quarterly Minimum Data Set (MDS) assessment (a standardized assessment tool that measures health status in nursing home residents), dated 8/8/23, indicated the resident received insulin injections during the assessment period. A quarterly Minimum Data Set (MDS) assessment (a standardized assessment tool that measures health status in nursing home residents), dated 6/1/23, indicated the resident received insulin injections during the assessment period. A care plan, dated 9/27/2019 and 7/12/2021, indicated resident was at risk for hypoglycemia and or hyperglycemia related to diagnosis of diabetes mellitus. Interventions included but were not limited to observe for signs and symptoms of			

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	hypoglycemia and or hyperglycemia and administer medications as ordered by the physician. On 9/07/23 at 12:40 p.m., Qualified Medication Aide (QMA) 6 indicated they gave the residents who received insulin a snack within 15 minutes of the nurse administering insulin to the resident. Employee indicated she did not know if the residents had been given a snack after insulin was administered. On 9/07/23 at 12:43 p.m., RN 14 indicated she gave a snack depending on what the blood sugar reading was. She administered insulin to the residents within an hour of when they were to eat. She indicated she administered a cookie to Resident 48 around 12:00 p.m. On 9/07/23 at 12:52 p.m., QMA 8 indicated she would administer a snack to residents who had received insulin within 20 minutes of insulin administration. She indicated she did not know if Resident's 2 or 48 were administered a snack after insulin administration. On 9/7/23 at 1:20 p.m., the Director of Nursing indicated she was not aware of guidelines for insulin administration. She advised her staff to not administer insulin to a resident until food or a meal was ready to be served. On 9/7/23 at 2:30 p.m., the Director of Nursing (DON) provided and identified an undated document as a currently facility policy, titled "FULL PRESCRIBING INFORMATION". The policy indicated, "1 INDCATIONS AND USAGE, 1.1 Treatment of Diabetes Mellitus. Novolog is an insulin indicated to improve glycemic control in adults and children with diabetes mellitus ...5.			

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	WARNINGS AND PRECAUTIONS, 5.1 Administration ...NovoLog has a more rapid onset of action and a shorter duration of activity than regular human insulin. An injection of NovoLog should immediately be followed by a meal within 5-10 minutes ...." On 9/7/23 at 2:30 p.m., the Director of Nursing (DON) provided and identified an undated document as a currently facility policy titled, "INSULIN TIP SHEET", dated March 2010. The policy indicated ... "RAPID ACTING INSULINS ...Humalog (lispro). Novolog (aspart). Apidra (glulisine) ...in general, administration must occur within 15 minutes of mealtime due to rapid action ...." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 1 of 2 medication storage rooms reviewed for medication storage. Finding includes: On 9/13/23 at 11:20 a.m., the rehabilitation unit medication storage room contained an undated multiple use vial of Tubersol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution. During an interview, on 9/13/23 at 11:21 a.m., Licensed Practical Nurse (LPN) 18 indicated Tubersol solution was good for 30 days once it had been opened. She would dispose of the vial since it was not labeled with an open date, and she wasn't sure how long it had been in the refrigerator. During an interview, on 9/13/23 at 11:22 a.m., Director of Nursing (DON) indicated the facility followed manufacturer guidelines regarding Tubersol solution storage and use. On 9/13/23 at 11:43 a.m., the DON provided an undated document, titled, "Medications with Shortened Expiration Dates," and indicated it was the current policy used by the facility. The policy indicated, " ...Tubersol solution discard vials in use after 30 days ...."	F 0761	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to date and label drugs and biologicals with currently accepted professional principles. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The undated vial of Tubersol was disposed of at the time of survey.	10/16/2023

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	3.1-25(j)		1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have orders for either medications or treatments; therefore, this plan of correction applies to all residents currently residing in the facility. Audit on all med carts and med rooms conducted on 9/14/23. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been re-educated by the DON/Designee relative to Label/Store Drugs and Biologicals, including but not limited to, ensuring that medications are dated when opened. Education was conducted on 9/14/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 1.How will the corrective action(s) will be monitored? The DON/Designee will be responsible daily audit 1 medication cart and 1 medication refrigerator 5 times a week for 4	

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			weeks to ensure medications and treatments are dated when opened. Thereafter, these audits will be conducted 2 times weekly for 8 weeks, and then 1 time weekly for 12 weeks. . If the facility is with 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	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 proper handwashing for 1 of 2 dining observations. Finding includes: During a dining observation, on 9/5/23 at 12:28 p.m., Certified Nursing Aide (CNA) 13 was observed to wash his hands for less than 20 seconds and touched the faucet handles with his bare hands, without paper towels, when turning off the water. The CNA placed clothing protectors on two different residents after washing his hands. During an interview, on 9/11/23 at 11:45 a.m., Housekeeping aide 11 indicated staff were to wash their hands with soap and water for approximately 30 seconds and they were to turn off the faucet handles by using a paper towel. During an interview, on 9/12/23 at 11:16 a.m., Director of Nursing (DON) indicated staff should not touch the faucet handles with their bare hands and should use a paper towel to turn the water off. On 9/12/23 at 11:15 a.m., the DON provided an undated document, titled, "Hand Hygiene Guidelines," and indicated it was the policy currently used by the facility. The policy indicated, " ...ii. Apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds ...v. Use towel to turn off faucet and exit the area ...."	F 0812	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to ensure proper hand washing during meal service. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? CNA 13 was addressed at the time of survey. No residents suffered any adverse effects related to the citied practice. 2. How other residents having the potential to be affected by the	10/16/2023

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	3.1-21(i)(3)		same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected. Thus, this plan of correction applies to all residents of the facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Facility staff have been educated by DON/designee relative to Food Procurement, Store/Prepare/Serve-Sanitary, including but not limited to proper hand hygiene procedure. Education was completed on 9/14/23. additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. How will the corrective action(s) will be monitored? DON/Designee will observe 10 random staff members daily 5 times a week x 4 weeks for proper hand hygiene to include meal service, then observe 5 random staff member 3 times a week x 8 weeks, then 3 staff members weekly x 12 weeks. If the facility is with 95% compliance at the end of the 6 months; then monitoring	

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			can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident			

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	representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and			

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	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure documented evidence of medication administration for 1 of 5 residents reviewed for unnecessary medications (Resident 91). Findings include: Resident 91's record was reviewed on 9/8/23 at 9:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar levels to be abnormally high), urinary tract infection (UTI-common infections that happen when bacteria, often from the skin or rectum, enter the urethra, and infect the urinary tract), hypertension (high blood pressure), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), and anxiety disorder (persistent and excessive worry that interferes with daily activities). An admission Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 7/7/23, indicated the resident received antipsychotic (medications used to treat psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality]) medication, and anti-anxiety medication (used to treat symptoms of anxiety). a. A physician's order, dated 6/26/23, indicated to administer insulin Detemir (diabetes medication) subcutaneous (SQ) solution 100 units/milliliter (ml). Staff were to inject 10 units SQ at bedtime	F 0842	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility respectfully requests a desk review for these findings. Completion date 10/16/2023.* It is the policy of this facility to ensure accurate documented evidence of medication administration. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a.-j. Resident 91 suffered no adverse effects related to lack of documentation of medication administration. Resident 91's eMARs have been reviewed to ensure documentation of medication is present. RNC conducted audit on 9/18/23.	10/16/2023

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	155223	A. BUILDING 00 B. WING	09/13/2023

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	related to diabetes mellitus. The resident's July 2023 medication administration record (MAR) lacked documentation of the 9:00 p.m., dose of the medication having been administered on 7/26/23. The resident's August 2023 MAR lacked documentation of the 9:00 p.m., dose of the medication having been administered on 8/6/23 and 8/26/23. b. A physician's order, dated 6/26/23, indicated to administer cranberry oral tablet (dietary supplement) 850 milligrams (mg); 1 tablet by mouth two times daily for UTI. The resident's July 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 7/6/23 and 7/7/23. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 8/12/23 and 8/19/23. c. A physician's order, dated 6/26/23, indicated to administer meclizine (used to treat allergy/cold symptoms, motion sickness and nausea) HCl (hydrochloride) tablet 12.5 mg, 1 tablet, by mouth, two times daily for prophylaxis (to preserve health). The resident's July 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 7/1/23, 7/6/23 and 7/7/23. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 8/12/23 and 8/19/23. d. A physician's order, dated 6/26/23, indicated to administer propranolol (used to treat high blood		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents receiving medications have the potential to be affected. Thus, this plan of correction applies to all residents of the facility. Medication sheets have been reviewed to ensure medications are documented as administered. Any identified concerns were promptly addressed with the responsible individual(s). Travel DON conducted Audit on 10/6/2023. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been educated relative to Resident Records – Identifiable Information, including but not limited to the importance of documentation of medication administration. Education was completed on 9/14/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. 4. How will the corrective action(s) will be monitored?	

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	pressure) HCl 60 mg tablet, 1 tablet, by mouth two times daily for hypertension. The resident's July 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 7/1/23, 7/6/23 and 7/7/23. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 8/12/23 and 8/19/23. e. A physician's order, dated 6/26/23, indicated to administer novolog (diabetes medication) injection solution 100 units/ml, as per sliding scale (increasing administration of an insulin dose based on the blood sugar level), SQ after meals and at bedtime related to diabetes mellitus. The resident's July 2023 MAR lacked documentation of the 1:00 p.m., dose of the medication having been administered on 7/9/23 and 7/10/23, and the 10:00 p.m., dose having been administered on 7/26/23 and 7/30/23. The resident's August 2023 MAR lacked documentation of the 1:00 p.m., dose of the medication having been administered on 8/20/23, and the 10:00 p.m., dose having been administered on 8/5/23, 8/6/23, and 8/26/23. f. A physician's order, dated 6/30/23, indicated to check the resident's blood glucose level and record four times daily for diabetes mellitus. The resident's July 2023 MAR lacked documentation of the 4:00 p.m., monitoring having been completed on 7/10/23 and 7/23/23, and the 8:00 p.m., monitoring having been completed on 7/26/23.		DON, or designee, will complete an audit of the medication records of 10 random residents per day 5 times per week for 4 weeks to validate that medications are documented as administered on the eMAR. Thereafter, DON, or designee, will complete these audits for 5 random residents 3 times per week for 8 weeks, and then for 3 random residents weekly for 12 weeks. If the facility is with 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	The resident's August 2023 MAR lacked documentation of the 4:00 p.m., monitoring having been completed on 8/10/23, 8/19/23, and 8/20/23, and the 8:00 p.m., monitoring having been completed on 8/5/23, 8/6/23, and 8/26/23. g. A physician's order, dated 8/6/23, indicated to administer cephalexin (antibiotic-a medication which can kill certain types of infections) capsule 500 mg, 1 capsule, by mouth four times daily for prophylaxis for 7 days. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered 8/12/23. h. A physician's order, dated 6/26/23, indicated to administer buspirone (anti-anxiety medication) hydrochloride (HCl) tablet 15 milligrams (mg), 1 tablet, by mouth two times daily for anxiety. The resident's July 2023 medication administration record (MAR) lacked documentation of the 4:00 p.m., dose of the medication having been administered on 7/6/23 and 7/7/23. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 8/12/23 and 8/19/23. i. A physician's order, dated 6/26/23, indicated to administer divalproex sodium (used to treat the manic phase [a period of extreme emotional highs, irritable moods, with excess activity and energy levels, rapid thoughts and speech, reckless behavior and feeling of invincibility] of bipolar disorder) tablet 500 mg, 1 tablet, by mouth two times daily for bipolar disorder.			

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	The resident's July 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 7/1/23, 7/6/23 and 7/7/23. The resident's August 2023 MAR lacked documentation of the 4:00 p.m., dose of the medication having been administered on 8/12/23 and 8/19/23. j. A physician's order, dated 6/26/23, indicated to administer quetiapine fumarate (used to treat certain mental/mood conditions) tablet 100 mg, 1 tablet, by mouth three times daily for bipolar disorder. The resident's August 2023 MAR lacked documentation of the 2:00 p.m., dose of the medication having been administered on 8/5/23. During an interview, on 9/8/23 at 11:29 a.m., the Director of Nursing (DON) was unsure as to why the resident's MARs would not have been completed as required. She believed the staff who were responsible for not completing the MARs were no longer employed at the facility. On 9/8/23 at 3:10 p.m., the DON provided a document, dated October 2021, titled, "Drug Administration--General Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...7...This individual records the administration on the resident's MAR at the time the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary medications were administered and all administered doses were documented...9. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration...."			

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	3.1-50(a) 3.1-50(a)(1) 3.1-50(a)(2)			