STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 Complaint IN00375899. Complaint IN00375899 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F692. Survey dates: April 18, 19, 20, and 21, 2022. Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 24 Total: 24 Census Payor Type: Medicare: 4 Medicaid: 16 Other: 4 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/25/22.	F 0000		
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. 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)			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	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 record review and interview, the facility failed to ensure residents were able to have visitors while in isolation related to being a new admission for 2 of 2 residents reviewed for choices. (Residents 69 and C) Findings include: 1. Interview with Resident 69 on 4/18/22 at 2:16 p.m., indicated he could not have visitors when he was in quarantine after being admitted. The record for Resident 69 was reviewed on 4/19/22 at 11:19 a.m. Diagnoses included, but were not limited to, vascular dementia with	F 0561	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Immediate in-service on resident visitation. Open visitation has been incorporated with visitation policy. All visitors will be allowed to visit residents in Green, Yellow and Red Zones. Visitors will be given education and proper PPE during the visits will in quarantine. 2. how other residents having the	04/22/2022

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	behavioral disturbance, type 2 diabetes, and history of stroke. The resident was admitted to the facility on 3/10/22. The Admission Minimum Data Set (MDS) assessment, dated 3/17/22, indicated the resident was cognitively intact for daily decision making. Nurses' Notes, dated 3/10/22 at 6:45 p.m., indicated the resident was admitted to the yellow zone for COVID-19 isolation. Nurses' Notes, dated 4/1/22 at 2:09 p.m., indicated the resident had called a family member, the family member had told him she was not allowed to visit. Documentation indicated that was not true and the only time she could not visit was when the resident was in isolation due to being a new admission. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the resident could have had visitors when in quarantine. 2. During an interview with Resident C's Granddaughter on 4/18/22 at 3:35 p.m., she indicated she was not allowed to go past the glass doors to see her grandmother in her room at the time of admission. She was told there was no visitation. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All newly admitted and re-admitted residents had potential for being affected by past procedures. 3.what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with updated visitation policy for residents. 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; and Pre-COVID visitation sign-in binder will be re-incorporated so that all visitors will sign on each visitor's sheet. This log will show how often and when each resident has a visitor. This will be in addition to the COVID screening book. All nursing staff and office staff will be responsible for the visitor signing in after being screened. D.O.N. Designee will review visitor sign in book weekly and report to QA Committee quarterly. Q.A. Committee will review	

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	assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. Nurses' Notes, dated 1/31/22 at 4:19 p.m., indicated the resident was admitted from the behavioral hospital. The resident begun yelling out "Why am I here. I am only 18 years old. I just want to die right now". She was comforted by staff and explained that we were here to help her. She did calm down and allowed staff to do an assessment. Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated she was not in the facility when the resident was admitted, but was aware the residents could have visitors all the time even if they were in TBP (Transmission Based Precautions) or positive for COVID-19. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the granddaughter had visited her grandma since admission. 3.1-3(u)(2)		visitation logs for newly admitted and re-admitted residents at quarterly meeting. Q.A. Committee will determine if any other revisions are needed. 5. by what date the systemic changes for each deficiency will be completed. 4/22/22	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance			

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	directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure a resident's advance	F 0578	-- what corrective action(s) will be accomplished for those	05/16/2022

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	directive information was documented for 1 of 14 residents reviewed for advance directives. (Resident 72) Finding includes: The record for Resident 72 was reviewed on 4/19/22 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, adult failure to thrive, and adjustment disorder with anxiety. The resident was admitted to the facility on 3/21/22. The Physician Order Summary, dated 4/2022, lacked any indication of the resident's code status. There was lack of any advance directive information in the resident's record. Telephone interview with the Director of Nursing (DON) on 4/21/22 at 11:12 a.m., indicated there was no documented code status for the resident. She was still waiting for the resident's wife to make a decision on his code status. 3.1-4(f)(5)		residents found to have been affected by the deficient practice; Wife was called and asked about her husband's living will decision, she was still unable to decide, so his code status is a Full Code. The current cognitive status of his wife is exhibiting signs of dementia, we are trying to get the number of their sons so that someone else can help her in making decisions for her husband. - 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; A review of all resident's advance directive status was reviewed, and log updated. Social Service documentation reviewed to ensure advance directive status of all residents were documented. If no living will or advance directive is available and decisions regarding code status are in process the residents are FULL CODE status until determined otherwise. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with admissions, licensed nurses, and care plan review team so that quarterly updates on advance directives	

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			status are done and documented with care plan review. This will ensure that the resident/family wishes are honored and updated as needed. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Care Plan review assessment will be reviewed by Social Worker upon admission and quarterly. Social Service will inform D.O.N. of changes in advance directives status and binder updated as living will decisions change. Licensed Nurse will notify physicians for all changes in advance directive decisions. Q.A. Committee will review advance directive log to track actual advance directive status and ensure each resident have received information on advance directives, their decisions are appropriately documented in their records and they have matching code status orders at quarterly meeting. Q.A. Committee will determine if any other revisions are needed. May 16, 2022	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure a resident's family was notified of a significant change in condition that resulted in a hospitalization for 1 of 1 residents reviewed for notification of change. (Resident C) Finding includes: During an interview with Resident C's Granddaughter on 4/18/22 at 3:35 p.m., she indicated it was "hit or miss" when she was notified of changes with her grandma. She was not aware the resident was in the hospital until the Social Worker from the hospital called to inform her they were sending her grandma back to the facility. She was made aware at that time, her grandma had developed pressure ulcers as well. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis.	F 0580	- - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON in-serviced all nurses on notifying the families of the change in condition of the resident. The communication tab in PCC will be used as part of shift-to-shift report so that each nurse will be able to review if family called back or if we still need to notify them of changes in resident's condition. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; There is a potential for all residents with change in condition to be affected. The nursing staff will leave a message on their phones, if no response, there will be continued attempts every 4 hours for 24 hours. The attempts will be documented in the resident record. The facility will try and	05/16/2022

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	The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. Nurses' Notes, dated 4/6/22 at 4:15 a.m., indicated the resident was awake in bed all night talking aloud to herself. She had refused fluids and snacks. Peri care was rendered by staff. Nurses' Notes, dated 4/6/22 at 8:04 p.m., indicated "Patient very sluggish this evening. Patient is leaning to her left while up in wheelchair. Patient is slurring her words. Patient is able to eat some pureed food. Patient is combative. Doctor is aware and patient is be transferred to hospital. Left for granddtr. EMT arrived at approx. 8:10 pm. Patient left facility at 8:24 pm." (sic) The resident returned on 4/11/22. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the nursing staff did not follow up or try calling the granddaughter again after she was discharged to the hospital. 3.1-5(a)(2)		contact family members for 24 hours then an email will be sent to the family member if email address is available, if no email available the family will be notified when the Notice of Transfer Discharge notice will be mailed. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with licensed nurses to inform families of change in condition policy and documentation of notification. DON and Social Service will review all notifications of changes in resident's condition according to log sheets completed by nursing staff. Administrator will review the records to ensure all family members are informed. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will review family notification log every morning at morning meetings for residents with change in conditions. Q.A. Committee will review family notification logs at quarterly meeting. Q.A. Committee will determine if any other revisions are needed.	

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			by what date the systemic changes for each deficiency will be completed. 5/16/22	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an allegation of verbal abuse was reported to the State Survey Agency in	F 0609	- - what corrective action(s) will be accomplished for those residents found to have been	04/22/2022

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	a timely manner for 1 of 1 allegations of abuse reviewed. (Resident 120) Finding includes: During an interview with Resident 120 on 4/18/22 at 10:32 a.m., she indicated LPN 2 told her she was going to send and have her locked up in the looney bin and tie the residents up. The resident indicated it had been going of for a long time. The Director of Nursing (DON) was aware of what the LPN had said. On 4/18/22 at 11:00 a.m., the allegation of abuse was reported to the DON. During an interview on 4/19/22 at 9:00 a.m., the resident indicated the DON had spoken to her yesterday about the allegation of abuse. The record for resident 120 was reviewed on 4/19/22 at 4:37 p.m. Diagnoses included, but were not limited to, paranoid disorder, high blood pressure, major depressive disorder, and schizophrenia. The resident was admitted to the facility on 1/13/22. The Admission Minimum Data Set (MDS) assessment, dated 1/20/22, indicated the resident was cognitively intact. Nursing Progress Notes from 1/2022 to 4/19/22 indicated there was no documentation regarding any allegations of verbal abuse from the resident. Interview with the DON on 4/19/22 at 11:00 a.m., indicated she had not reported the allegation of abuse yet. She had 24 hours to report it, however, she had started the investigation.		affected by the deficient practice; Resident 120 never reported any allegations of abuse about any staff member. I began my investigation immediately after being informed by the surveyor. I called the nurse referred to in this allegation via telephone and she denied every saying anything like that to any resident. I interviewed the president of the resident's council and he had just had a meeting with all the cognitive residents and stated no one had any complaints. The resident indicated that she felt the nurse did not treat the black male residents right. I interviewed all the black residents, and no one indicated the nurse treating them in any abusive way. The therapy staff and nursing staff held a conference about the resident 120 changes in behavior which included refusal of wanting therapy, excessive movements while speaking, the tone of her voice while speaking and increase inquiries about wanting to go home. The resident does have a guardian and was admitted from the Nuero Behavioral Hospital and is unable to be discharged due to psychological disorders that include paranoid personality disorder, schizophrenia, and major depressive disorder. D.O.N. was unaware of the allegation of verbal abuse until surveyor informed her at 11:00	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Interview with the DON on 4/19/22 at 2:00 p.m., indicated the gateway was down, but she would continue to try and report the allegation. Telephone interview with the DON on 4/21/22 at 8:30 a.m., indicated she had reported the allegation of abuse and was still working on the follow up. She was not aware she needed to report an allegation of abuse within 2 hours to the State Agency Interview with LPN 1 on 4/21/22 at 9:45 a.m., indicated the resident was pretty good, very quiet, and stays in her room most of the day. 3.1-28(c)		a.m. DON thought she had 24 hours after doing the investigation to submit report to the gateway. The below was the policy she was going by. **Serious Bodily Injury Reporting** – 2 Hour Limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. **All Other Reporting** – Within 24 Hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. DON discussed investigation and findings with Administrator who determined no abuse occurred to Resident 120, any black male residents, and all other residents in the facility. Administrator reviewed abuse policy with DON and noted the DON is responsible for reporting all allegations to the SBOH within 2 hours. DON tried to submit the report to the gateway within 24 hours but on the initial state log site it stated technical problems. I provided a copy of a copy of the log in screen stating the technical problems. The DON continued throughout the day to submit the	

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	155845	A. BUILDING 00 B. WING	04/21/2022

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			report, but the technical problem screen still appeared throughout the night. DON was eventually able to get to the gateway and complete the initial complaint and follow-up report thru the gateway. - 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; There is a potential for all residents reporting allegations of abuse would have been affected for not reporting them within 2 hours, however no other reports were noted. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Resident Council president will monitor for complaints from residents at his meetings and report them to Administrator and DON. Charge nurses monitor for allegations of abuse and any other complaints ever shift every day and report them to DON and Administrator. Allegations will be reported immediately to the DON, and she will report the allegations within 2 hours. - how the corrective action(s) will be monitored to ensure the	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator will review log sheet to ensure that all allegations have been reported to the ISBOH and within 2 hours.. Q.A. Committee will review all allegations and reports to ISBOH at quarterly meeting. by what date the systemic changes for each deficiency will be completed. 4/22/22	
F 0636 SS=A 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 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.			

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	(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 §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.			

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	Based on record review and interview, the facility failed to complete comprehensive assessments in a timely manner related to an admission assessment for 1 of 14 residents reviewed for comprehensive assessments. (Resident 72) Finding includes: The record for Resident 72 was reviewed on 4/19/22 at 2:16 p.m. The resident was admitted to the facility on 3/21/22. The Admission MDS (Minimum Data Set) assessment, dated 3/28/22, indicated it was still in progress. Interview with the Director of Nursing (DON) on 4/19/22 at 2:39 p.m., indicated the assessment was still in progress. She still had to send some information to the MDS Nurse so she could complete it. 3.1-31(d)	F 0636	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON had nursing to complete the areas of social service due to social worker being on maternity leave. immediately and transmitted the MDS. DON reported deficient practices to Administrator. - 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 MDS had the potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. will monitor MDS calendar weekly and address compliance at morning meetings on Wednesdays to ensure timely completion of MDS. MDS Coordinator will submit MDS/Care Plan tracking log weekly to DON. DON will provide Administrator with MDS submission logs for review weekly. - how the corrective action(s)	05/15/2022

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will be responsible for ensuring all MDS are completed timely and present reports to Q.A. Committee for review. Q.A. Committee will review the MDS completion log and monthly calendar. D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A. Committee as it occurs. 5/15/22	
F 0638 SS=A Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment timely for 3 of 21 residents whose MDS assessments were reviewed. (Residents 18, 7, and 13) Findings include: 1. The record for Resident 18 was reviewed on 4/20/22 at 11:11 a.m. There was an Admission Minimum Data Set (MDS) assessment, dated 11/18/21 and completed on 11/24/21. The Quarterly MDS assessment was dated 2/18/22, but was completed on 3/4/22. The Quarterly	F 0638	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON had nursing to complete the areas of social service due to social worker being on maternity leave. immediately and transmitted the MDS. DON reported deficient practices to Administrator. - how other residents having the potential to be affected by the	05/15/2022

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	MDS was not completed within 3 months. 2. The record for Resident 7 was reviewed on 4/20/22 at 11:25 a.m. There was an Admission Minimum Data Set (MDS) assessment, dated 11/19/21 and completed on 11/25/22. The Quarterly MDS assessment was dated 2/19/22, but was completed on 3/5/22. The Quarterly MDS was not completed within 3 months. Telephone Interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated she was aware the Quarterly MDS assessments were not completed timely.3. Resident 13's record was reviewed on 4/19/22 at 11:18 a.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 2/15/22, was completed on 3/1/22. The previous completed MDS assessment was the Annual assessment, dated 11/15/21. Interview with the DON on 4/19/22 at 2:39 p.m., indicated the assessment had been completed late. 3.1-31(d)(3)		same deficient practice will be identified and what corrective action(s) will be taken; All MDS had the potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. will monitor MDS calendar weekly and address compliance at morning meetings on Wednesdays to ensure timely completion of MDS. MDS Coordinator will submit MDS/Care Plan tracking log weekly to DON. DON will provide Administrator with MDS submission logs for review weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will be responsible for ensuring all MDS are completed timely and present reports to Q.A. Committee for review. Q.A. Committee will review the MDS completion log and monthly calendar. D.O.N. will be responsible to report any deficient practices to	

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			the Administrator and Q.A. Committee as it occurs. 5/15/22	
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System,			

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	including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to successfully export the Minimum Data Set (MDS) assessment within 14 days of completion for 10 of 21 residents whose MDS assessments were reviewed. (Residents 12, D, 18, 15, 10, 7, 2, 4, 13, and 11) Findings include: 1. The record for Resident 12 was reviewed on 4/19/22 at 12:03 p.m. The 1/12/22 Annual Minimum Data Set (MDS) assessment was completed on 1/26/22. The MDS was not exported until 2/27/22. Interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the Annual MDS should have been exported in a more timely	F 0640	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON immediately transmitted the MDS to the QUIES system. DON reported deficient practices to Administrator. - 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 MDS had the potential to be affected by late transmissions by DON.	05/15/2022

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	manner. 2. The record for Resident D was reviewed on 4/20/22 at 10:08 a.m. The 1/31/22 Quarterly Minimum Data Set (MDS) assessment was completed on 2/14/22. The MDS was not exported until 4/17/22. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the Quarterly MDS should have been exported in a more timely manner. 3. The record for Resident 18 was reviewed on 4/20/22 at 11:11 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/22, but was completed on 3/4/22 and exported on 4/17/22. The assessment was not exported within 14 days of completion. 4. The record for Resident 15 was reviewed on 4/20/22 at 11:15 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 3/6/22, but was completed on 3/20/22 and exported on 4/19/22. The assessment was not exported within 14 days of completion. 5. The record for Resident 10 was reviewed on 4/20/20 at 11:20 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 2/19/22, but was completed on 3/5/22, and exported on 4/17/22. The assessment was not exported within 14 days of completion. 6. The record for Resident 7 was reviewed on 4/20/20 at 11:25 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 2/19/22, but was completed on 3/5/22, and exported on 4/19/22. The assessment was not exported within 14 days of completion.		- what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. will monitor MDS calendar weekly and address compliance at morning meetings on Wednesdays to ensure timely completion of MDS and transmission. MDS Coordinator will submit MDS/Care Plan tracking log weekly to DON. DON will provide Administrator with MDS submission logs for review weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will be responsible for transmitting all completed MDS and present reports to Q.A. Committee for review. Q.A. Committee will review the submission reports and assess the need for further training and new staff according to report assessment quarterly. D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A. Committee should they occur. 5/15/22	

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	7. The record for Resident 2 was reviewed on 4/20/22 at 11:30 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 3/12/22, but was completed on 3/26/22, and exported on 4/19/22. The assessment was not exported within 14 days of completion. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated she was aware the MDS assessments had not been submitted in a timely manner.8. Resident 4's record was reviewed on 4/19/22 at 1:21 p.m. The Quarterly MDS assessment, dated 3/2/22, was completed on 3/16/22. It was not accepted until 4/17/22. 9. Resident 13's record was reviewed on 4/19/22 at 11:18 a.m. The Quarterly MDS assessment, dated 2/15/22, was completed on 3/1/22. It was not accepted until 4/17/22. 10. Resident 11's record was reviewed on 4/20/22 at 2:19 p.m. The Annual MDS assessment, dated 3/11/22, was completed on 3/25/22. It was not accepted until 4/17/22. Telephone interview with the Director of Nursing (DON) on 4/21/22 at 11:12 a.m., indicated the assessments had not been transmitted timely. The Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual," dated October 2017, indicated, "...The MDS must be transmitted			

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	(submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date..."			
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. (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 record review and interview, the facility failed to ensure residents were invited to attend and participate in care planning conferences for 3 of 3 residents reviewed for participation in care planning. (Residents 69,	F 0657	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	05/15/2022

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	120, and 13) Findings include: 1. Interview with Resident 69 on 4/18/22 at 2:16 p.m., indicated he had not been invited to a care conference since he was admitted to the facility. The record for Resident 69 was reviewed on 4/19/22 at 11:19 a.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, type 2 diabetes, and history of stroke. The resident was admitted to the facility on 3/10/22. The Admission Minimum Data Set (MDS) assessment, dated 3/17/22, indicated the resident was cognitively intact for daily decision making. The resident had an Interim Care Plan dated 3/10/22. The resident also had another Care Plan dated 3/17/22. There was no documentation indicating the resident had been invited to either care conference. Interview with the Director of Nursing on 4/21/22 at 8:45 a.m., indicated the resident should have been invited to his care conference.2. During an interview with Resident 120 on 4/18/22 at 10:35 a.m., she indicated she had not been invited to a Care Planning conference. The record for Resident 120 was reviewed on 4/19/22 at 4:37 p.m. Diagnoses included, but were not limited to, paranoid disorder, high		Cognitive and comprehension abilities assessed for all 3 of the residents. The care plan will be reviewed with the resident and response documented. - 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 had potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. and Nurse Supervisor will meet weekly to discuss care plans. MDS Coordinator will be responsible for reviewing interim care plans and ongoing updating of care plan. Nurse Supervisor and D.O.N. will meet weekly to review progress and concerns related to the Care Plan process of new admissions, changes in treatment plan and quarterly reviews and indicate if the resident has the cognitive and comprehension skills to be invited to care plan review. Residents, their families, guardians, and POA's will be invited to care plan conference.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	blood pressure, major depressive disorder, and schizophrenia. The resident was admitted to the facility on 1/13/22. The Admission Minimum Data Set (MDS) assessment, dated 1/20/22, indicated the resident was cognitively intact. A Care Conference Note, dated 4/13/22, indicated the resident did not attend due to being "non-cognitive." Telephone interview with the Director of Nursing on 4/21/22 at 8:30 a.m., indicated the resident was alert and oriented and should have been invited to attend the care conference.3. Interview with Resident 13 on 4/19/22 at 9:15 a.m., indicated she did not recall being invited to or attending a care plan meeting. Resident 13's record was reviewed on 4/19/22 at 11:18 a.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 2/15/22, indicated the resident was cognitively intact. A Care Conference Review Note, dated 4/13/22, indicated the care conference had been completed on 3/1/22. The resident had not attended the meeting. "Non-cognitive" was written in the box as the reason why the resident had not attended. A message had been left for the resident's daughter. Interview with the DON on 4/19/22 at 1:40 p.m., indicated the resident should have been invited to her care plan meeting.		DON will follow-up with residents to see if they have been invited to their care conference. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monitor Care Plan calendar weekly and address compliance at weekly meetings. . Nurse Supervisor will update care plans as needed and discuss with Residents, their families, guardians, and POA's all interactions will be documented on care conference review. Q.A. Committee will review care plan invitations quarterly for next 6 month and assess the need for further training and new staff according to report. D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A. Committee. 5/15/22	

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	3.1-35(c)(2)(C)			
F 0684 SS=D 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 comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident was sent to the hospital promptly after a change in condition as well as collecting a urinalysis timely prior to hospitalization for 2 of 2 residents reviewed for change in condition. (Residents D and C) Findings include: 1. The record for Resident D was reviewed on 4/20/22 at 10:08 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), type 2 diabetes mellitus, convulsions, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/31/22, indicated the resident was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. He also received insulin injections. Nurses' Notes, dated 2/26/22 at 10:37 a.m., indicated the resident was noted to be unresponsive in his geri chair in the main dining	F 0684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Documentation for Resident D was discovered by DON prior to survey and discussed with nurse responsible on 2/28/22 while DON was doing charting audits. Her documentation on the EMR was not detailed, however she provided the text messages between the physician and her which revealed her correspondence with physician starting on 2/26/22 at 10:40a.m. In reviewing the situation, I discussed with her there was a delay in response in getting resident transferred to ER. I have enclosed the text messages between the nurse and physician. Documentation in-service one to	04/28/2022

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	room. The resident was taken to his room and vital signs were obtained. The resident's oxygen saturation was 97% on room air, his temperature was 97.6, blood pressure was 127/81, and his pulse was 102. His lungs were clear in all lobes and his lower abdomen was semi hard. The Physician was texted at the time. At 11:30 a.m., a response was received from the Physician to send the resident to the emergency room for evaluation. A message was left for the Director of Nursing at 11:58 a.m. and the transport company was contacted at 12:02 p.m. At 12:17 p.m., the resident left the facility enroute to the hospital. Report was called to the emergency room at 12:25 p.m. and the resident's sister was notified at 1:33 p.m. A text was sent to the Physician at 2:00 p.m. to notify him the resident was in the emergency room. There was no documentation to indicate resident's blood sugar level was checked. Telephone interview with the Director of Nursing on 4/21/22 at 11:20 a.m., indicated the Physician should have been called related to the condition change instead of texted. She also indicated the resident's blood sugar should have been checked as well due to him being diabetic. 2. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She		one was provided with each nurse on every shift by DON and use of communication and report tool in PCC so that each nurse knows to provide follow up documentation until problem is resolved. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Every resident has potential for being affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Proper documentation is continuously reviewed with licensed nurses one on one continuously by the D.O.N. Clinical morning meetings held with D.O.N. Monday thru Friday to ensure proper documentation is completed and that orders/tests are being executed in a timely fashion. Complete documentation is done when there is a delay in treatment and fulfilling of an order. Nurse Supervisor will assist DON in reviewing documentation and investigations of causing factors	

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	had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. Nurses' Notes, dated 4/2/22 at 7:33 a.m., indicated the resident was awake the entire night screaming. She received all medication with pudding. Scheduled for urine specimen for urinalysis with a culture and sensitivity. "Hat" in her room for urine collection. There was no other documentation regarding the urinalysis in Nurses' Notes on 4/3 and 4/4/22. Nurses' Notes, dated 4/5/22 at 9:58 a.m., indicated the resident was incontinent of bladder. The urine was dark yellow with an odor. The doctor was notified and received an order for a urinalysis with a culture and sensitivity. A specimen was obtained and hospital lab was notified for pick up. Physician's Orders, dated 4/5/22, indicated UA/C&S (Urinalysis/Culture and Sensitivity) Nurses' Notes, dated 4/6/22 at 8:04 p.m., indicated "Patient very sluggish this evening. Patient is leaning to her left while up in wheelchair. Patient is slurring her words. Patient is able to eat some pureed food. Patient is combative. Doctor is aware and patient is be transferred to hospital. Left for granddtr. EMT arrived at approx. 8:10 pm. Patient left facility at 8:24 pm." (sic) The resident was admitted to the hospital with		that delay collection of specimens and receiving medications. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will continue to review documentation to ensure proper documentation ongoing. Charge nurses are responsible in reviewing communication and report tool every shift/ every day. D.O.N. will monitor documentation daily during morning meetings Monday-Friday and continue in-servicing nurses ongoing. Q.A. Committee will review performance of nurse's deficient practices in documentation quarterly, ongoing. Completion Date: 4/28/2022	

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	diagnosis of Urinary Tract Infection. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated there was a delay in obtaining the urine sample and for the lab to come and pick it up. This Federal tag relates to Complaint IN00375899. 3.1-37(a)			
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 observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the treatment and services to promote healing related to turning and repositioning every 2 hours for 1 of 2 residents reviewed for pressure ulcers. (Resident C) Finding includes:	F 0686	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? DON reviewed routing times of Resident C. She was provided with incontinent care after breakfast between 10:30 a.m. and 11:00 a.m. Incontinent care was	05/15/2022

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	On 4/19/22 at 9:00 a.m. to 10:30 a.m., Resident C was observed sitting in a wheelchair. She had no socks to either foot, but was wearing heel boots. From 11:00 a.m., to 12:15 p.m., the resident remained in the dining room sitting in her wheelchair. No staff had repositioned her. There were still no socks on either foot, but she had her heel boots on her feet. On 4/19/22 at 1:30 p.m., the resident was seated in her wheelchair at the dining room table. She was observed with a heel boot to the left foot and there was no heel boot on the right foot. At 1:36 p.m., LPN 1 removed the resident from the dining room and placed her in front of the nursing station. At 2:10 the resident wheeled herself back into the dining room. At 3:08 p.m., the resident remained in the dining room still sitting in the wheelchair. At 3:30 p.m., QMA 1 and LPN 1 were asked to lay the resident down for a skin assessment. The resident was placed in bed, at that time, the back of her pants and down her legs were soaked with urine. Her brief was removed and it was heavily saturated with urine and bowel movement. She was observed with 2 non-blanchable areas to the buttocks. The skin was intact and not open. QMA 1 provided incontinence care and applied zinc cream. At that time, CNA 1 entered the room and indicated she had provided incontinence care at 12:30 p.m. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder,		provided again at 12:30 p.m. Her next routing time would be between 2:30-2:45p.m. The resident is also on a diuretic and heaviness of urine output varies depending on how much fluid retention present. Re-evaluation of plan of care was reviewed to ensure all skin preventive and healing measures are in place. All problems in skin integrity have healed. Resident propels self in wheelchair with pressure preventive cushion. Resident does reposition self in wheelchair by moving from side to side and leaning forward and back. Resident is not a candidate to be placed in bed when not sleepy due to her behaviors in which alarm sensors and safety floor mat is used. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other residents have pressure areas. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.	

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	insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. The Care Plan, dated 4/11/22, indicated the resident was at further risk for impairment to skin integrity related to decreased mobility. Current breakdown left heel, right and left buttocks. Physician's Orders, dated 4/12/22, indicated to apply heel protectors to both feet every shift. Leave left heel open to air. Physician's Orders, dated 4/14/22, indicated A & D Zinc Oxide Cream (Dimethicone-Zinc Oxide-Vit A-D) apply to buttocks topically every shift. The wound measurements for the left buttock were 1.6 centimeters (cm) by 3 cm, described as a Stage 1. The right buttock measured 2.5 cm by 3 cm and also described as a Stage 1. The left heel was a deep tissue injury that measured 1 cm by 1 cm. and was purple in color. Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated the resident was readmitted with the pressure sores from the hospital. The resident		In-service all nursing staff on incontinent plan of care for residents Skin Pressure Injuries and treatment. All PCA, C.N.A. have index cards on routing times for each resident to ensure timely routing. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Charge nurse responsible for ensuring residents remain clean, dry, and free of pressure areas. Weekly skin assessments are completed and if potential problem with skin is noted nurse will contact physician for proper treatment and notifying the family. D.O.N. will review routing schedule, weekly skin assessments and weekly pressure area wound sheets. DON will update task for C.N.A's POC documentation ongoing as resident's needs change. D.O.N. will consult with MDS Coordinator to discuss any new and need for revisions of care plans according to each resident's needs. Q.A. Committee will review all care plans and wound sheets monthly	

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	was to be turned and repositioned every 2 hours and her heel boots were to be on at all times. 3.1-40(a)(2)		times 3 months then quarterly thereafter. 5. Completion Date: 5/15/22	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed, supplements not given as ordered and clarified, and dietary recommendations not acted upon for 2 of 3 residents reviewed for nutrition. (Residents E and C)	F 0692	What corrective action will be accomplished for those residents found to have been affected by deficient practice? Resident C care plan for weight loss was developed and placed in plan of care. Resident C & E order was revised	05/15/2022

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	Findings include: 1. On 4/19/22 at 11:05 a.m., Resident E was observed in the dining room being fed by CNA 2. The resident had not received a carton of Resource. On 4/20/22 at 1:00 p.m., the resident was being fed his breakfast. The resident did not receive a carton of Resource. On 4/21/22 at 1:45 p.m., the resident was being fed his lunch by CNA 2. The resident had a cup of water and a cup of juice. He had not received a carton of Resource. The record for Resident E was reviewed on 4/20/22 at 2:59 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia with behavior disturbance, anxiety disorder, major depressive disorder, psychotic disorder with hallucinations, anorexia, and a eating disorder. The Annual Minimum Data Set (MDS) assessment, dated 1/4/22, indicated the resident was cognitively impaired for daily decision making and required limited assistance with eating. The Care Plan, dated 1/29/22, indicated the resident had an unplanned/unexpected weight loss related to fluctuating food intake, constant wandering behavior, vitamin deficiency, and anorexia. Interventions included, but were not limited to, give supplements as ordered and monitor and record food intake at each meal. Give super cereal at breakfast, super mashed potatoes at lunch, and two snacks.		to include amount of supplement consumed. Staff gives the supplements prior to mealtime in a cup or glass because the residents will not drink from the carton. DON interviewed staff members regarding resident not receiving supplement. Investigation revealed the C.N.A.'s are committed to giving the supplements to residents on NAR. Surveyor did not inquire with staff about if supplement was given. Hospice order was discontinued due to resident continued weight gain: Resident E 5/3/2022 15:48 131.6 Lbs hjakes (Manual) ·MDS: +5.0% change over 30 day(s) [Comparison Weight 4/5/2022, 124.4 Lbs, +5.8% , +7.2 Lbs] ·+5.0% change [Comparison Weight 4/5/2022, 124.4 Lbs, +5.8% , +7.2 Lbs] ·+7.5% change [Comparison Weight 3/29/2022, 120.8 Lbs, +8.9% , +10.8 Lbs] 4/26/2022 15:37 129.2 Lbs hjakes (Manual) ·MDS: +5.0% change over 30 day(s) [Comparison Weight 3/29/2022, 120.8 Lbs, +7.0% , +8.4 Lbs] ·+5.0% change [Comparison	

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	A Physician's Order, dated 4/4/22, indicated the resident was to receive Resource 2.0, 1 box three times a day at breakfast, lunch, and dinner. A Physician's Order, dated 4/9/22, indicated the resident was to receive a regular diet with mechanical soft texture. The resident was to receive super cereal at breakfast and super mashed potatoes at lunch. A Registered Dietitian (RD) progress note, dated 3/30/22 at 9:04 p.m., indicated the visit was for a follow up related to a significant weight change. The resident had a 15% decrease in weight in 90 days and a 16.2% decrease in 180 days. The weight loss was not desired secondary to advanced dementia. Review of progress notes dated 3/14/22 suggested hospice care and/or peg tube (a tube inserted into the stomach for nutrition). Intake was variable and he needed assistance/fed with meals. Nurses' Notes, dated 3/14/22 at 4:54 p.m., indicated the resident was seen by the Physician today and he suggested hospice related to advanced dementia and wasting. He also suggested a peg tube. There was no documentation regarding family notification and their response. The March 2022 meal consumption log was not completed on 3/8-3/13, 3/15, 3/18-3/20, 3/22, 3/23, 3/27, 3/29, and 3/30/22. The April 2022 meal consumption log was not completed on 4/4, 4/13, 4/14, 4/16, and 4/17/22. The April 2022 Medication Administration Record (MAR) indicated the Resource 2.0 was signed out for each meal on 4/19 and 4/20/22.		Weight 3/29/2022, 120.8 Lbs, +7.0% , +8.4 Lbs] In-servicing on food consumption and POC documentation with C.N.A. and P.C.A is ongoing and with staffing changes we are continuing to train old and new employees on proper food consumption documentation. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had potential of being affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Weekly NAR meetings continue for all residents that have a >5% weight loss or gain and all new admissions X 4 weeks to ensure weight is stable. D.O.N. designee held In-Service held with nursing departments pertaining to food consumption documentation and care plan interventions updates. D.O.N. will review food consumption and supplement consumption 3 times weekly x 3	

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	The Resource was signed out as being received for lunch on 4/21/22. Telephone interview with the Director of Nursing on 4/21/22 at 11:05 a.m., indicated the food consumption logs should have been completed and the facility was working on getting those completed. She also indicated the resident should have received his Resource as ordered and the Physician would be contacted about his recommendation for hospice and a PEG tube. 2. On 4/19/22 at 9:30 a.m., Resident C was observed sitting in the dining room at the table being assisted with the breakfast meal. She was served a pureed diet. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. The resident's weight was 120 pounds with no weight loss noted. There was no Care Plan for nutrition. The resident's weight on 3/7/22 was 118 pounds		months then monthly thereafter. D.O.N. will continue to identify residents for NAR program weekly. Dietary Manager will monitor food intake, weights and review recommended dietary interventions for residents with weight loss. All meal intakes for all residents will be recorded in PCC for every meal every day. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will supply monthly weights for Q.A. Committee review. D.O.N. will monitor MARS for documentation of dietary supplement consumption weekly. Q.A. Committee review NAR meeting documentation monthly x 3 months then quarterly. D.O.N. will submit monthly weights, dietary supplement and food consumption to Administrator and Q.A. Committee for review. Interdisciplinary team NAR meeting with DON, RD, Dietary, Admin, and MDS Coordinator will be held and documentation will be available in residents record.	

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	155845	A. BUILDING 00 B. WING	04/21/2022

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	and her weight on 4/5/22 was 111 pounds. The resident was weighed again on 4/11/22 and her weight was 113 pounds. A Registered Dietitian (RD) Note, dated 3/26/22 at 12:38 p.m., indicated the resident had a significant weight loss in the last 30 days of 6.4%, which was not desired. The resident was receiving a dietary supplement 2 times a day. The noon meal was observed and the resident needs redirection and encouragement to continue to consume meals, as she tends to wander off from the table. Will recommend weekly weights times 4 weeks to track planned weight gain. A Nurses' Note, dated 4/3/22 at 7:14 p.m., indicated the resident continued to have a poor appetite. She consumed 75% of breakfast and 50% lunch and dinner. She continued to have weight loss and her dementia was increasing as the resident was very hard to redirect. She will spit out food or refuse to eat after a few bites. The Physician was notified and a new order was received for Megace (an appetite stimulant) 5 milliliters (ml) every day. Physician's Orders, dated 3/29/22, indicated weekly weights thru April (every Tuesday). Physician's Orders, dated 4/5/22, indicated a no added salt diet, pureed texture with super cereal at breakfast and super mashed potatoes at lunch. Resource 2.0 three times a day for supplement. Physician's Orders, dated 4/6/22, indicated Megace ES Suspension (Megestrol Acetate) Give 20 ml by mouth one time a day for appetite stimulant. The Medication Administration Record (MAR)		5. Completion Date: 5/15/22	

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	for 4/2022, indicated the Resource 2.0 three times a day was signed out as being administered from 4/11-4/19, however, there was no documentation of how much the resident consumed. There was also no clarification on how much Resource was to be administered. The meal consumption logs for 4/2022, indicated the breakfast meal was not documented on 4/1, 4/13, 4/14, 4/16, 4/17, 4/19, and 4/20/22. The lunch meal was not documented on 4/2, 4/4 4/13, 4/14, 4/16, 4/17, 4/19, and 4/20/22 and the dinner meal was not documented on 4/2, 4/3, 4/4, 4/5, 4/13, 4/14, 4/16, 4/17, 4/18, 4/19, and 4/20/22. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the meal consumption logs were incomplete and there was no documentation of how much of the Resource 2.0 the resident was supposed to receive or how much she consumed. This Federal tag relates to Complaint IN00375899. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not			

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	fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on record review and interview, the facility failed to ensure residents receiving enteral nutrition received appropriate treatment and services related to the tube feeding orders for 1 of 1 residents reviewed for tube feeding. (Resident 72) Finding includes: The record for Resident 72 was reviewed on 4/19/22 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, adult failure to thrive, and adjustment disorder with anxiety. The resident was admitted to the facility on 3/21/22. A Care Plan indicated the resident required a tube feeding. The interventions included the Registered Dietician (RD) to evaluate quarterly and as needed and to make recommendations for changes to the tube feeding as needed. A Registered Dietician note, dated 4/9/22, indicated the resident was to receive Resource 2.0 (tube feeding formula) 2 cans three times a day. A Physician's Order, dated 4/4/22, indicated	F 0693	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Original order 4/4/22 is attached with this report and the order indicated 2 boxes to be administered three times a day. Order modification done to include 2 boxes added to the direction line of order. All peg tube residents orders reviewed to ensure that the amount is specified in the body of the order and not just in the instructions. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other resident affected by this deficient practice. 3. What measures will be put into place or what systemic changes	04/22/2022

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	enteral feed Resource 2.0 three times a day. The order did not specify the amount to administer. The Medication Administration Record (MAR), dated 4/2022, lacked indication of the amount of Resource 2.0 administered to the resident. Telephone interview with the Director of Nursing (DON) on 4/21/22 at 11:12 a.m., indicated she would have to clarify the tube feeding orders. 3.1-44(a)(2)		will be made to ensure that the deficient practice does not recur. D.O.N. reviewed proper peg tube order to ensure amount of feeding displays on the order direction line with all nurses. Future orders will include the amount in the body of the order, not just in the order instructions. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will monitor monthly peg tube orders to ensure amount proper completion of physician order. D.O.N. will review all new peg tube orders written by licensed nurses as they occur. Q.A. Committee will review D.O.N. reports on proper peg tub orders quarterly, ongoing. 5. 4/22/22	
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 record review and interview, the facility failed to ensure fluid intake was monitored for residents on a fluid restriction for	F 0698	What corrective action will be accomplished for those residents found to have been affected by	05/15/2022

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	2 of 2 residents reviewed for dialysis. (Residents 12 and 13) Findings include: 1. The record for Resident 12 was reviewed on 4/19/22 at 12:03 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependent on renal dialysis, type 2 diabetes mellitus, dementia with behavior disturbance, and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 1/12/22, indicated the resident was cognitively impaired for daily decision making and he required supervision with eating. The resident received a therapeutic diet and dialysis. The Care Plan, dated 10/12/20 and reviewed on 1/12/22, indicated the resident had renal insufficiency related to end stage renal disease. The goal was for the resident to have no signs and symptoms of complications related to fluid overload through the next review date. The April 2022 Physician's Order Summary (POS), indicated the resident had an order for a no added salt diet with regular texture and consistency. No banana, tomato, baked potato, or orange juice. Fluid restriction 1500 cubic centimeters (cc's) per day, two 8 ounce cups per shift related to dependence on renal dialysis. The resident received dialysis three times a week on Tuesday, Thursday, and Saturday. The April 2022 fluid consumption sheets indicated fluid intake was not documented on 4/1, 4/2, 4/4, 4/5, 4/7, 4/13, 4/14, 4/16, 4/17, 4/18, 4/19, and 4/20/22.		the deficient practice? Consultation with facility dietician and dialysis dieticians re-evaluated our 3 dialysis residents and determined they do not need fluid restrictions because there are no signs of complications of fluid overload, or significant changes in weight pre-dialysis and post-dialysis. All fluid restrictions for current dialysis residents have been discontinued. In-service with POC documentation was provided immediately with C.N.A.'s and P.C.A.s to ensure proper knowledge for documenting resident fluid consumption. - 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 3 residents on dialysis affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-servicing on fluid consumption and POC documentation with all C.N.A.'s and P.C.A.'s. In-service training is ongoing and with staffing changes. Continued training of old and new employees	

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	Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the resident's fluid consumption sheets should have been completed. 2. Resident 13's record was reviewed on 4/19/22 at 11:18 a.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 2/15/22, indicated the resident was cognitively intact and received dialysis. The resident had a care plan for a fluid restriction. She was on a 1.5 liter (1500 milliliter) fluid restriction per day. She was to receive 250 milliliters (ml) with each meal from dietary to equal 750 ml total from dietary daily. She was to receive 750 ml total from nursing daily. A Physician's Order, dated 10/19/21, indicated the resident was on a fluid restriction of 1500 cc (cubic centimeters, 1 cc is equivalent to 1 ml) per day and was to receive two 8 ounce cups per shift. This would total 1440 ml per day. The fluid intake record, dated 4/2022, indicated fluids were only documented on the following dates 4/1/22 750, 750=1500 ml total 4/2/22 750, 750=1500 ml total 4/3/22 800, 800, 750, 750= 3100 ml total 4/6/22 1500 4/7/22 800 4/8/22 800, 800, 800, 500=ml total 4/9/22 500, 800, 800=2100 ml total 4/10/22 800, 800, 900=2500 ml total 4/11/22 800, 800=1600 ml total 4/12/22 880		on proper fluid consumption documentation will be provided ongoing. D.O.N. designee held In-Service held with nursing departments pertaining to fluid consumption documentation and care plan interventions updates. D.O.N. will review fluid consumption and supplement consumption 3 times weekly x 3 months then monthly thereafter. Dietician will monitor fluid restrictions of renal dialysis residents ongoing as their needs change, ongoing. All fluid intakes for all residents will be recorded in PCC for every meal every day. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will review POC fluid consumption weekly times 3 months then monthly, ongoing for Q.A. Committee review. Q.A. Committee review fluid consumption records quarterly. 5. Completion Date: 5/15/22	

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	4/15/22 800, 800=1600 ml total Telephone interview with the DON on 4/21/22 at 11:12 a.m., indicated she would do some training with the CNAs on documentation of the fluids. 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'			

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	needs, as identified through resident assessments, and described in the plan of care. Based on observation, record review, and interview, the facility failed to ensure a QMA's (Qualified Medication Aide) record of annual inservice training was available for review for 1 of 10 employee records reviewed. (QMA 1) Finding includes: On 4/19/22 at 9:39 a.m., QMA 1 was observed preparing medications and administering them to a resident. On 4/19/22 at 11:29 a.m., QMA 1 was observed preparing medications and administering them to a resident. QMA 1's employee record was reviewed 4/21/22 at 1:27 p.m. QMA 1 was hired on 3/21/22. The file lacked any record of annual inservice training. Telephone interview with the Director of Nursing (DON) on 4/21/22 at 2:15 p.m., indicated QMA 1 had completed her QMA training class and provided her record of annual inservice training. QMA 1's record of annual inservice, dated 3/17/20, indicated she had completed 6 hours of inservices on that date. There was lack of documentation of any inservices completed for 2021. Continued telephone interview with the DON on 4/21/22 at 4:00 p.m., indicated she did not have any further information to provide for QMA 1.	F 0726	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. D.O.N. investigated the Q.M.A. records to gather information for the continuation training for 2021. She was removed from the schedule. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No other Q.M.A.'s are hired by the facility. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility does not have a need for QMA's currently due to the hiring of licensed nurses. If Q.M.A's are used in the future all continued education hours will be submitted and verified by D.O.N. prior to employment. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	04/22/2022

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	3.1-14(j)		DON will perform pre-employment of all credentials for nursing staff and annually for updated licensure and certification requirements. The employee credentials will be kept in a binder for quick review. Q.A. Committee will review credential binder quarterly times 6 months then reviewed annually to ensure updated licensure and certification requirements. by what date the systemic changes 4/22/21	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure medications were received from the pharmacy in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident E) Finding includes: The record for Resident E was reviewed on 4/20/22 at 2:59 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia with behavior disturbance, anxiety disorder, major depressive disorder, psychotic disorder with hallucinations, anorexia, and insomnia. The Annual Minimum Data Set (MDS) assessment, dated 1/4/22, indicated the resident was cognitively impaired for daily decision making and required limited assistance with eating. The resident received antipsychotic and antidepressant medications during the assessment reference period. A Physician's Order, dated 1/6/22, indicated the resident was to receive Restoril (a hypnotic	F 0755	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. New pharmacy was contracted during the month of January due to problem with receiving medications. Charge nurses were in serviced to indicate any medications that are not available for the resident on the communication tab of PCC. The nurse is to notify the pharmacy and document who they spoke to and why the medication has not been received. Each nurse is to check for the medication and continue to notify the pharmacy until the medication arrives. If the medication is not available due to lack of stock physician should be notified and new order received for medication replacement. -how other residents having the potential to be affected by the	04/22/2022

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	medication) 15 milligrams (mg) at bedtime for insomnia. Nurses' Notes, dated 1/9/22 at 10:13 p.m., indicated the Restoril had not been delivered. Documentation on 1/13 at 11:22 p.m., 1/23 at 9:49 p.m., 1/24 at 10:51 p.m., 1/27 at 9:41 p.m., and 1/30/22 at 9:30 p.m., indicated the facility was awaiting the delivery of the Restoril. The January 2022 Medication Administration Record (MAR) indicated the resident did not receive his Restoril on 1/9, 1/11, 1/13, 1/15, 1/17, 1/23, 1/24, and 1/26-1/31/22. The February 2022 MAR indicated the resident did not receive the Restoril 2/1-2/16/22. Nurses' Notes, dated 2/8/22 at 10:51 p.m., indicated awaiting delivery of the Restoril. Nurses' Notes, dated 2/15/22 at 9:04 p.m., indicated the Restoril was not in the medication cart and the Physician was notified for a new prescription. A Physician's Order, dated 7/10/21, indicated the resident was to receive Albuterol Sulfate Syrup (a bronchodilator) 2 mg/5 milliliters (mls), give 10 mls three times a day for bronchospasm. Nurses' Notes, dated 3/31/22 at 4:06 p.m. and 7:41 p.m., indicated the Albuterol Sulfate Syrup was not given due to it was not available. Nurses' Notes, dated 4/1/22 at 2:06 p.m. and 4/3/22 at 9:27 p.m., indicated the Albuterol Sulfate Syrup was not available. There was no documentation the pharmacy was		same deficient practice will be identified and what corrective action(s) will be taken. Every resident has the potential for this to occur. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Charge nurse is responsible for ordering medications and notifying pharmacy of needs. A weekly medication cart audit will be performed every Thursday by a designated licensed nurse. DON will review audits weekly to ensure all medications are available for residents. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON monitor medication cart audits and notify administrator of any concerns with receiving medications from the new pharmacy company. Q.A. Committee will review medication cart audits quarterly. by what date the systemic changes 4/22/22	

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	contacted related to the medication delivery. Telephone interview with the Director of Nursing on 4/21/22 at 11:05 a.m., indicated staff should have contacted the pharmacy about the delay in receiving the Restoril and the Albuterol Syrup. 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure insulin was given as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident D)	F 0757	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	04/22/2022

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	Finding includes: The record for Resident D was reviewed on 4/20/22 at 10:08 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), type 2 diabetes mellitus, convulsions, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/31/22, indicated the resident was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. He also received insulin injections. The Care Plan, dated 10/12/20 and reviewed on 1/31/22, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, diabetes medications as ordered by Physician. Monitor/document for side effects and effectiveness. A Physician's Order, dated 1/25/22, indicated the resident was to receive Novolog 70/30 insulin 15 units subcutaneously before meals for hyperglycemia. The February 2022 Medication Administration Record (MAR), indicated the resident did not receive his 6:00 a.m. dose of insulin on 2/8, 2/9, 2/10, 2/11, and 2/13/22. The March 2022 MAR indicated the resident's insulin was held at 6:00 a.m. on the following dates: - 3/5 blood sugar 87 - 3/16 blood sugar 99 - 3/21 blood sugar 86 - 3/25 blood sugar 154		D.O.N. had identified this error prior to survey and it was corrected on 4/15/22 while doing an audit. I interviewed each nurse who had held the insulin and asked why, and each stated that was too much insulin to give the resident prior to eating. My next questions were why didn't you correct the order and contact the physician, they stated they just didn't think of doing it. I also informed that when in doubt notify the DON immediately. The order was received correctly but the times of administration was for 8:00, 12:00 and 17:00 however the computer made the specific times 0600, 1100 and 1600. The insulin should be given prior to eating a meal and since this resident does not eat until 9:00am the nurses held the medication so that his blood sugar would not drop, and he became hypoglycemic. The nursing staff should have informed the physician and had the order revised properly timelier. DON in-serviced all licensed nurses on her findings, properly checking insulin orders and insulin peak times were discussed. Physician was notified on 4/15/22 and order was changed to a sliding scale and at the appropriate times. DON had placed this in her PIP plan.	

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	- 3/28 blood sugar 100 - 3/30 blood sugar 91 The resident's insulin was held at 11:00 a.m. on 3/5/22 for a blood sugar of 119. The resident's 4:00 p.m. insulin was held on 3/20/22 for a blood sugar of 88. The April 2022 MAR indicated the resident's insulin was held at 6:00 a.m. on the following dates: - 4/2 blood sugar 93 - 4/5 blood sugar 120 - 4/6 blood sugar 116 - 4/7 blood sugar 126 - 4/14 blood sugar 106 - 4/15 blood sugar 103 The resident did not have a Physician's Order for blood sugar parameters. There was also no documentation on the above dates regarding the Physician being notified of the blood sugar results. Telephone interview with the Director of Nursing on 4/21/22 at 11:20 a.m., indicated the Physician should have been contacted before holding the insulin and the administration time of 6:00 a.m. should have been clarified. 3.1-48(a)(3)		how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. will monitor MAR weekly to monitor for proper administration of insulin and accu-check levels. D.O.N. will monitor new physician order log weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monitor MAR weekly to monitor for proper administration of insulin and accu-check levels. D.O.N. will monitor new physician order log weekly. Q.A. Committee will review D.O.N. report of insulin order review, accu-check and MAR logs quarterly for the next 6 months. by what date 4/15/22 reviewed again 4/22/22.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use			

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	§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for			

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	the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure as needed (prn) psychotropic medications were administered after interventions were attempted prior and not given for longer than 14 days for 2 of 5 residents reviewed for unnecessary medications. (Residents E and C) Findings include: 1. The record for Resident E was reviewed on 4/20/22 at 2:59 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia with behavior disturbance, anxiety disorder, major depressive disorder, psychotic disorder with hallucinations, anorexia, and a eating disorder. The Annual Minimum Data Set (MDS) assessment, dated 1/4/22, indicated the resident was cognitively impaired for daily decision making and required limited assistance with eating. The resident received antipsychotic and antidepressant medications during the assessment reference period. The Care Plan, dated 10/7/20 and reviewed on 1/4/22, indicated the resident had a history of combative behaviors related to a psychotic disorder with hallucinations. Interventions included, but were not limited to, administer medications as ordered. Monitor/document for	F 0758	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; In-service with all licensed nurses on proper documentation for use of psychotic medications and all PRN medications. 1. What is the resident's behavior? 2. What interventions were performed to redirect the inappropriate behaviors? 3. Outcome of each intervention tried. 4. Why did you give the psychotropic medication? 5. What was the effect of the administration of the medications? Each charge nurse received this que card to help them with proper documentation. Ques are also placed on the communication tab in PCC for it to be reviewed each day for every shift. - 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;	05/15/2022

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	side effects and effectiveness. A Physician's Order, dated 1/12/22, indicated the resident was to receive Haldol Solution (an antipsychotic medication) 5 mg (milligrams)/ml (milliliters), inject 5 mg intramuscularly (IM) every 8 hours as needed for combative, agitated behaviors related to psychotic disorder with hallucinations for 14 days. Nurses' Notes, dated 1/22/22 at 6:36 a.m., indicated the resident had stayed awake and active the entire night. He had all medications and prn Haldol with no change. Served snacks and cold water with little effect. Cooperative with ADL's (activities of daily living). Still in chair in room at this time. The prn Haldol was not signed out as being administered on the January 2022 Medication Administration Record (MAR). Telephone interview with the Director of Nursing on 4/21/22 at 11:05 a.m., indicated documentation of interventions attempted prior to giving the prn Haldol should have been completed. She also indicated the medication should have been signed out on the MAR. 2. The record for Resident C was reviewed on 4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She		No other residents were affected but any resident receiving a PRN medication order has the potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All charge nurses will use Que cards for proper documentation. In-Service held with licensed nurses on behavior documentation for Nurse Practitioner and Pharmacist Consultant review. Nurse Practitioner will continue to evaluate all resident receiving antipsychotic medication and behaviors. Psychiatric Nurse Practitioner and Pharmacist Consultant will communicate about resident receiving psychoactive medications and review 14 day psychotropic orders. MDS Nurse and Charge Nurse will update care plans according to behavior and order changes. DON will review all PRN orders and documentation for proper use of medications. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monitor documentation of changes in medication	

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	had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. The resident's weight was 120 pounds with no weight loss noted. The Care Plan, dated 2/7/22, indicated the resident used psychotropic medications related to the diagnoses of depression, insomnia, anxiety and psychosis. Physician's Orders, dated 4/1/22, indicated Lorazepam (an anti-anxiety medication) 1 milligram (mg). Give 1 tablet by mouth every 12 hours as needed for anxiety. The Medication Administration Record (MAR) for 4/2022 indicated the Lorazepam was administered on 4/4 at 12:01 a.m., 4/13 at 12:31 a.m., 4/17 at 7:30 a.m., on 4/18 at 10:11 p.m. and 4/20/22 at 9:24 p.m. Nurses' Notes, dated 4/3/22 at 3:47 p.m., indicated the resident had several yelling and screaming episodes earlier. Administered Ativan per prn order. The medication had positive effectiveness noted. Nurses' Notes, dated 4/4/22 at 12:01 a.m., indicated Lorazepam 1 mg given prn for agitation Nurses' Notes, dated 4/12/22 at 11:11 p.m., indicated the resident was awake and sitting in the dinning room at this time. The resident slept most of the evening. She kept asking for water. Nurses' Notes, dated 4/13/22 at 12:31 a.m.,		indications and resident outcome. D.O.N. will monitor communication board weekly and assess documentation of nurses. D.O.N. will meet with Nurse Practitioner and Pharmacist monthly to discuss GDR recommendations and resident's response to treatment. DON will monitor new orders log bi-weekly. Q.A. Committee will monitor reports from D.O.N. quarterly to assess effectiveness of medication and need for continued use. by what date the systemic changes 5/15/2022.	

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	indicated Lorazepam 1 mg given prn for anxiety. Nurses' Notes, dated 4/17/22 at 6:26 a.m., indicated the resident was awake through the night. Gave her food to eat. She was sleeping at the moment. Nurses' Notes, dated 4/17/22 at 7:30 a.m., indicated Lorazepam 1 mg given prn for anxiety and agitation. . Nurses' Notes, dated 4/18/22 at 11:11 p.m., indicated Lorazepam 1 mg given prn for anxiety for yelling. Nurses' Notes, dated 4/20/22 at 9:24 p.m., indicated Lorazepam 1 mg given prn for anxiety. The MAR for 4/2022 indicated the resident was to be monitored for behaviors of agitation, biting, kicking, hallucinations, psychosis, spitting, picking at skin and restlessness. The resident had no behaviors documented and each shift was coded with "No" for 4/4, 4/13, 4/17, 4/18, and 4/20/22. There was no documentation on the above dates that interventions were tried first before the administration of the prn anti-anxiety medication. Telephone Interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated there were no interventions tried first before administering the prn Ativan. Those interventions were to be documented in nursing notes. The prn order for the psychotropic medication was beyond 14 days. 3.1-48(b)(2)			

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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 a resident was free from significant medication errors related to the incorrect administration of insulin for 1 of 5 residents observed during medication pass. (Resident 13) Finding includes: During a medication administration observation on 4/20/22 at 9:27 a.m. LPN 1 prepared Resident 13's insulin. She took the Lantus (insulin glargine) insulin pen out of the cart, cleaned the hub with an alcohol prep pad, and attached the needle. She then dialed the pen to 17 units. She cleaned the resident's left upper arm with an alcohol prep pad and injected the insulin. She did not prime the insulin pen or perform an air shot prior to administering the insulin. Manufacturer's instructions for the Lantus insulin pen, dated 3/2020, indicated, "...Step 3. Perform a safety test. Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each	F 0760	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nurse performing deficient practice was in-serviced according to policy on Accu-Check and properly using insulin pen. All nurses were immediately in-serviced on all shifts and the policy and procedure for insulin pen administration. DON provided que cards for each licensed nurse on proper administration of insulin via insulin pen. DON place que card for proper procedure for using insulin pen on medication cart and in medication room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Every resident receiving insulin thru insulin pen had potential to be	04/22/2022

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	injection...Step 5. Inject your dose..." Telephone interview with the Director of Nursing (DON) on 4/21/22 at 11:12 a.m., indicated the insulin pen should have been primed prior to administration. 3.1-48(c)(2)		affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. reviewed proper use of Insulin Pen to all licensed nurses. New licensed nurses will be in serviced on proper use of insulin pen. Que cards will be reviewed monthly with every licensed nurse for 6 months then quarterly, ongoing. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will monitor insulin administration with every nurse and new hires to ensure insulin is primed properly monthly. Q.A. Committee will review Monitoring tool and nurse training semi-annually. 5. Completion Date: 4/22/2022	
F 0880 SS=E 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			

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	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 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			

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	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. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on random observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed before donning personal protective equipment (PPE), the correct PPE not worn in isolation rooms, masks worn incorrectly, not monitoring COVID-19 signs and symptoms, and not testing for COVID-19 upon admission and readmission and when residents develop symptoms of COVID-19 for 5 of 7 residents reviewed for infection control. (Residents 4, 11, 72, B and C)	F 0880	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON was informed of infection control deficient practices and contacted risk management who was present for the exit for the development of DPOC. DON held the following in-services: Handwashing, hand sanitation,	05/15/2022

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	Findings include: 1. During a random observation on 4/18/22 at 9:35 a.m., Dietary Employee 1 was passing beverages to the 13 residents in the dining room. Her surgical mask was pulled down by her chin. The employee did not pull up her mask until she was instructed to do so. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the employee's mask should have been pulled up to cover her mouth and nose. 2. During a random observation on 4/19/22 at 8:58 a.m., the Infection Preventionist and Custodian 1 were in Resident 4's room. They were wearing surgical masks and no other personal protective equipment (PPE). After walking out of the room, neither staff member performed hand hygiene. At 9:00 a.m., the Custodian entered the resident's room again just wearing a surgical mask. Signage on the door indicated the resident was in contact and droplet isolation precautions which required the use of a gown, eye protection, N95 mask, and gloves upon entrance. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated the employees should have been wearing full PPE in the isolation room and hand hygiene should have been completed when they left the room. 3. During a random observation on 4/19/22 at 11:02 a.m., CNA 3 was in the dining room with her mask pulled down and she was drinking from a styrofoam cup. She was within 6 feet of two		proper mask application, proper PPE for green, yellow and red zones policy reviewed with all staff. Green, Yellow and Red Stop signs are posted on the resident's room indicating what TBP are being used. The importance of reading was stressed to each staff member. The deficient practice was discussed and investigated on why this behavior occurred with Dietary Employee 1, Custodian 1, Dietary Cook 1 no longer employed, Laundry aide no longer employed, C.N.A. 1 and administrator. DON held in-service with licensed nurses to indicate proper procedures for COVID Red and if resident test positive on quick test which includes the following to be assessed every shift: 1. COVID test done upon admission and retest performed in 5 days we tested the residents every 3 days. 2. COVID orders have been updated to include monitor oxygen level, respiratory status, temperature, loss of smell, SOB and cough. - 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;	

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	other residents. When she did pull up her mask, it was below her nose. 4. On 4/19/22 at 3:18 p.m., Resident 11 was taken to her room for incontinence care. At 3:44 p.m., the resident was transferred to bed. CNA 2 donned a pair of disposable gloves, she did not complete hand hygiene before applying the gloves. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated hand hygiene was to be completed before applying gloves. 5. During a random observation on 4/20/22 at 9:00 a.m., CNA 1 was observed outside of Resident 4's room. She donned a gown, an N95 mask, eye protection, and gloves. She did not complete hand hygiene before donning the personal protective equipment. Before leaving the resident's room, she removed her gown and gloves in the doorway. She rolled up the gown and discarded it in the isolation trash bin in the hallway outside of the resident's room. After discarding the gown and gloves, she removed her N95 mask and threw it away. She reapplied her surgical mask at that time and then completed hand hygiene. Telephone interview with the Director of Nursing on 4/21/22 at 11:30 a.m., indicated hand hygiene should have been completed prior to donning PPE and the PPE should have been thrown away in the resident's room. 6. During a random observation on 4/18/22 at 1:57 p.m., Dietary Cook 1 left the kitchen and walked through the dining room with her face mask below her nose and mouth. The face mask was		Everyone had the potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. reviewed handwashing policy with all staff and will complete speedy hand and PPE audit evaluations on all nursing staff weekly ongoing, so that tracking and trends can be established, and deficient practices addressed promptly. DON reviewed proper N95 and surgical mask applications with all staff and does rounds each day and every shift for proper mask wearing. DON reviewed proper PPE procedures for apply and removing of PPE according to Green, Yellow and Red zones. Proper disposal of PPE inside the resident's room in Biohazard waste for Red Zone and plastic bags for Yellow and Green zones. DON will monitor staff ongoing since weather is becoming warmer for proper mask wearing, handwashing, hand sanitation, proper PPE usage ongoing with current staff and newly hired staff 3 times a week on every shift for the next 6 weeks then weekly thereafter.	

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	around her neck as she walked through the dining room and passed by the residents. 7. During a random observation on 4/18/22 at 2:20 p.m., CNA 1 was observed talking to the Administrator and was standing in the dining room with her face mask below her nose and mouth. There were 3 residents within 6 feet of her. At 2:39 p.m., the CNA walked in the dining room through a side door carrying a trash can, her mask was still around her neck and not over her nose and mouth. 8. During a random observation on 4/19/22 at 12:00 p.m., Custodian 1 entered a room with yellow TBP signage on the door and a TBP cart outside the room by the door. He was wearing a surgical mask and made the unoccupied bed. There was a resident present in bed one with oxygen on. At 12:10 p.m., the custodian exited the room and retrieved a mop bucket and mop, and re-entered the same room. The Administrator came to the door and asked the Custodian to get a bedspread for the unmade bed. She did not address his lack of wearing PPE in the TBP room. At 12:13 p.m., the Custodian exited the room and then entered the room across the hall where Administrator was checking the room. He did not wash or sanitize his hands at any point. At 12:15 p.m. when queried, Custodian 1 indicated he was unaware of the TBP status of the room. He was shown the signage. He then started to retrieve a gown from the cart of supplies outside the room. Signage on the door indicated the resident was in contact and droplet isolation precautions which required the use of a gown, eye protection, N95 mask, and gloves upon entrance.		- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Infection control practices including handwashing and proper PPE will be completed by charge nurse everyday and every shift. The monitoring will be located on the nurse rounds log. Reports from each department will be given to Q.A. Committee for review quarterly. D.O.N. will provide handwashing evaluations on all nursing staff current and new hires monthly ongoing. D.O.N. will review all new admission orders for TBP related to COVID-19. D.O.N reviewed proper disposal of PPE for TBP Date 5/15/2022	

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	Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated all staff were to don the appropriate PPE before entering the TBP room. Telephone interview with Director of Nursing on 4/19/22 at 11:30 a.m., indicated staff were to don the correct PPE before entering the TBP room. 9. The record for Resident 11 was reviewed on 4/20/22 at 1:46 p.m. The resident tested positive for COVID-19 on 1/4/22. The Treatment Administration Record for the month of 1/2022 indicated the resident was only monitored 1 time a day for COVID-19 while she was in her quarantine period from 1/4-1/14/22. Staff were to monitor for COVID-19 signs and symptoms of temperature of 100 or above, shortness of breath, loss of smell and coughing every 24 hours for COVID-19 prevention. There were no Physician's Orders for droplet/contact isolation. 10. The record for Resident 4 was reviewed on 4/20/22 at 1:55 p.m. The resident tested positive for COVID-19 ON 1/4/22. The Treatment Administration Record for 1/2022 indicated the resident was only monitored 1 time a day for COVID-19 while she was in her quarantine period from 1/4-1/15/22. Staff were to monitor for COVID-19 signs and symptoms of temperature of 100 or above, shortness of breath, loss of smell and coughing every 24 hours for COVID-19 prevention The resident was readmitted from the hospital on 4/13/22. There was no evidence a COVID-19			

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test had been performed at the time of admission and/or 5 to 7 days later.

Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated she was unaware the residents were not monitored every shift when they tested positive for COVID-19. She was also unaware the residents needed to be tested at the time of admission and 5 to 7 days later.

Telephone interview with Director of Nursing on 4/19/22 at 11:30 a.m., indicated there was no monitoring for COVID-19 every shift when the residents had tested positive for COVID.

11. During a random observation on 4/20/22 at 2:45 p.m., Laundry Aide 1 was observed walking in and out of resident rooms with her face mask around her neck. She entered Resident 72's room and proceeded to stand within 2 feet of his bed and talked to him with her face mask around her neck.

Interview with Laundry Aide 1 at that time, indicated she was aware her face mask was to be covering her nose and mouth.

12. The closed record for Resident B was reviewed on 4/19/22 at 11:23 a.m. The resident was admitted on 2/24/22 and discharged to the hospital on 3/6/22. Diagnoses included, but were not limited to, epilepsy, depression, fetal alcohol syndrome, impulse disorder, intellectual disabilities, stroke, and mild intellectual disabilities.

There was no evidence the resident was tested for COVID-19 on admission or 5 to 7 days later.

The Admission Minimum Data Set (MDS)

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	assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. A Nurses' Note, dated 3/5/22 at 3:16 p.m., indicated the resident refused breakfast and stated she had a headache and a slight sore throat. "I did notice she has a moist non-productive cough and her lungs with slight wheezing that clear with a cough." Her temperature was 99.1 degrees. Notified the Physician and new orders were obtained for Tylenol and Sudafed cough syrup. There was no evidence a rapid COVID-19 test had been performed due to the resident having signs and symptoms of COVID-19. Nurses' Notes, dated 3/6/22 at 9:00 a.m., a head to toe assessment was completed for the resident. The resident was alert and indicated she had felt hot, had a sore throat, lower flank pain and there she had moist cough with chest congestion. The Physician was notified and she was sent to the hospital and admitted with the diagnosis of pneumonia. Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated a rapid COVID-19 test should have been completed for the resident when she exhibited signs and symptoms on 3/5/22. She indicated a COVID-19 test was not performed on admission to the facility or within 5 to 7 days afterwards. Interview with Director of Nursing on 4/19/22 at 11:30 a.m., indicated if a resident developed signs and symptoms of COVID-19 than they needed to be rapid tested. 13. The record for Resident C was reviewed on			

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	4/19/22 at 1:36 p.m. The resident was admitted to the facility on 1/31/22. Diagnoses included but were not limited to, Alzheimer's disease, overactive bladder, major depressive disorder, insomnia, adjustment disorder with mixed emotions and conduct, high blood pressure, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was severely impaired for decision making. She had feelings of hopelessness, had trouble falling asleep, trouble concentrating in the last 2 to 6 days. The resident had physical, verbal and wandering behaviors for 1 to 3 days during the assessment period. The resident was dependent on staff for transfers, bed mobility, dressing, toileting and eating. The resident's weight was 120 pounds with no weight loss noted. The resident was readmitted from the hospital on 4/11/22. There was no evidence a COVID-19 test had been performed at the time of admission and/or 5 to 7 days later. The CDC "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", dated 2/8/22, indicated, "Testing: Newly-admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection; immediately and, if negative, again 5-7 days after their admission." Interview with LPN 1 on 4/21/22 at 9:30 a.m., indicated she was unaware vaccinated residents needed to be tested for COVID-19 at the time of admission.			

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F 9999 Bldg. 00	3.1-18(b) 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) moths, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete related to the lack tuberculosis	F 9999	2nd Step TB the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Infection Control will be responsible for ensuring all 2nd step PPD are performed until a unit secretary can be hired. QMA no longer employed OTA was screened for TB. Housekeeper 1 no longer employed. Dietary Cook 2 no longer employed. Administrator review of policy with Unit Manager who will be responsible for employee files. Mantoux within 1 month prior to employment. Mantoux 2nd step within 3 weeks on first step Mantoux Mantoux must be repeated annually, and chest x-ray is good for 2 years if employee is allergic to Mantoux.	05/15/2022

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	screening for 4 of 5 newly hired employees. (QMA 1, Dietary Cook 2, OTA 1, and Housekeeper 1) Findings include: The Employee Records were reviewed on 4/21/22 at 1:27 p.m. a. QMA 1 was hired on 3/21/22. Her first step tuberculosis was completed on 3/15/22. There was no documentation a second step was completed. b. Dietary Cook 2 was hired on 2/24/22. Her first step tuberculosis was completed on 12/21/21. There was no documentation a second step was completed. c. OTA 1 was hired on 3/4/22. There was no documentation a tuberculosis screen had been completed. d. Housekeeper 1 was hired on 3/17/22,. Her first step tuberculosis was completed on 3/11/22. There was no documentation a second step was completed. Interview with LPN 1 on 4/21/22 at 3:00 p.m., indicated if there was no documentation in their files then they were not completed.		Annual Mantoux will be performed every January of each year. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held employee annual updates reviewed. In-Service held on proper documentation of new employee checklist form and annual review. Unit Manager will be designated to do employee files. Administrator will review check off list of all new hires and review annual employee records. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator and/or D.O.N. will review all new hires employee checklist form. Administrator and/or D.O.N. will review annually review employees file for updated health information. Q.A. Committee will review new	

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			policy and checklist for new employees semi-annually to ensure compliance. by what date 5/15/2022	