STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00423010, IN00425038, IN00425810 and IN00427356. Complaint IN00423010 - Federal/State deficiencies related to the allegations are cited at F550 and F689. Complaint IN00425038 - No deficiencies related to the allegations are cited. Complaint IN00425810 - Federal/State deficiencies related to the allegations are cited at F550 and F689. Complaint IN00427356 - Federal/State deficiencies related to the allegations are cited at F550 and F689. Survey dates: January 30, 31 and February 1, 2, 5 and 6, 2024 Facility number: 000468 Provider number: 155378 AIM number: 100290270 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 67 Other: 7 Total: 78	F 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 2/26/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Hurt	Administrator	02/25/2024

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 16, 2024.			
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights			

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	without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure staff treated residents with respect and dignity and to ensure a resident was provided clothing for 4 of 4 residents reviewed for respect and dignity. (Residents J, D, K, and C) Findings include: 1. During an interview, on 1/30/24 at 3:13 p.m., Resident J indicated a few nights ago she fell asleep in her wheelchair in her father's room next to his bed. A staff member came in the room when she was in there and rudely told her to get out. She was unsure of who the staff member was. The clinical record for Resident J was reviewed on 2/1/24 at 1:45 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety, and other reduced mobility. During an interview, on 1/30/24 at 3:56 p.m., the Administrator indicated Resident J's father reported an incident when the staff asked Resident J to leave her father's room in a disrespectful tone. During an interview, on 2/2/24 at 11:25 a.m., Resident J's father indicated Resident J fell asleep in his room the other night and a staff member rudely told Resident J to get out and wheeled her	F 0550	1 /p> !--[endif]--> WWhat corrective action will be accomplished for those residents found to have been affected by the deficient practices: a Residents in the sample were anonymous. b All residents that can be interviewed will be questioned to ensure that staff are treating them with respect and dignity. c All residents that can be interviewed will be questioned to ensure they have proper clothing per their preference. d All residents that cannot be interviewed will have a psychosocial assessment completed by SSD/or designee. e CEO/DON held emergency Resident Council meetings on 2/23/2024 to reassure them that we expect our staff to treat all residents with dignity and respect, all allegations will be taken seriously, and no retaliation will be displayed, reviewed Abuse Policy and Grievance Policy and Procedure.	02/26/2024

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	away. He heard Resident J express frustration while being wheeled away. He was unsure of who the staff member was or what they looked like. 2. During an interview, on 1/31/24 at 10:34 a.m., Resident D indicated a staff member (CNA 5) had given him rough care including throwing him around when changing him, putting his socks on roughly, and being rude to him. The clinical record for Resident D was reviewed on 2/1/24 at 11:07 a.m. The diagnoses included, but were not limited to, reduced mobility, major depressive disorder, vascular dementia, and muscular weakness. During an interview, on 2/2/24 at 3:25 p.m., CNA 9 indicated she did know of the incident between the aide and the resident. CNA 5 no longer worked at the facility. When you provided care to the resident, you had to be gentle because he was sensitive with care. During an interview, on 2/5/24 at 3:03 p.m., the Administrator and Clinical Support Nurse indicated CNA 5 no longer worked at the facility due to customer service issues.3. During an observation, on 1/30/24 at 1:19 p.m., Resident K was in bed wearing a hospital gown and no pants with stains on the front of the gown and had a noticeable mustache and long chin hair. During an observation, on 1/31/24 at 11:55 a.m., Resident K was in bed wearing a stained hospital gown, incontinence brief, no pants, or socks, and had a noticeable mustache and long chin hair. During an observation, on 2/1/24 at 11:39 a.m., Resident K was in bed in a clean hospital gown with no pants or socks.		f All staff will be re-educated on Abuse Policy, Grievance Policy, and Customer Service. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alleged deficient practice. b All residents that can be interviewed will be questioned to ensure that staff are treating them with respect and dignity. c All residents that can be interviewed will be questioned to ensure they have proper clothing per their preference. d All residents that cannot be interviewed will have a psychosocial assessment completed by SSD/or designee. e CEO/DON held emergency Resident Council meetings on 2/23/2024 to reassure them that we expect our staff to treat all residents with dignity and respect, all allegations will be taken seriously, and no retaliation will be displayed, reviewed Abuse Policy and Grievance Policy and Procedure. f All staff will be re-educated on Abuse Policy, Grievance Policy, and Customer Service by 2/25/2024. 3 What measures will be put into place and what systemic	

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	During an observation, on 2/1/24 at 1:53 p.m., Resident K was in bed in a clean hospital gown with no pants or socks. During an observation, on 2/2/24 at 11:56 a.m., Resident K was wearing a clean hospital gown with no pants or socks. The clinical record for Resident K was reviewed on 2/1/24 at 4:16 p.m. The diagnoses included, but were not limited to, catatonic disorder due to known physiological condition, paranoid personality disorder, schizophrenia, acute embolism, and thrombosis of unspecified deep veins of left lower extremity, need for assistance with personal care, and cognitive communication deficit. A resident admission belonging list, dated 12/19/23, indicated Resident K had no belongings. The electronic medical record did not include documentation of any facility requests for clothing. During an interview, on 2/5/24 at 2:53 p.m., the Administrator indicated Resident K arrived at the facility with no belongings and had no clothes.4. During an interview, on 1/30/24 at 12:56 p.m., Resident C indicated CNA 5 was very rude and provided rough peri-care. The clinical record for Resident C was reviewed on 2/2/24 at 12:18 p.m. The diagnoses included, but were not limited to, Wernicke's encephalopathy, bipolar disorder, intellectual disabilities, depressive disorder, cognitive communication deficit, borderline personality disorder, schizoaffective disorder, and anxiety		changes will be made to ensure that the alleged deficient practice does not recur: a CEO/DON held emergency Resident Council meetings on 2/23/2024 to reassure them that we expect our staff to treat all residents with dignity and respect, all allegations will be taken seriously, and no retaliation will be displayed, reviewed Abuse Policy and Grievance Policy and Procedure. b All staff will be re-educated on Abuse Policy, Grievance Policy, and Customer Service by 2/25/2024. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a SSD/or designee will interview 5 residents weekly for 4 weeks, then 5 residents monthly for 3 months to ensure residents are being treated with dignity and respect and have proper clothing per their personal preference. b Interviews results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to	

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	disorder. In a facility reported incident, dated 1/8/24 at 8:49 a.m., Resident C indicated CNA 5 was rough with morning peri care. CNA 5 was suspended pending the investigation. On 1/16/24, the allegations were unsubstantiated. CNA 5 was returned to work. During an interview, on 1/31/24 at 2:30 p.m., an anonymous resident indicated there were issues with some staff being rude and providing rough care. The resident was very uncomfortable with the second shift and did not look forward to them coming into the resident's room. The resident was not treated with dignity or respect and had rough care provided by a CNA. When the resident was incontinent with diarrhea, the CNA would ask why the resident had a bowel movement in their depends and not use the toilet. The resident indicated they had not reported these incidents to management in fear they would take it out on them. During an interview, on 2/2/24 at 4:06 p.m., the same anonymous resident indicated the rude CNA who treated the resident rough had also dropped the resident on the floor during a transfer. The CNA who provided rough care did not work again. During the resident council meeting, on 2/1/24 at 1:31 p.m., the residents indicated if /they or their families complained about their care someone would retaliate against them. During an interview, on 2/2/24 at 4:10 p.m., a second anonymous resident indicated they witnessed a CNA on second shift speaking in a rude tone and being rough while providing care to a resident.		outcomes.	

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	During an interview, on 2/5/24 at 3:03 p.m., the Director of Nursing (DON) indicated the incident for Resident C was investigated and there were no findings. She thought there was a cultural conflict with the CNA involved and CNA 5 was let go after the second incident was reported. A current policy, titled "Resident Rights," dated as revised on 9/15/23 and received from the Administrator on 1/30/24 at 12:26 p.m., indicated "...All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life...The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity...." This citation relates to Complaints IN00423010, IN00425810 and IN00427356. 3.1-3(t)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care			

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	planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on observation, interview and record review, the facility failed to ensure a new Preadmission Screening and Resident Review (PASARR) was completed when a new diagnosis of psychosis was added along with an antipsychotic medication and to implement the PASARR recommendations for a resident with a known mental health condition for 2 of 3 residents reviewed for PASARR. (Resident 36 and K) Findings include: 1. The clinical record for Resident 36 was reviewed on 2/2/24 at 10:38 a.m. The diagnoses included, but were not limited to, age related cognitive decline, dementia with agitation, a psychotic disorder with delusions due to a known physiological condition, hallucinations, recurrent major depressive disorder, anxiety disorder, and an altered mental status. A PASARR, dated 11/25/19, indicated the resident's mental health diagnoses included a mood disorder due to a known physiological condition with depressive features. The resident also had a diagnosis of dementia. The resident was not taking any mental health medications. If changes occurred or additional information suggested a primary mental illness, then a rescreening should occur to reassess the need for PASARR evaluation.	F 0644	Deficiency ID: F 644 Coordination of PASARR and Assessments 1 What corrective action will be accomplished for those residents found to have been affected by alleged deficient practice: a Resident 36 had a new level 1 screening was completed with current antipsychotic medications and update mental health diagnosis on 2/05/2024, with determination on 2/08/2024 indicating Dementia/Mental Illness exclusion. b Resident K was admitted to the Witham Health Services on 2/05/2024. Resident K received a psychiatric consultation and work up on 2/06/2024. Resident K received services for mental health through 2/15/2024. Resident K returned to facility on 2/16/2024, with orders to continue weekly psych services at facility. Resident was seen 2/23/2024 by in house psych NP, Cheryle Davis-Land. Resident K has a behavioral treatment plan in place, dementia workup, along with	02/26/2024

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	A physician's order, dated 1/5/23 through 2/14/23, indicated to give quetiapine (an antipsychotic medication) twice a day for schizophrenia. A physician's order, dated 3/8/23 through 6/9/23, indicated to give olanzapine (an antipsychotic medication) once a day for a psychotic disorder with delusions. During an interview, on 2/5/23 at 2:36 p.m., the Director of Nursing (DON) indicated the resident was admitted from a different facility with the diagnosis of schizophrenia and then the family indicated the resident did not have this diagnosis in the past. During an interview, on 2/5/23 at 2:38 p.m., the Administrator indicated a PASARR Level I should have been completed again when the antipsychotic medication and the new diagnosis of psychosis with delusions was added in January 2023. 2. During an observation, on 1/30/24 at 1:19 p.m., Resident K was in bed with no television or activities observed in the room. During an observation, on 1/31/24 at 11:55 a.m., Resident K was in bed with no television or activities observed in the room. During an observation, on 2/1/24 at 11:39 a.m., Resident K was in bed with no activities or stimulation observed in the resident's room. One small pink stuffed animal was seen on the resident's bedside table. Resident K had no television, music, reading material, puzzles, or games at the bedside. During an observation on 2/1/24 at 1:30 p.m., Resident K was in bed with no activities or stimulation observed in the resident's room. One		socialization/leisure/recreation activities including a TV and radio, and 1 on 1 activities. Resident K did receive a temporary guardian, Debra Woods, on 2/13/2024 with a Permanent Guardianship hearing scheduled for April 2, 2024 at 8:30am. 2 How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken. a All residents have the potential to be affected by alleged deficient practice. b Audit completed of all residents to ensure current level 1 screening reflected residents' current diagnosis and antipsychotic medications. c Audit completed of all residents with level 2 screening to ensure PASARR recommendations were being followed. 3 What measures will be put into place and what systemic changes will be made to ensure that alleged deficient practice does not occur. a SSD, Activity Director, and Transition Nurse educated on Preadmission Screening and Resident Review Policy. b IDT will review all new orders daily in clinical meeting. All	

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	small pink stuffed animal was seen on the resident's bedside table. Resident K had no television, music, reading material, puzzles, or games at the bedside. During an observation, on 2/2/24 at 11:56 a.m., Resident K only had a small pink stuffed animal on the bedside table. The clinical record for Resident K was reviewed on 2/1/24 at 4:16 p.m. The diagnoses included, but were not limited to, catatonic disorder due to known physiological condition, paranoid personality disorder, schizophrenia, need for assistance with personal care, cognitive communication deficit, and encounter for screening for global developmental delays (milestones). The PASRR Level II, dated 12/4/23, listed the following, but were not limited to, required services: mental health services- individual therapy and outpatient treatment services, psychiatric evaluation, socialization/leisure/recreation activities, supportive counseling from the nursing facility staff, dementia workup, and a behaviorally based treatment plan. The PASRR indicated, according to APS (Adult Protective Services), Resident K had a history of catatonia (a group of symptoms which usually involved a lack of movement and communication, and could include agitation, confusion, and restlessness) and not eating and drinking when psychiatric symptoms were left untreated and had four medical admissions in the last two months due to medical trouble resulting in catatonia. A progress note, dated 12/22/23 at 2:39 p.m., indicated the Social Service Director left a voice		residents with new antipsychotic medication and/or new mental health diagnosis will have a new level 1 screening completed. c All level 2 screenings received will be reviewed by IDT the next day during clinical meeting for PASARR recommendations. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a CEO/designee will conduct weekly audits of 5 residents for 4 weeks, then 5 residents monthly times 3 months to ensure accuracy for all level 1 and PASARR recommendations. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	mail for Resident K's guardian to contact him at the guardian's earliest convenience regarding consent for psychiatric services and sent a consent form for a signature. A history and physical, dated 12/28/23, indicated the physician had a plan for a psychiatric service consult for the management of schizophrenia, paranoid personality disorder, and developmental delay. A care plan, dated 12/29/23, indicated a problem category for mood. Interventions included, but were not limited to, consulting with psychiatry/psychology as needed with a start date of 12/29/23. The electronic medical record did not include progress notes, an evaluation, or a history and physical for a psychiatric service provider. There were no documentation psychiatric services were provided to Resident K. A nursing progress note, dated 2/5/2024 at 1:22 p.m., indicated Resident K was sent to the hospital emergency room for failure to thrive and mental health needs. During an interview, on 2/5/24 at 1:53 p.m., the DON indicated Adult Protective Services (APS) refused to sign consent for psychiatric services so the facility could not get a psychiatrist to evaluate and treat Resident K. The facility had not been successful in obtaining a guardian for Resident K, so they could not get a consent signed. Resident K had signed her own admission forms. Both the Administrator and the DON indicated the resident had not received psychiatric services. They had decided to call APS to evaluate Resident K and the decision was			

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	made to transfer her to the hospital emergency room for failure to thrive, psychiatric services, and treatment to help with her behaviors. A current policy, titled "Pre-Admission Screening and Resident Review [PASRR]," dated as last reviewed on 9/15/23 and received from the Administrator on 2/6/24 at 2:54 p.m., indicated "...PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that...all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness...and/or intellectual disability...be offered the most appropriate setting for their needs...and receive the services they need in those setting...PASARR level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD [mental disorder], ID [intellectual disorder] or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs...." 3.1-16(d)(1)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident,			

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	encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to ensure a resident who resided on the dementia unit was provided cognitively stimulating activities for 1 of 3 residents reviewed for activities. (Resident K) Finding includes: During an observation, on 1/30/24 at 1:20 p.m., Resident K was in bed while group activities were occurring in the common area. The resident was awake, and no staff offered to get the resident out of bed. There was no television or music observed in the room. During an observation, on 1/31/24 at 12:06 p.m., the resident was in bed and awake. No activity opportunities were noted at the bedside. During an interview, on 1/31/24, Activity Staff 11 indicated Resident K refused to come out of the room for any activities. She had brought the resident whipped cream from the morning group activity of making strawberries and whipped cream because the resident refused to come out of the room and did not want any strawberries. During an observation, on 2/1/24 at 11:39 a.m., 1:30 pm, and 1:53 pm, Resident K was observed awake in bed with no television, music, reading material, puzzles, or games in the room. No staff members were observed in Resident K's room. A television was playing in the common area. During an observation, on 2/2/24 at 10:00 a.m., the resident was awake in bed with no television, music, or visible activity materials at the bedside. Activity Staff 11 was with the other residents in	F 0679	Deficiency ID: F 679 Activities Meet Interest/Needs Each Resident 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a Resident K had an updated Activity Assessment completed on her return to facility on 2/16/202, with input from her temporary guardian and mother. Resident K stated interest in Christian music, spiritual readings, and coloring. Resident K prefers independent activities at this time. Resident K has a TV, radio, and coloring books and coloring pencils in her room. Resident K was added to 1 on 1 activities 3 times weekly. Resident K is invited to group activities daily. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents on the dementia unit have the potential to be affected by alleged deficient practice. b Activity Assessments were reviewed for all residents on the dementia unit for current activity preferences. c Activity Staff, Department	02/26/2024

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	the common area listening to gospel music. Activity Staff 11 read a story from chicken soup for the soul after the music. During an observation, on 2/2/24 at 10:33 a.m., Activity Staff 11 was starting Bingo in the dining room. No staff members were observed going into Resident K's room. During an observation, on 2/2/24 at 11:56 a.m., Resident K was in her room with no activities or stimulation observed. The clinical record for Resident K was reviewed on 2/1/24 at 4:16 p.m. The diagnoses included, but were not limited to, catatonic disorder due to known physiological condition, paranoid personality disorder, schizophrenia, cognitive communication deficit, and encounter for screening for global developmental delays (milestones). A care plan with a problem category for activities indicated Resident K had a television in her room to watch, a stuffed animal, and had worked in laundry in the past. Interventions included, but were not limited to, provide support/assistance for in-room activity opportunities as needed, provide sensory stimulation as needed, provide activities in a setting which meets the resident's needs (small group, large group, in-room, outdoors), provide linens to fold, and to provide large print materials as needed. A care plan with a problem category for psycho-social well-being had interventions which included, but were not limited to, invite the resident to small groups and/or provide 1:1 interaction as desired.		Managers, and nursing staff on the dementia unit will be educated on activity calendar, resident's activity assessments, and location of activities. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a Activity Staff, Department Managers, and nursing staff on the dementia unit will be educated on activity calendar, resident's activity assessments, and location of activities. b Guardian Angel's will ensure residents activity preference are available to them daily during rounds. 4 How the corrective action will be monitored to ensue the alleged deficient practice will not recur, what quality assurance program will be put into place: a Activity Director/or designee will conduct weekly audits of 5 residents for 4 weeks, then 5 residents monthly times 3 months to ensure resident residing on the dementia unit is provided cognitively stimulating activities. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved.	

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	The activity notes, dated 1/30/24, 1/31/24, 2/1/24, and 2/2/24, indicated the resident refused group activity. The Electronic Health Record (EHR) did not include documentation of in-room individual activities or cognitive stimulation. There were no 1:1 activity visit documented in the electronic medical record. A nursing progress note, dated 2/5/2024 at 1:22 p.m., indicated Resident K was sent to the hospital for failure to thrive and mental health needs. During an interview, on 2/2/24 at 10:30 a.m., LPN 13 indicated Resident K refused to come out of her room and did not really interact with staff. LPN 13 did not know if Resident K had any activities in her room or if she wanted to have anything to do in her room. A current policy, titled "Activity Program," dated as revised on 8/22/23 and received from the Administrator on 2/6/24 at 2:54 p.m., indicated "...Individual activities will be offered to provide adequate opportunities to residents who prefer not to engage in a large or small group setting, but do not require a one-to-one delivery method. The Life Enrichment Department will provide support and materials as needed to facilitate individual activities. Individual activities will be facilitated in a way that reflects the Resident's individual needs and preferences related to activity and leisure pursuits. One-to-one activities (1:1 Visits) will be offered to provide adequate activity opportunities...." 3.1-33(a)		The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a cognitively impaired and dependent resident was safe from an injury of unknown origin (Resident F), failed to ensure a resident did not have vaping materials in the room (Resident 72) and failed to prevent recurring falls for a resident who was identified as a high risk to experience falls (Resident H) for 3 of 3 residents reviewed for accidents. The deficient practice resulted in Resident F sustaining a left arm fracture. Findings include: 1. During an observation, on 2/1/24 at 12:01 p.m., Resident F was sitting up in a wheelchair in the dining room, a Hoyer pad was under the resident and there was a splint on the left upper arm. A Facility Reported Incident (FRI), dated 1/9/24, indicated a Certified Nursing Aide (CNA) had reported to the charge nurse Resident F had a bruise on the left elbow and was complaining of pain. The resident was assessed, and an order was obtained to send the resident to the Emergency Room (ER) for an evaluation. The resident had an injury of a left distal humerus fracture (the largest bone of the arm). The	F 0689	**Deficiency ID: F 689** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident F has had no further falls Resident 72 has discharged from the facility Resident H has had no further falls 2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Newly admitted residents will be considered at risk for falls and a basic fall care plan will be implemented upon admission to minimize risks Fall audit will be completed for the past 90 days to ensure interventions are in place, care plans and resident profiles updated with fall interventions.	02/26/2024

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	follow-up on the incident report included the resident was returned to the facility with a splint to the left arm. The follow-up incident report did not include documentation to show the facility completed an investigation of the injury or the facility had identified the root cause of the injury. The clinical record for Resident F was reviewed on 2/1/24 at 4:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, a fracture of the shaft of the humerus in the left arm, a history of falling, recurrent major depressive disorder, unsteadiness on feet, a cognitive communication deficit, restless leg syndrome, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/12/23, indicated the resident had a Brief Interview for Mental Status (BIMS) of 00 which indicated a severe cognitive impairment. The resident was totally dependent on staff for transfers to and from a chair to the bed, totally dependent on staff to propel in the wheelchair, totally dependent on staff to shower, totally dependent on staff to get dressed, and totally dependent on staff to eat. A care plan, dated 2/28/22 and last revised on 2/2/24, indicated the resident was at risk for falls due to decreased cognition, safety awareness, and a history of falls. The goal included the resident would be free of falls with injury. The approaches included, but were not limited to, the bed would be in the lowest position 2/2/24, the wheelchair would have anti rollbacks 7/17/23, a bolster mattress for the bed 2/17/23, to lay the resident down after lunch 2/23/23, and to encourage the resident to be up for breakfast each		Smoking policy reviewed with residents who smoke 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be educated on Fall prevention process to include: Policy and Procedure Immediate fall interventions for use to minimize the risk of falls and fall related injuries Documentation requirements and expectations following an event/fall Ensuring fall interventions are in place Facility staff to be educated on smoking policy Falls will be discussed in daily clinical meeting to ensure fall review is complete, interventions are appropriate, and documentation is complete. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: DON/designee will perform fall audits Monday-Friday x 4 weeks, then 3x weekly x 4 weeks; then weekly x 4 weeks and reviewed in QAPI meeting monthly x 3 or until committee determines that substantial compliance has been achi	

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	morning 12/7/22. A care plan, dated 2/28/22 and last revised on 1/29/24, indicated the resident had a need for assistance with activities of daily living (ADL) including hygiene, dressing, grooming, toileting, transfers, bed mobility, eating and locomotion related to the diagnosis of dementia, muscle weakness, re-current urinary tract infections, and a history of Covid-19. The approaches included, but were not limited to, cue, set up, supervise, and assist as needed with eating, toileting and transfers. The care plan did not include the Quarterly MDS information, dated 12/12/23, of the resident being totally dependent on staff for transfers to and from a chair to the bed, to propel in the wheelchair, to shower, to get dressed, and to eat. A hospital service note, dated 1/9/24, indicated the resident presented from an extended care facility with the Emergency Medical Services (EMS) for an evaluation of a fall. The history was obtained by the EMS. The facility did not call the hospital to provide the history of the injury. The resident reportedly had a fall believed to be 2 days ago and was unwitnessed. The resident had pain in the left arm and was holding it close to the body. There was pain in the distal humerus with bruising posteriorly (behind) with the soft tissue. The resident was holding the arm flexed and pronated (turned so the palm was facing downward or inward) and unable to assess range of motion. The resident also had pain in the left wrist and tenderness in the left hip. Differential considerations were broad and included a mechanical fall, chronic gait disturbance, medication side effects, and many others. The facility was updated. The resident was discharged			

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	back to the facility, was to wear the splint, and to not remove the splint or get it wet. An x-ray report, dated 1/9/24, indicated the impression was a distal (close to the elbow) humerus (the long bone which runs from the shoulder to the elbow) fracture. During an interview, on 2/1/24 at 3:44 p.m., the Administrator indicated there was no written conclusion on the FRI. No one could explain the bruising and the injury to the resident's arm. The facility did not have cameras. The staff who worked on the dementia unit were interviewed and no staff had observed a fall for the resident. During an interview, on 2/1/24 at 3:45 p.m., the Director of Nursing (DON) indicated Resident F required the assistance of two staff for transfers and was not able to propel the wheelchair independently. There were no staff who had witnessed the resident trying to get up independently during the time frame prior to the injury. The DON had ruled out abuse as a root cause of the injury since there were no finger marks on the resident's skin or changes in the resident's psychosocial well-being. It was typical for the resident to be grumpy, a loner, holler out, not wanting to be changed and not liking to be provided with any care. The DON suspected the resident had a fall but was not able to provide sufficient documentation to corroborate the suspicion. The resident's bruising was more consistent with a fall or the resident bumping her arm and not from abuse. During an interview, on 2/2/24 at 3:50 p.m., the Clinical Support Nurse indicated abuse was ruled out because skin assessments for the resident and other residents did not show finger marks and			

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	abusers usually leave finger marks. A bruise on the resident's elbow would not be typical unless someone grabbed the resident and then there would be finger marks or something different. The Clinical Support Nurse did not have written documentation of the outcome of the FRI. 2. During an observation, on 1/31/24 at 10:19 a.m., Resident 72 had two vapes (battery-powered device used to inhale an aerosol) in his room on his bed. The clinical record for Resident 72 was reviewed on 2/1/24 at 1:28 p.m. The diagnoses included, but were not limited to, cognitive communication deficit, brain injury without loss of consciousness, and attention-deficit hyperactivity disorder (ADHD). A Minimum Data Set (MDS) assessment, dated 1/12/24, indicated Resident 72 had current tobacco use. A document, titled "Admission Paperwork Signature HealthCARE", dated as revised on 5/15/23 and received from the Administrator on 2/2/24 at 11:50 a.m., indicated " ...Certain Items Are Not Allowed in Your Room, Ever ...Any type of smoking or vaping materials or items, including lighters ...." During an interview, on 2/1/24 at 1:42 p.m., Resident 72 indicated he did use his vape in his room occasionally. He did not use cigarettes. He was not sure if he was supposed to use the vape in his room or not. During an interview, on 2/2/24 at 9:45 a.m., the Administrator indicated nobody vapes in the facility, and nobody should have a vape in their room or be using it in their room.			

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	During an interview, on 2/6/24 at 4:15 p.m., the Clinical Support Nurse indicated the resident was not smoking when he was readmitted on 1/5/24.3. During an interview, on 1/30/24 at 10:36 a.m., Resident H indicated she had fallen many times and was afraid of falling out of the bed again. The clinical record for Resident H was reviewed on 1/31/24 at 4:47 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following a CVA (cerebrovascular accident or stroke) affecting the left non-dominant side, contracture of the left hand, altered mental status, TIA (transient ischemic attack is a brief stroke like attack), abnormal posture, repeated falls, muscle spasms, sciatica, peripheral vascular disease (narrowed blood vessels in the limbs), and a history of falling. An annual Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was totally dependent with transfers requiring two persons to assist. A. An interdisciplinary team fall review progress note, dated 7/24/23 at 3:20 p.m., indicated a fall occurred on 7/22/23. The resident was found on the floor next to the bed. The resident stated she slid off the bed. The new intervention was to evaluate a low air loss mattress with bolsters. A fall event report, dated 7/31/23 at 11:59 a.m., indicated the resident had a fall on 7/22/23 with no injuries. The resident slid off the low air loss mattress. She was in her room and fell from the left side of the bed. The fall was unwitnessed. B. A fall event report, dated 11/28/23 at 9:50 a.m., indicated the resident fell from the shower bed in			

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	the shower room. She sustained a skin tear on her head and right elbow. The resident complained of pain in the right elbow and had a headache. A progress note, dated 11/28/23 at 10:00 p.m., indicated at approximately 9:15 a.m., the nurse was called to the shower room by the QMA (Qualified Medication Aide) due to the resident having a fall. The resident was laying on the floor on her right hip with her right leg extended and bilateral arms supporting her head. Bleeding was noted to the right elbow. The resident complained of neck, head, right shoulder, and right arm pain. Bruising, swelling, and lacerations were noted to the right eye with minimal bleeding. A skin tear to the right elbow was noted with a moderate amount of bleeding. Emergency Room discharge instructions, dated 11/29/23 at 7:18 a.m., indicated the diagnosis for the emergency room visit was a ground-level fall, contusions with multiple sites, and a skin tear to right elbow without complications. A progress note, dated 11/29/23 at 11:00 a.m., indicated the resident returned from the hospital. The resident was seen due to a fall with contusions and a skin tear to the right elbow. An interdisciplinary fall review progress note, dated 11/29/23 at 1:10 p.m., indicated the resident had a fall on 11/28/23. The resident rolled off the shower bed onto the floor. A skin tear was noted on the right elbow. The resident was sent to the emergency room. The new interventions were to have showers in the shower chair or a bed bath. A root cause analysis, dated 11/29/23, indicated an event was to be investigated and to gather preliminary information for a fall from the shower			

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	bed for Resident H. Resident H was lying on the shower bed, the Certified Nursing Assistant (CNA) 12 walked away from the resident to get supplies and the resident rolled off the shower bed. The identified contributing factors was the resident was too large for the shower bed and CNA 12 did not have supplies ready before the shower. The root causes identified were CNA 12 walked away from the resident without engaging the side rails, did not lock the wheel on the shower bed, should have used a shower chair due to the resident being too large for the shower bed, and did not have supplies ready prior to starting the shower. The changes to be implemented were staff to offer a shower in the shower chair or a bed bath only and staff education. An investigation statement, not dated and timed at 9:15 p.m., indicated RN 7 was called to the shower room related to the fall. The shower bed was unlocked, and the bilateral sides were down. The bed was dry and there was no water involved. An investigation note, not timed or dated, indicated the DON (Director of Nursing) had spoken with the resident regarding the events with the fall. The resident indicated CNA 12 took her to the shower room in her wheelchair and transferred her without any assistance. The resident had a bowel movement, CNA 12 rolled her onto her side towards the wall to clean her up, and the resident noted the side rail was down. CNA 12 diverted her attention away from her to get towels and wash cloths as she felt the bed slide away from the wall and she went rolling to the ground. A termination notice, dated 12/6/23, indicated CNA 12 was terminated, on 12/6/23, due to conduct and behavior. CNA 12 failed to follow			

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	policy and procedure related to the care plan. The termination notice was completed via telephone, on 12/6/23. During an interview, on 2/05/24 at 11:49 a.m., the DON indicated CNA 12 was bathing the resident on the shower bed, turned away from the resident to get linens, and the resident fell off the bed. She now receives a bed bath due to the resident being afraid of falling in the shower. C. A progress note, dated 12/15/23 at 9:15 p.m., indicated the resident arrived at 8:35 p.m. today on a stretcher by ambulance. The resident transfers with 2 assists with a mechanical lift. The resident's bed mobility was extensive assist of one. An emergency department note, dated 1/30/24, indicated the resident arrived via ambulance for evaluation after a mechanical fall. The resident indicated she slipped getting out of bed this morning. She was found by the staff immediately. Steri-strips had been placed on her upper extremities. The resident stated she thought she hit her head. She complained of pain to the entire left side. The exam indicated the head had scuffs and abrasions without lacerations to the head. The extremities had lacerations and steri-strips which had been applied to the bilateral forearms. A fall event report, dated 1/31/24 at 9:59 a.m., indicated the resident had a fall off the left side of her bed in her room. The injury was located on her head. The intervention put into place was mats to both sides of the bed and the bed should be placed in the low position. A wound management detail report, dated 1/31/24 at 10:05 p.m., indicated the resident had a skin tear on the left elbow, identified on 1/30/24 at 8:50 a.m.,			

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	which measured 3 centimeters (cm) by 4 cm. A wound management detail report, dated 1/31/24 at 10:06 p.m., indicated the resident had a skin tear on the right ring finger, identified on 1/30/24 at 8:50 a.m., which measured 0.3 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:07 p.m., indicated the resident had a skin tear on the right wrist, identified on 1/30/24 at 8:50 a.m., which measured 1 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:08 p.m., indicated the resident had a skin tear on her right hand, identified on 1/30/24 at 8:50 a.m., which measured 1 cm by 0.5 cm. A wound management detail report, dated 1/31/24 at 10:09 p.m., indicated the resident had a skin tear on her right hand, identified on 1/30/24 at 8:50 a.m., which measured 1.2 cm by 1 cm. A wound management detail report, dated 1/31/24 at 10:10 p.m., indicated the resident had a skin tear to the right hand measuring 1.3 cm by 1 cm. During an observation, on 2/02/24 at 3:20 p.m., the resident was laying in the bed with the head of the bed elevated and her eyes closed. The resident had a low air loss mattress with bolsters and the bed was in a low position with mats on both sides. The bolsters on the bed were snuggly against the resident's arms without room to roll in the bed. During an interview, on 2/05/24 at 11:54 a.m., the Administrator indicated the resident had requested a regular mattress and not an air mattress due to the air mattress scaring her. She did not feel safe. They had not assessed her for a bariatric bed.			

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	During an interview, on 2/05/24 at 12:23 p.m., the DON indicated the resident was eating breakfast in her room, on 1/30/24, and had a body pillow to her left side. When the staff discovered her fall, the resident indicated to staff she was not sure how she fell. She also indicated they had ordered a bariatric bed. A current policy, titled "Falls," dated as last revised 9/15/23 and received from the Administrator on 2/6/24 at 2:53 p.m., indicated "...the intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls...all residents will have a fall risk assessment on admission/readmission, quarterly, annually, and with a significant change of condition to identify risk for falls...a Comprehensive Care Plan will be implemented based on the resident's risk for falls with an individual goal and interventions specific to each resident to reduce the risk of avoidable falls...the care plan will be reviewed following each fall, quarterly, annually and with a significant change in condition...care plan goals and interventions will be revised as applicable, with each review. The interdisciplinary team which includes the director of nursing or their designee reviews during the at-risk meeting as applicable...falls maybe reviewed at the facility quality assurance/performance improvement committee...." A current policy, titled "Assisting with Transfers to/from a Shower/Tub," dated 2021 and received from the Administrator on 2/5/23 at 1:30 p.m., indicated "...this checklist identifies the steps needed to assist a person with transfers to and from a shower or tub...it also provides rationales			

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	to explain why these steps are performed...gather supplies...check your state and agency policies before performing task to ensure it is within your scope of practice...." A current policy, titled "Abuse, neglect and Misappropriation of Property," dated as last revised on 9/15/22 and received from the Administrator upon entrance, indicated "...It is the organizations intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident residing in the facility...Definitions...Injury of Unknown Source...This means an injury that meets both of the following conditions: [1] the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident...[2] the injury is suspicious because of the extent of the injury, or the location of the injury...Such occurrences will be investigated by the Administrator, Director of Nursing, or designee as outlined below in the investigation guidelines...Investigating Guidelines...The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute 'allegations of abuse', 'injuries of unknown source'...as defined in this document. The Facility			

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	Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident...The investigation should be documented...The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents...." This citation relates to Complaints IN00423010, IN00425810 and IN00427356. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives			

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	one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to provide incontinence care for 1 of 3 residents reviewed for activity of daily living (ADL) care. (Resident 47) Finding includes: During an observation, on 1/31/24 at 10:41 a.m., Resident 47 was sitting in a high back wheelchair in the common area. The resident's pants were soaked in the front and going down his right side. The resident was agitated and repeatedly tried to stand up. During an observation, on 1/31/24 at 11:17 a.m., the Activity Director asked the resident if he wanted to go to the activity room. The Activity Director was unaware the resident was wet. The clinical record for Resident 47 was reviewed on 2/1/24 at 2:06 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, anxiety disorder, and depressive disorder.	F 0690	**Deficiency ID: F 690** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 47 will be provided incontinence care every 2-3 hours and as needed. 2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents with incontinence are potentially at risk. Audit completed to identify residents with potential for incontinence. Resident profiles updated to reflect potential for incontinence. Nursing staff will ensure all incontinent resident are provided	02/26/2024

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	A care plan, dated 5/11/23, indicated the resident had a potential for complications associated with urinary and bowel incontinence such as skin breakdown and urinary tract infections (UTI). Interventions included, but were not limited to, checking the resident for incontinent episodes and to provide peri care after each incontinent episode. A care plan, dated 5/10/23, indicated the resident was at risk for pressure injury. Interventions included, but were not limited to, check and change every 2-3 hours, provide incontinence care after incontinence episodes, and turn every 2-3 hours. A care plan, dated 1/13/23, indicated the resident was at risk for skin integrity. Interventions included, but were not limited to, providing incontinence care when needed. A quarterly Minimum Data Set (MDS) assessment, dated 12/12/23, indicated Resident 47 was dependent on staff for toileting. During an interview, on 1/31/24 at 11:22 a.m., Certified Nursing Assistant (CNA) 2 indicated she was not taking care of the resident and did not know when the last time the resident was changed. During an interview, on 1/31/24 at 11:23 a.m., CNA 3 indicated she was working on the other hall and assisting with Resident 47. The resident was most likely changed when he got up and he would get up early between 7:00 a.m., to 7:30 a.m. The residents needed to be checked and changed every 2 hours and when needed.		with incontinence care every 2-3 hours and as needed. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff have been educated regarding incontinence care and the requirement to provide incontinence care every 2-3 hours and as needed. Resident profiles updated to reflect potential for incontinence. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: DON/designee will monitor incontinence care for 10 random residents 3 x weekly for 4 weeks, then weekly x 4 weeks then monthly x 3 months. Results of audit will be shared during QAPI meetings until substantial compliance has been determined by the QAPI committee.	

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	During an interview, on 1/31/24 at 11:30 a.m., CNA 4 indicated she was assigned to Resident 47 and was taken off another hall at 9:00 a.m. to work on Resident 47's hall. When the CNA started working at 9:00 a.m., she started to give other residents showers and did not change the resident. CNA 4 indicated the policy for incontinence care was to check every 2 hours. During an interview, on 2/1/24 at 4:44 p.m., the Director of Nursing (DON) indicated residents should be checked every two hours and changed when needed. A Certified Nursing Assistant (CNA) job description, dated 12/2011, indicated the CNA was to provide personal care including, but not limited to, grooming, bathing, dressing, and oral care of the residents daily and as needed. A current policy, titled "Activities of Daily Living (ADLS)," dated 9/15/23 and received from the Administrator on 2/2/24 at 9:08 a.m., indicated "...Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility provides the necessary care and services...Direct healthcare staff will assist, support and encourage the resident...Bathing, Grooming, Eating, Toileting, Bed Mobility, Transfers...For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of cares...." 3.1-38(a)(2)(C)			
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			

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	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 record review and interview, the facility failed to recognize significant weight changes, complete re-weights, implement timely interventions, and to make notifications to the physician and resident representative for 3 of 5 residents reviewed for nutrition. (Resident F, L and J) Findings include: 1. The clinical record for Resident F was reviewed on 2/1/24 at 4:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, unspecified protein-calorie malnutrition, dysphagia (difficulty swallowing), type 2 diabetes mellitus, and recurrent major depressive disorder. The resident had the following weights: a. On 12/8/23, the weight was 140.1 pounds. b. On 1/3/24, the weight was 112.2 pounds which	F 0692	Deficiency ID: F 692 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents in sample (F, L, and J) were anonymous. 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: Any resident with a significant weight change (gain/loss) will be identified when scheduled weight is obtained (daily/weekly/monthly) Any resident with a significant weight change (gain/loss) will be reweighed for accuracy and if	02/26/2024

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	was a 19.91% significant weight loss in 26 days. c. On 1/16/24, the weight was 129.5 pounds which was a 15.42% significant weight gain in 13 days. d. On 1/25/24, the weight was 132.5 pounds which was still a 5.42% significant weight loss from the weight on 12/8/23 of 140.1 pounds. The resident did not have a re-weight documented in the clinical record after the significant weight changes on 1/3/24, 1/16/24 and 1/25/24. A facility event, dated 1/4/24, indicated the Registered Dietitian (RD) recommended a supplement of med pass 30 ml two times daily and to weigh weekly. The physician and the family were notified. A physician's order, dated 1/10/24, indicated to offer 30 milliliters (ml) of med pass supplement twice daily. A physician order, dated 1/10/24, indicated to weigh the resident weekly. The resident did not have a weight documented for the week of 1/10/24. The order for the weekly weights was not implemented until 12 days after the RD made the recommendation. A RD note, dated 1/25/24 at 10:20 a.m., indicated the resident was nutritionally at risk. The weight was up three pounds in 9 days and down one pound in 181 days. The resident received adequate nutrition. The RD note did not include the significant weight changes from 1/3/24 to 1/16/24 with the significant weight gain.		accurate MD, RD, and resident/family will be notified of significant change. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Facility staff educated on policy titled “Resident weight documentation” to ensure accurate weights are being obtained. Facility staff educated on form titled “9 steps to an accurate weight” and the policy titled “Weighing and measuring height”. Weight scale calibrations are up to date per facility policy. Residents determined to have a significant weight change are ordered weekly weights for increased monitoring and to ensure weights are accurate. RD has assessed and documented on residents with documented significant changes. Family and physician were notified. Care plans updated per policy. The facility has added method of weighing each resident on the resident medical record. Residents with significant weight loss will be followed in IDT risk meetings to ensure timely interventions are in place and supplements are provided as ordered and amount consumed being recorded.	

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	The physician and the family representative were not notified of the significant weight change on 1/16/23. During an interview, on 2/2/24 at 4:02 p.m., the Director of Nursing (DON) indicated the weekly weights did not get entered until 1/10/24 so a weight was not done until 1/16/24. The Registered Dietician had recommended weekly weights on 1/4/24 and the facility waited until the physician gave the order for the weekly weights until they were completed. The nutrition at risk (NAR) would only be added for 30, 60 and 90 days. If the significant weight change occurred earlier than 30 days, then the resident would not be added to the NAR. 2. The clinical record for Resident L was reviewed on 2/1/24 at 10:11 a.m. The diagnoses included, but were not limited to, dementia with agitation, anxiety disorder, severe protein-calorie malnutrition, dysphagia (difficulty swallowing), and generalized anxiety disorder. A care plan, dated 2/2/21, indicated the resident had a potential for nutritional risk related to the diagnoses of dementia, dysphagia, and the use of a mechanically altered diet. The approaches included, but were not limited to, the RD to assess the resident's nutrition status and make appropriate recommendations as needed. The resident had the following weights: a. On 11/2/23, the weight was 94.1 pounds. b. On 11/7/23, the weight was 101.3 pounds which was a 7.65% significant weight gain of 7.2 pounds in 5 days. c. On 11/28/23, the weight was 100.7 pounds. d. On 12/8/23, the weight was 95.1 pounds which		4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: DON/designee will monitor resident weights weekly x 8 weeks and will notify RD/MD of any significant changes. Residents with significant changes will be followed by IDT Risk members. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and approval of the facility QAPI committee.	

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	was a 5.56% significant weight loss from 11/28/23. There was no re-weight after the significant weight gain on 11/7/23 documented in the clinical record. A RD progress note, dated 11/28/23, indicated the residents most recent weight was up 5 pounds in 28 days which was a gain of 5.7%. The resident continued weekly weights and current nutrition interventions. The RD progress note was 21 days after the significant weight gain on 11/7/23. A facility event, dated 12/28/23, indicated the resident had a weight loss. Labs and a speech therapy referral were ordered. The event was entered 20 days after the significant weight loss on 12/8/23. 3. The clinical record for Resident J was reviewed on 2/1/24 at 12:16 p.m. The diagnoses included, but were not limited to, unspecified dementia with other behavioral disturbance, dysphagia, unspecified protein-calorie malnutrition, and a psychotic disorder with delusions due to a known physiological condition. The resident had the following weights: a. On 12/8/23, the weight was 158.3 pounds. b. On 1/3/24, the weight was 138.8 pounds which was a significant 12.32% weight loss in 25 days. c. On 1/16/24, the weight was 147.3 pounds which was a 6.12% significant weight gain in 13 days. The re-weight for the significant weight loss was not completed after 1/3/24 until 13 days later, on 1/16/24.			

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	A nutrition progress note, dated 1/16/24 at 1:37 p.m., indicated the resident's January weight indicated a weight loss in 28 days. The RD recommended the resident was re-weighed as a nursing measure and to increase the 2 Cal supplement from 60 ml twice daily to 120 ml twice daily. The RD nutrition note, and recommendations occurred 13 days after the significant weight loss and then did not acknowledge the significant weight gain from 1/3/24 to 1/16/24. During an interview, on 2/2/24 at 4:11 p.m., the DON indicated the resident was not seen by NAR since the computer did not pick up the resident's significant weight changes. There were no re-weights documented in the electronic record. A current policy, titled "Weighing and Measuring Height," dated 3/22/22 and received from the DON on 2/1/24, indicated "...Resident's weight will be obtained and documented int the EMR [electronic medical record] upon...Admission and weekly x 2...Re-admission...Monthly...Physician order...As needed...Notify the Charge Nurse, Physician, Registered Dietician, responsible party/resident of any significant weight loss or gain...Significant weight changes are considered significant changes in condition and require facility staff assessment/intervention...1 month...5%...Greater than 5%...3 months...7.5%...Greater than 7.5%...6 months...10%...Greater than 10%...In order to accommodate timely notification of changes, a schedule for weighing residents will be established and followed...Facility staff will notify the Charge Nurse and Registered Dietician of 5% gain or loss...The Charge Nurse will...Recheck weight...notify physician of weight			

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	change...Evaluate cause of change...Outline plan for at least weekly weight, if indicated...Notify physician of significant changes as noted...Notify resident or family of significant changes as noted...." 3.1-46(a)(1)			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview and record review, the facility failed to provide appropriate treatment, interventions, and psychiatric services for a resident diagnosed with a mental disorder for 1 of 5 residents reviewed for behavioral-emotional health. (Resident K) Finding includes: During an observation, on 1/30/24 at 1:19 p.m., Resident K was lying on her back, in bed, wearing only a hospital gown and incontinence brief. There were stains on the front of the gown, a noticeable mustache, and long chin hairs. There was no television or music present in the room. Resident K was staring at the ceiling and nodding her head up and down.	F 0742	Deficiency ID: F 742 Treatment/Services Mental/Psychosocial Concerns 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practices: a Resident K was admitted to the Witham Health Services on 2/05/2024. Resident K received a psychiatric consultation and work up on 2/06/2024. Resident K received services for mental health through 2/15/2024. Resident K returned to the facility on 2/16/2024, with orders to continue	02/26/2024

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	During an observation, on 1/31/24 at 11:55 a.m., Resident K was lying on her back, in bed, wearing a stained hospital gown, an incontinence brief, and no pants or socks. During an observation, on 1/31/24 at 12:06 p.m., Resident K was in bed and awake. No activity opportunities were noted at the bedside. Resident K was talking quietly with no one else present in the room. During an interview, on 1/31/24, Activity Staff 11 indicated Resident K refused to come out of the room for any activities. She had brought the resident whipped cream from the morning group activity of making strawberries and whipped cream because the resident refused to come out of the room and did not want any strawberries. During an observation, on 2/1/24 at 11:39 a.m., Resident K was in bed, awake, with no activities or stimulation observed in the resident's room. One small pink stuffed animal was seen on the resident's bedside table. Resident K had no television, music, reading material, puzzles, or games at the bedside. She was nodding her head back and forth. There was a drink and applesauce at the bedside with no spoon. During an observation, on 2/1/24 at 1:30 p.m., Resident K was in bed, awake, with no activities or stimulation observed in the resident's room. One small pink stuffed animal was seen on the resident's bedside table. Resident K had no television, music, reading material, puzzles, or games at the bedside. She was nodding her head back and forth. During an observation, on 2/1/24 at 1:53 p.m.,		weekly psych services at facility. Resident was seen 2/23/2024 by in house psych NP, Cheryle Davis-Land. 2 How other residents having the potential to be affected by the same alleged deficient practices will be identified and what corrective action will be taken: a All residents with a mental disorder have the potential to be affected by the alleged deficient practice. b All residents with a mental disorder were reviewed to ensure they were receiving appropriate treatment, interventions, and psychiatric services. 3 What measures will be put into place and what systemic changes will be made to ensue that the alleged deficient practice does not recur: a CEO/or designee will educate SSD/Activity Director/Transition Nurse/IDT on mental disorders and Behavioral Management policy by 2/26/2024. b IDT will review all new admission daily, Monday – Friday in clinical meeting for a mental disorder and refer to psych services for evaluation. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place:	

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	Resident K was seen awake, in bed, wearing a hospital gown and incontinence brief with no television, music, reading material, puzzles, or games in the room. She was nodding her head back and forth. During an observation, on 2/2/24 at 10:00 a.m., the resident was awake in bed with no television, music, or visible activity materials at the bedside. Activity Staff 11 was with the other residents in the common area listening to gospel music. Activity Staff 11 read a story from chicken soup for the soul after the music. During an observation, on 2/2/24 at 10:33 a.m., Activity Staff 11 was starting Bingo in the dining room. No staff members were observed going into Resident K's room. During an observation, on 2/2/24 at 11:56 a.m., Resident K was in her room with no activities or stimulation observed and only a small pink stuffed animal on the bedside table. She was wearing a clean hospital gown, incontinence brief, and no pants or socks. The clinical record for Resident K was reviewed on 2/1/24 at 4:16 p.m. The diagnoses included, but were not limited to, catatonic disorder due to known physiological condition, paranoid personality disorder, schizophrenia, need for assistance with personal care, cognitive communication deficit, and encounter for screening for global developmental delays (milestones). A care plan with a problem category for activities indicated Resident K had a television in her room to watch, a stuffed animal, and had worked in laundry in the past. Interventions included, but		a CEO/designee will conduct weekly audits of 5 residents for 4 weeks, then 5 residents monthly times 3 months to ensure residents with mental disorder are receiving appropriate treatment, interventions, and psychiatric services. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	were not limited to, provide support/assistance for in-room activity opportunities as needed, provide sensory stimulation as needed, provide activities in a setting which meets the resident's needs (small group, large group, in-room, outdoors), provide linens to fold, and to provide large print materials as needed. A care plan with a problem category for psycho-social well-being had interventions which included, but were not limited to, invite the resident to small groups and/or provide 1:1 interaction as desired. A care plan with a problem category for mood had interventions which included, but were not limited to, 1:1 with social services as needed and to consult with psychiatry/psychology as needed. The PASRR Level II, dated 12/4/23, listed the following, but were not limited to, required services: mental health services- individual therapy and outpatient treatment services, psychiatric evaluation, socialization/leisure/recreation activities, supportive counseling from the nursing facility staff, dementia workup, and a behaviorally based treatment plan. The PASRR indicated, according to APS (Adult Protective Services), Resident K had a history of catatonia (a group of symptoms which usually involved a lack of movement and communication, and could include agitation, confusion, and restlessness) and not eating and drinking when psychiatric symptoms were left untreated and had four medical admissions in the last two months due to medical trouble resulting in catatonia. A nursing progress note, dated 12/21/23 at 10:59 p.m., indicated Resident K refused her medicine			

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	and dinner. She was screaming and crying out "help, help, help me" since 8:00 p.m. The nursing progress notes indicated the same behavior continued throughout the day on 12/22/23. A progress note, dated 12/22/23 at 2:39 p.m., indicated the Social Services Director left a voice mail for Resident K's guardian to contact him at the guardian's earliest convenience regarding consent for psychiatric services and sent consent form for a signature. A history and physical, dated 12/28/23, indicated the physician had a plan for a psychiatric service consult for the management of schizophrenia, paranoid personality disorder, and developmental delay. A nursing progress note, dated 1/13/24 at 3:35 a.m., indicated Resident K was heard talking to herself and then loudly repeated a mantra of leave the door open for approximately one hour. An Interdisciplinary Team (IDT) Nutrition at Risk (NAR) review, dated 1/31/24 at 8:36 a.m., indicated the resident was being reviewed for weight loss. She was sporadic in her intakes. She was paranoid that her food had been poisoned. A nursing progress note dated 1/31/2024 at 11:21 a.m., the Minimum Data Set (MDS) Coordinator indicated she offered the resident her lunch tray in her room since she refused to come to the dining room. The resident requested her food be placed in bowls with lids. She removed each lid from the bowls and then refused to eat any of it. Typically, she would eat applesauce, but she refused that as			

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	well. The food was left at the bedside until the end of lunch. Two (2) other staff members offered her something different to eat, she refused, and then asked for the tray and bowls to be removed from her room. A nursing progress note, dated 2/2/24 at 11:43 a.m., indicated Resident K refused water, to be repositioned, to have her linen changed, and food. A vitals record indicated the following weights: a. On 12/19/23, the resident weighed 130.8 pounds. b. On 1/16/24, the resident weighed 108.5 pounds. c. On 2/2/24, the resident weighed 100.8 pounds. Resident K had refused to eat with little to no food intake documented for multiple dates from 12/21/23 until her discharge on 2/5/24. The electronic medical record did not include progress notes, an evaluation, or a history and physical for a psychiatric service provider. The facility did not provide any documentation psychiatric services were provided to Resident K. During an interview, on 2/2/24 at 10:30 a.m., LPN 13 indicated Resident K refused to come out of her room and did not interact with staff. She did not know if the resident had any activities in her room or if the resident wanted to have anything to do in her room. LPN 13 indicated the resident often refused medications unless they were sneaky when they gave medications to the resident. The resident just laid in the bed and refused most care. Staff had difficulty getting the resident to turn, to allow incontinence care, or to bathe. The resident had not eaten or drank very much at all for days. She really did not know what to do for the resident.			

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	During an interview, on 2/5/24 at 1:53 p.m., the DON indicated Adult Protective Services (APS) refused to sign a consent for psychiatric services so the facility could not get a psychiatrist to evaluate and treat Resident K. The facility had not been successful in obtaining a guardian for Resident K, so they could not get a consent signed. Resident K had signed her own admission forms. Both the Administrator and the DON indicated the resident had not received psychiatric services. They had decided to call APS to evaluate Resident K and the decision was made to transfer her to the hospital emergency room for failure to thrive, psychiatric services, and treatment to help with her behaviors. A nursing progress note, dated 2/5/2024 at 1:22 p.m., indicated Resident K was sent to the hospital emergency room for failure to thrive and mental health needs. A current policy, titled "Behavioral Health," dated as revised on 9/15/23 and received from the DON on 2/1/24 at 3:30 p.m., indicated "...Behavioral Health: encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders." 3.1-43(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §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			

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	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 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			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to provide a clinical rationale for not considering a gradual dose reduction (GDR), to ensure an as needed (prn) antianxiety medication was not ordered for longer than 14 days, and to assess a resident for abnormal involuntary movements (AIMS) when an antipsychotic was started for 3 of 5 residents reviewed for unnecessary medications. (Resident M, 52 and 72) Findings include: 1.The clinical record for Resident M was reviewed on 2/1/24 at 10:11 a.m. The diagnoses included, but were not limited to, dementia with agitation, anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and a psychotic disorder with delusions due to a known physiological condition. A care plan, dated 3/9/22, indicated the resident received psychotropic medications related to depression, anxiety and a psychotic disorder and was at a risk for adverse side effects. The approaches included, but were not limited to, drug reduction as recommended by the pharmacist or physician and to monitor the resident's mood and response to the medication. The care plan did not include the symptoms of the resident's psychotic disorder. A physician's order, dated 5/12/22, indicated to give divalproex (an anticonvulsant and mood stabilizer) 500 milligram (mg) twice a day for a psychotic disorder. A physician's order, dated 1/4/23 and open ended,	F 0758	**Deficiency ID: F 758** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident M – psych provider has provided clinical rationale and documentation for contraindication of gradual dose reduction Resident 52 is on palliative care and has been prescribed lorazepam PRN, order has been updated with a stop date of 14 days and will be reviewed by MD for renewal. Resident 72 is no longer in the facility 2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Psychotropic medication audit completed to assure all PRN medications have a 14 day stop date and will be reviewed for renewal by MD. Psychotropic medication audit completed to assure medications are reviewed for GDR and clinical rationale documented for any contraindications if applicable. Audit completed to assure all residents prescribed an antipsychotic medication have an	02/26/2024

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	indicated to give divalproex 500 mg twice daily for a psychotic disorder. The resident had been on the same dose of divalproex since 5/12/22 and no GDR had been completed on the medication. A psychiatry progress note, dated 8/22/23, indicated the resident was seen for psychiatric medication management for dementia and agitation. The resident had behaviors with occasional agitation, cursing and yelling at staff, was resistant to care and was easily redirected. The resident's perception included paranoid delusions and no hallucinations. The diagnosis included Alzheimer's disease with late onset, anxiety disorder due to a known physiological condition and unspecified psychosis not due to a substance or known physiological condition. The resident was not a harm to herself or to others. The psychiatry progress note did not include what the resident's paranoid delusions included. A psychiatry progress note, dated 9/21/23, indicated the resident's behavior was reviewed with the staff. The resident had behaviors with occasional agitation, cursing and yelling at staff, resistance to care and was easily redirected. The resident had no delusions and no hallucinations. A pharmacy note, dated 9/25/23, indicated the resident was reviewed during the behavioral team meeting for the current medications of buspirone (an antianxiety) 7.5 mg three times a day for anxiety, divalproex 500 mg twice daily for a psychotic disorder, mirtazapine (an antidepressant) 7.5 mg at bedtime, and sertraline (an antidepressant) 50 mg daily. A GDR was contraindicated by the psychiatric Nurse		abnormal involuntary movement scale observation completed on admission/start of medication and quarterly. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be educated on psychotropic medications policy and medication monitoring – medication management policy. Psych providers/pharmacist will be educated on need for proper documentation on clinical rationale for contraindications of gradual dose reductions of psychotropic medications. All new psychotropic medication orders and order changes will be reviewed in daily clinical meeting to assure all documentation is completed and accurate. All psychotropic medications will be reviewed in monthly behavior meeting to assure GDR policy is followed and contraindication is documented properly if applicable. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: DON/designee will perform psychotropic medication audits	

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	Practitioner (NP). The physician signed as agreed on 9/27/23. There was no clinical rationale given for the reason the GDR was contraindicated. The pharmacy note also did not indicate which medication was to be considered for the GDR. A care plan, dated 12/15/23, indicated the resident had been experiencing visual hallucinations. The resident had been talking to a person who was not there. The goal was for the resident to have few or no visual hallucinations. The approaches included, but were not limited to, frequent medication reviews to maintain the lowest dose requirements and the highest level of functioning. During an interview, on 2/6/24 at 11:17 a.m., the Dementia Unit Manager indicated the resident used to see things on the walls, used to be physically combative and now the resident would just use curse words and was no longer physically combative. During an interview, on 2/6/24 at 2:00 p.m., the Director of Nursing (DON) indicated the resident would talk and argue with herself in the room prior to being administered the valproic acid (divalproex) and now she just argued with real staff instead of someone imaginary in her room since she had been on the medication. During an interview, on 2/6/24 at 2:03 p.m., the Clinical Support Nurse indicated the provider would not complete a GDR on the valproic acid if the resident was stable on the medication even if the resident had been on the same medication for a couple of years. The clinical rationale for not completing the GDR was the resident was "stable".2. The clinical record for Resident 52 was		Monday-Friday x 4 weeks, then 3x weekly x 4 weeks; then weekly x 4 weeks and reviewed in QAPI meeting monthly x 3 or until committee determines that substantial compliance has been achieved.	

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	reviewed on 2/1/24 at 10:39 a.m. The diagnoses included, but were not limited to, fracture of the neck of the right femur, metabolic encephalopathy (delirium-an acute confusional state), contracture of the right elbow and hand, and depressive disorder. A physician's order, dated 12/27/23, indicated Lorazepam Intensol concentrate (a liquid medication for anxiety), to give 0.25 ml (milliliters) every 2 hours when needed (PRN) for anxiety and restlessness. The PRN Lorazepam Intensol concentrate order did not have a stop date. During an interview, on 2/1/24 at 3:20 p.m., the DON indicated when a resident had an order for PRN Lorazepam, there should be a stop date. The medication was only good for 14 days then the physician had to order the medication again and renew the order every 14 days.3. The clinical record for Resident 72 was reviewed on 2/1/24 at 1:28 p.m. The diagnoses included, but were not limited to, brain injury without loss of consciousness and cognitive communication deficit. A physician's order, dated 1/5/24, indicated the resident was on olanzapine (an antipsychotic medication)15 mg once a day. This was a new antipsychotic medication the resident was put on. A physician's order, dated 1/8/24, indicated to complete an abnormal involuntary movement scale (AIMS) assessment quarterly once a day on the 5th of January, April, July, and October. An admission observation report, with a scheduled date of 1/5/24 and a due date of 1/7/24,			

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	indicated the AIMS assessment was completed on 2/5/24 at 4:45 p.m. The AIMS assessment was not completed until 2/5/24 with a due date of 1/7/24. During an interview, on 2/6/24 at 12:01 p.m., the DON (Director of Nursing) indicated the AIMS assessment should have been done when he was readmitted on 1/5/24. A current policy, titled "Psychotropic Medications Policy," dated as revised on 10/19/22 and received from the Administrator on 2/2/24 at 9:09 p.m., indicated "...A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior...Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs...PRN orders for psychotropic drugs are limited to 14 days...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...." A current policy, titled "Medication Monitoring - Medication Management," dated as revised on 1/2023 and received from the Administrator on 2/2/24 at 9:08 p.m., indicated "...The required evaluation of a resident before writing a new PRN order for antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed...."			

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	A current policy, titled "Roles and Responsibilities of Each Discipline," not dated and received from the Administrator on 2/5/24 at 11:30 a.m., indicated "...Each discipline is instrumental to the success of the facility's Behavior Management Program, as each discipline allows for the resident to receive and comprehensive care...Complete AIMS assessment upon admission, and every 6 months...." 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were refrigerated when needed, medications were discarded when not in use and the packaging for controlled medication was not compromised for 2 of 3 carts reviewed for medication storage. (the dementia unit cart and the Rosewood North cart) Findings include: 1. During an observation of the dementia unit medication cart, on 2/2/24 at 10:53 a.m., with LPN 8, the following was observed: a. One (1) bottle of Lorazepam Intensol (an antianxiety medication) for Resident 75 was in the medication cart and not refrigerated. b. One (1) bottle of Lorazepam Intensol for Resident 5 was in the medication cart and not refrigerated. The bottle had a red sticker which indicated to keep the medication refrigerated. The clinical record for Resident 75 was reviewed on 2/6/24 at 10:00 a.m. The diagnoses included, but were not limited to, dementia, low back pain, major depressive disorder, and anxiety. A physician's order, dated 1/11/24 through 1/19/24, indicated to give Lorazepam Intensol 0.5 milliliter (ml) every 4 hours as needed for anxiety/restlessness. The clinical record for Resident 5 was reviewed on 2/6/24 at 10:15 a.m. The diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, and anxiety disorder. A physician's order, dated 11/17/23, indicated to	F 0761	**Deficiency ID: F 761** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 75 is no longer in the facility. Resident 5 – lorazepam bottle in cart was discarded and new bottle was ordered and has been refrigerated. Resident 70 is no longer in the facility. Resident 17 compromised medication was discarded, and order was discontinued. 2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All medication carts, rooms and refrigerators were audited for compromised medications and proper storage of medications. All medication carts, rooms and refrigerators were audited to ensure all discharged residents' medications were removed. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be educated	02/26/2024

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	give Lorazepam Intensol 0.5 ml every 6 hours as needed for anxiety. The Physician's Desk Reference (PDR) indicated Lorazepam Intensol should be stored refrigerated at 36 to 46 degrees Fahrenheit and to discard an opened bottle after 90 days. During an interview, on 2/24/24 at 10:57 a.m., LPN 8 indicated she did not see the sticker on the Lorazepam Intensol to keep refrigerated. Resident 75 had been gone from the facility for several weeks. She was not sure who was responsible for taking medications out of the cart when residents were no longer at the facility.2. During an observation of the Rosewood North medication cart, on 2/5/24 at 9:16 a.m., with QMA 6, the following was observed: a. On the back of the narcotic card of hydrocodone-acetaminophen (a controlled pain medication) 5/325 milligrams(mg) tablets for Resident 70, there was an opening in slot 4. b. On the back of the narcotic card of oxycodone/acetaminophen (a controlled pain medication) 10-325 mg tablets for Resident 17, there was an opening in slot 7. The clinical record for Resident 70 was reviewed on 2/5/24 at 10:00 a.m. The diagnoses included, but were not limited to, cognitive communication deficit, mood disorder due to known physiological condition with depressive features, bipolar disorder, and anxiety disorder. A physician's order, dated 1/22/24, indicated to give hydrocodone-acetaminophen 5/325 mg 1 tablet every 12 hours when needed. The clinical record for Resident 17 was reviewed on 2/5/24 at 10:15 a.m. The diagnoses included,		on Disposal of medication policy and Medication storage policy. All medications will be removed from medication carts, rooms and refrigerators upon discharge of a resident and returned to pharmacy or disposed of properly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: DON/designee will perform medication cart, room and refrigerator audits Monday-Friday x 4 weeks, then 3x weekly x 4 weeks; then weekly x 4 weeks and reviewed in QAPI meeting monthly x 3 or until committee determines that substantial compliance has been achieved.	

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	but were not limited to, chronic pain, atrial fibrillation, depression, and congestive heart failure. A physician's order, dated 7/26/24, indicated to give oxycodone/acetaminophen 10-325 mg 1 tablet every 4 hours when needed. During an interview, on 2/5/24 at 9:21 a.m., RN 7 acknowledged the narcotic cards were compromised on the back of the cards and indicated the slots were not taped. She instructed QMA 6 to give copies of the narcotic cards to the Director of Nursing (DON). During an interview, on 2/5/24 at 9:24 a.m., QMA 6 indicated he thought the policy was to destroy the medication and he would check the policy with the DON. A current policy, titled "Disposal of Medication," dated 1/23 and received from the Director of Nursing on 2/5/24 at 10:40 a.m., indicated "...Discontinued medications and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition...these controlled substances shall be disposed of by the nursing care center in the presence of appropriately titled professional...two licensed nurses employed by the nursing care center...Dispose of discontinued medication within 90 days of the date the medication was discontinued, unless it is reordered within that time and applicable per state...." 3.1-25(j) 3.1-25(o) 3.1-25(r)			

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure staff identified low dishwasher temperatures to ensure the dishwasher was cycling at the recommended temperature for 1 of 1 dishwasher reviewed. Finding includes: During an observation, on 2/2/24 at 10:32 a.m., Dietary 10 went to wash the puree bowl in the facility's low temperature dishwasher. The wash cycle reached a temperature of 116 degrees. During an interview, on 2/2/24 at 10:33 a.m., Dietary 10 indicated the wash cycle should reach	F 0812	Deficiency ID: F 812 Food Procurement, Store/Prepare/Serve-Sanitary 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practices: a Facility added a circulation pump that feeds the line to the dish machine and increased the hot water heater to the dish machine on 2/6/2024. b The Dietary Manager educated all Dietary Staff on Ware	02/26/2024

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	a temperature of 120 degrees and it looked like 120 degrees. Dietary 10 looked closer and indicated the temperature was 116 degrees. During an interview and observation, on 2/2/24 at 10:34 a.m., the rinse cycle came on and reached a temperature of 120 degrees. Dietary 10 indicated to "look", see it was temping at 120 degrees. The cycle was in rinse mode when it reached 120 degrees. The wash cycle only got up to 116 degrees. Dietary 10 did not identify the wash cycle had not reached the minimum temperature. Dietary 10 did not show any concern with the wash temperature and had to be asked to wash it again. It was not until the 5th time the dishwasher cycled that it reached 121 degrees. During an interview, on 2/2/24 at 10:37 a.m., the Dietary Manager indicated the dishwasher could take up to 3-4 cycles of running the machine to reach the minimum temperature. An education document, titled "Education on Dish Machine," received from the Administrator on 2/2/24 at 2:00 p.m., indicated "...As a HCSG employee, it is your responsibility to be knowledgeable in the proper technique for processing dirty dishes through the dish machine. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature and low temperature machines. Low Temp Machine - Wash and Rinse Temperature 120*F-140*F...." 3.1-21(i)(3)		Washing policy. 2 How other residents having the potential to be affected by alleged deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a Education provided to dietary staff related to correct temperature to run dish machine cycle completed by 2/26/2024. 4 How the corrective active will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a Audits will be completed by the Dietary Manager and/or designee related to dish machine temperature logs. Audits will be completed weekly times 4 weekly, then twice a month times 1 month, and then 1 time a month times 3 months. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial	

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			compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure toilet bolts were covered, walls were free from marks, scratches, peeled paint, gouges, and paint chips, cabinets were free from dirty towels and common area ceilings were free from black spots and uneven areas for 17 of 74 rooms and common area reviewed for environment. (Rooms 3, 4, 5, 6, 7, 9, 11, 14, 17, 18, 27, 28, 30, 58, 60, 71, 72) Findings include: During an environmental tour, beginning on 2/05/24 at 1:41 p.m., with the Administrator and the Plant Director, the following was observed: 1. Room 3's door to the bathroom had missing paint and gouges towards the bottom of the door. There was scattered white paint on the flooring and around the back of the wall towards the toilet and under the sink. 2. Room 4's bathroom had scale buildup and a leaking faucet. Paint was chipped along the floorboard. 3. Room 5's toilet paper holder was open and	F 0921	Deficiency ID: F912 Safe/Functional/Sanitary/Comfortable Environment 1 What corrective action will be accomplished for those residents found to have been affected by alleged deficient practices: a Concerns noted for Rooms 3, 4, 5, 6, 7, 9, 11, 14, 17, 18, 27, 28, 30, 58, 60, 71, and 72 were repaired. 2 How other residents having the potential to be affected by the same alleged deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alleged deficient practices. b All residents' rooms were reviewed to identify any damaged walls, missing toilet bolts covers, cabinets were free of dirty towels, uneven flooring, and that common	02/26/2024

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	hanging. The mirror had blackened edges. 4. Room 6's floor was buckled by the bathroom. The bathroom door had gouges with missing paint and the base of the toilet was not sealed with caulking. 5. Room 7 had gouges on the door frame outside of the room in the hallway. 6. The ceiling outside of Room 8 has some missing paint and appeared like part of the ceiling was not level with the rest of the ceiling. 7. Room 9 had a missing right bolt cover for the toilet and the bolt was sticking up about 2 inches. 8. Room 11 had no bedside tables in the room for either resident, bolt covers on both sides of the toilet were missing and the bolts were sticking up about one inch, the door to the bathroom had three spots of missing paint and about 3 inches of a horizontal gouge, gouges were on the walls behind both beds with missing paint, the door in the hallway had gouges and missing paint on the bottom panels, and the floors were uneven. 9. Outside of the door to Room 13, the flooring was missing about 1 inch and was unlevel. 10. Room 14's bathroom had a missing bolt cover on the left side with bolts sticking up about one inch. 11. Room 17 and 18's bathroom had a missing right bolt cover for the toilet and the bolt was sticking up about 2 inches. 12. Room 71 had missing bolt covers to the toilet on the right and left side and was sticking up		area ceilings were free from black spots and repairs and/or cleaning were completed. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a Education will be completed with all staff on the Tels system for notifying Maintenance of maintenance needs/requests by 2/26/2024. b Maintenance Team re-established the weekly routine maintenance repair/paint schedule beginning 2/26/2024. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a Audits will be completed by the Maintenance Director/or designee related to damaged walls, missing toilet bolt covered, dirty towels in cabinets, uneven flooring, and black spots on ceilings weekly for 4 weeks, then monthly for 3 months. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the	

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	about 2 inches. The door to the sink cabinet was wrapped and had a nail on the bottom of the door. A towel was under the sink which was white but covered in an unknown black substance. 13. Room 72 had a dip in the floor, the toilet tank was not sitting on the toilet properly, bolt covers were missing on the bottom of the toilet, the door had gouges, and the handrails outside of the room had missing varnish. 14. Room 27 had a hole in the front of the bathroom door and caps missing on the toilet bolts. There was a hole near the television. 15. Room 28's wall behind the head of the bed was missing paint and had gouges. 16. Room 30 had missing paint and gouges behind the bed, the toilet had a missing bolt cover and there were black spots on the ceiling. 17. Room 58 had missing paint and scuff marks behind the bed. 18. Room 60's door was scuffed up on the edges. 19. The common area had a large black spot with black dots on the ceiling near the exit door. During an interview, on 2/5/24 at 1:42 p.m., the Administrator and Plant Director indicated the facility was on a crawlspace so there were several areas in the building which were uneven. They were remodeling and repainting the walls. They were not sure what the towel under the sink had on it. The toilet bolts in all the rooms would be checked and replaced. A current policy, titled "Resident Rights," dated		right to modify or extend monitoring times according to outcomes.	

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	as last revised on 9/15/23 and received from the Administrator on 11/30/24 at 12:26 p.m., indicated "...All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life...." 3.1-19(f)(5)			