STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155743	A. BUILDING 00 B. WING	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, IN 47944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00391519. Complaint IN00391519 - Federal/State deficiencies related to the allegations are cited at F677, F727, and F921. Survey dates: March 5, 6, 7, 8, and 9, 2023. Facility number: 000288 Provider number: 155743 AIM number: 100287380 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 4 Medicaid: 21 Other: 2 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/14/23.	F 0000	This plan of correction is to serve as Greenhill Manor Nursing and Rehab Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenhill Manor Nursing and Rehab Center or its management company that the allegations contained in this survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure residents had a	F 0554	**What Corrective Action(s) Will Be Accomplished For Those**	04/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kiri Burks	HFA	03/27/2023

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	medication self- administration assessment completed for medications left at bedside and for administering their own medications for 3 random observations. (Residents 7 and 27) Findings include: 1. On 3/5/23 at 2:21 p.m., Resident 7 was observed sitting in his room. There was a plastic medicine cup on the bedside table with 3 different colored pills in it. The resident indicated they were Tums (anti-acid). On 3/8/23 at 10:39 a.m., Resident 7 was observed receiving medication during a medication pass with QMA 1. On the resident's bed, he had a package of wipes for his eyes and a bag that had eye drops in it. The QMA indicated the resident would wipe his eyes with the eyelid wipe and then a little later administer his eye drops himself. She was unsure if he had a self-medication administration assessment. The resident's eye drops were always left in his room. Record review for Resident 7 was completed on 3/6/23 at 3:51 p.m. Diagnoses include, but were not limited to, anemia, diabetes mellitus, hypocalcemia, gerd (gastro-esophageal reflux disease) and hypertension. The March 2023 Physician's Order Summary (POS) indicated the following: - Calcium Antacid Chewable; give 2 wafers by mouth every 4 hours as needed for acid reflux and give 2 wafers by mouth in the morning related to GERD (reflux) - OcuSoft Lid Scrub Plus Pad (Eyelid Cleanser); Apply to both eyes topically two times a day for eye care - TheraTears Solution; instill 1 drop in both eyes		**Residents Found To Have Been Affected By The Deficient Practice:** Resident 7 and 27 will not have any adverse effects related to this alleged deficient practice. Eye wipes and eye drops were removed from resident 7's room. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. All resident rooms were observed for medications and/or treatments left for self-administration with no negative findings. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All licensed/qualified nursing staff will be inserviced over Self-Administration of Medication and Medication Administration General Guidelines policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will observe 3 medication administrations at varying times on varying shifts	

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	four time a day for dry eyes There was no documentation to indicate a self-medication administration assessment had been completed for the medications. Interview with the DON at 3/8/23 at 3:58 p.m., indicated she could not find any documentation that a self-medication administration assessment had been completed. 2. On 3/7/23 at 1:17 p.m., Resident 27 was observed receiving medication during a medication pass with QMA 1. The QMA handed the resident an inhaler. The resident took the inhaler, shook it up, and administered 2 puffs simultaneously. The box of the inhaler was labeled Albuterol Sulfate (inhalant medication). The directions indicated to receive 2 puffs and to wait 1 minute between each puff. The QMA had not given any instructions to the resident about waiting 1 minute in between the puffs. Interview with the QMA indicated she had not instructed him to wait 1 minute in between puffs but should have. She was unsure if the resident had a self-medication administration assessment completed. Record review for Resident 27 was completed on 3/7/23 at 2:44 p.m. Diagnoses included, but were not limited to, hypertension and COPD (chronic obstructive pulmonary disease). The March 2023 POS indicated an order for Albuterol Sulfate; 2 puff inhale orally every 2 hours for COPD. There was no documentation to indicate a self-medication administration assessment had been completed for the medication.		during scheduled workdays weekly times 2 months, then every two weeks times 2 months, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and plan adjusted accordingly.	

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	Interview with the DON at 3/8/23 at 3:58 p.m., indicated she could not find any documentation that a self-medication administration assessment had been completed. A medication administration policy was requested, but not received prior to exit. 3.1-11(a)			
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-			

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	(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities			

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	established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure transfer/discharge papers were provided to the resident's POA (power of attorney) during a hospitalization for 1 of 1 residents reviewed for hospitalization. (Resident 2) Finding includes:	F 0623	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 2 will not have any adverse effects related to this alleged deficient practice.	04/08/2023

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	The record for Resident 2 was reviewed on 3/6/23 at 2:41 p.m. Diagnoses included, but were not limited to, congestive heart failure and dementia. A Nurse Note, dated 1/28/23, indicated the resident was pale, anxious and having shortness of breath. The resident wanted to go to the hospital and emergency medical services was called for transport. The resident was admitted to the hospital from 1/28/23 through 2/2/23. There was no documentation that transfer or discharge paperwork had been sent to the POA. Interview with the Administrator, on 3/7/23 at 11:30 a.m., indicated they were unable to locate documentation the resident's POA had been provided transfer/discharge papers. 3.1-12(a)(6)(A)		Resident 2 and POA (if applicable) will be notified in writing within 24 hours of the resident's transfer/discharge. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. All residents and their POA (if applicable) will be notified in writing within 24 hours of the resident's transfer/discharge. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All residents and their POA's will be notified in writing within 24 hours of the resident's transfer/discharge. All nursing staff and SSD will be in-serviced over transfer/discharge/bed-hold policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** SSD/Designee will monitor all transfer/discharges weekly for 2 months, then monthly for 4 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded	

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			to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a dependent resident related to not assisting a resident with shaving for 1 of 1 residents reviewed for activities of daily living (ADLs). (Resident B) Finding includes: On 3/5/23 at 3:50 p.m., Resident B was observed lying in bed. The resident had a beard and indicated he was supposed to get shaved and had not been shaved in a while. On 3/8/23 at 10:58 a.m., Resident B was observed lying in bed. The resident still had a beard. Record review for Resident B was completed on 3/8/23 at 9:38 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, stage 4 pressure ulcer, wound infection, and UTI (urinary tract infection). The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact. The resident required an extensive 1 person assist for personal hygiene. The ADL Task indicated the last time the resident	F 0677	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident B will not have any adverse effects related to this alleged deficient practice. Resident B was shaved. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. A shaving audit will be conducted on all residents residing at the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All nursing staff will be in-serviced over shaving policy and procedure. Shaving will be provided during	04/08/2023

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	was shaved was 2/25/23. There was no documentation to indicate the resident had refused to be shaved since that date. Interview with CNA 1 on 3/8/23 at 2:53 p.m., indicated the resident received a bed bath twice a week on the evening shift. The residents were to be offered to be shaved with each bathing. If the resident refused, the staff should document the refusal. This Federal Tag relates to Complaint IN00391519. 3.1-38(a)(3)(D)		residents scheduled shower days and as needed. This will be indicated on the resident's shower sheet completed after each scheduled shower. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor completion of shower sheets daily on scheduled workdays on-going by initialing shower sheet after reviewing for completion of shaving. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure interventions were in place for a resident with a history of falls for 1 of 2 residents reviewed for accidents. (Resident 26)	F 0689	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 26 will not be affected by	04/08/2023

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	Finding includes: On 3/6/23 at 2:17 p.m., Resident 26 was observed seated in his wheelchair in the dining room. There was no chair alarm on his wheelchair. On 3/8/23 at 11:00 a.m., the resident was observed seated in the dining room in his wheelchair, there was no alarm in place. At that time, the alarm was observed attached to the resident's bed. The resident's record was reviewed on 3/6/23 at 4:09 p.m. Diagnoses included, but were not limited to, weakness and coronary artery disease. A Reportable Event, dated 2/6/23, indicated the resident had fallen out of his wheelchair and sustained a fractured first distal phalanx (index finger). The Fall Care Plan had been updated to include the intervention of a pressure pad alarm to bed and wheelchair. A Physician's Order, dated 2/9/23, indicated to have a pressure pad chair alarm on when resident was in recliner or wheelchair. Interview with LPN 3 on 3/8/23 at 11:20 a.m., indicated the alarm on the resident's bed should have been on his wheelchair. 3.1-45(a)		this alleged deficient practice. Pressure pad alarm was placed under Resident 26. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All nursing staff will be in-serviced on Incident/accident policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor fall interventions weekly on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure that proper care and treatment was provided to residents receiving oxygen therapy related to outdated and undated oxygen tubing and humidification bottles, and oxygen not provided as ordered for 3 of 3 residents reviewed for respiratory care. (Residents 2, 27 and B) Findings include: 1. On 3/5/23 at 2:02 p.m., Resident 2 was observed seated in a recliner near the nurses station. She had a nasal cannula in place, connected to a portable oxygen unit. There was no date noted on the oxygen tubing. In the resident's room, there was an oxygen concentrator with no humidification bottle attached and the tubing was undated. The resident's record was reviewed on 3/6/23 at 2:41 p.m. Diagnoses included, but were not limited to, congestive heart failure. A Physician's Order, dated 2/27/23, indicated to use oxygen as needed to maintain oxygen saturation above 90%. 2. On 3/5/23 at 12:19 p.m., Resident 27 was observed seated in his room. He had a nasal	F 0695	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: Resident 2, 27, and B will have no negative affect due to this alleged deficient practice. Residents 2 and 27's O2 tubing, and humidification bottles were dated, and order obtained to change O2 tubing and humidification bottle and to date them weekly. Resident B's O2 order was clarified by the MD. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. O2 for resident's will be administered at the flow directed by the physician order. O2 tubing, humidification bottle, and/or other disposable O2 equipment will be changed weekly	04/08/2023

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	cannula in place that was connected to a humidification bottle on the oxygen concentrator. The humidification bottle was empty and undated. The date on the oxygen tubing was 12/7/22. The resident's record was reviewed on 3/7/23 at 10:14 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and heart disease. A Physician's Order, dated 10/18/22, indicated the resident was to use oxygen at 3 liters per minute while at rest. Interview with the Director of Nursing on 3/5/23 at 3:44 p.m., indicated oxygen equipment should be changed and dated weekly. The current policy, "Oxygen Therapy", was received from the Administrator on 3/6/23, indicated, "...10. Attach humidifier to the flowmeter....", and "...19. Maintenance:...Prefilled humidifier bottles shall be replaced weekly and prn (as needed)...all oxygen delivery devices shall be replaced weekly and prn...."3. On 3/5/23 at 3:03 p.m., Resident B was observed lying in bed. The resident had a portable oxygen tank and an oxygen concentrator in his room. Neither oxygen device was on or connected to the resident. The resident indicated he had been on oxygen "a while ago" when he had COVID-19 but not since then. He would sometimes have trouble breathing. On 3/8/23 at 10:58 a.m., Resident B was observed lying in bed. The oxygen devices were no longer in the resident's room. LPN 2 and the Director of Nursing (DON) were performing a dressing change on the resident's pressure ulcer. The resident indicated he was having some trouble		and will be dated for the day it was changed. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** O2 for resident's will be administered at the flow directed by the physician order. O2 tubing, humidification bottle, and/or other disposable O2 equipment will be changed weekly and will be dated for the day it was changed. All licensed nursing staff will be in-serviced over the "Oxygen Therapy" policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** ADON/Designee will monitor O2 tubing, humidification bottle, and/or other disposable O2 equipment and O2 flow weekly times 2 months, then 2 times a month times 2 months, then monthly time 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	

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	breathing. Neither LPN 2 or the DON assessed the resident's oxygen saturation level. Record review for Resident B was completed on 3/8/23 at 9:38 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, stage 4 pressure ulcer, wound infection, and UTI (urinary tract infection). The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact. The March 2023 Physician's Order Summary (POS) indicated an order to titrate oxygen up to 6 liters via mask or nasal cannula to maintain oxygen saturation greater than 92%. Interview with LPN 1 on 3/8/23 at 2:59 p.m., indicated the resident did not wear oxygen. The oxygen order was supposed to be transcribed as PRN (when necessary). Interview with the DON on 3/8/23 at 3:15 p.m., indicated the resident's oxygen order was supposed to be a PRN order. The resident had complained of not being able to breathe earlier during the wound treatment and they should have assessed his oxygen saturation at that time, but had not. 3.1-47(a)(6)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days			

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	a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 9 out of 30 days reviewed. This had the potential to affect all 27 residents residing in the facility. Finding includes: On 3/9/23 at 2:00 p.m., the Payroll Based Journal (PBJ) Staffing Data Report for 9/2022 was reviewed. It had triggered for no RN hours on 9/1/22, 9/9/22, 9/10/22, 9/11/22, 9/15/22, 9/23/22, 9/24/22, 9/25/22, and 9/29/22. The Nursing Staff Schedules, dated 9/2022, indicated there was no RN scheduled for 9/1/22, 9/9/22, 9/10/22, 9/11/22, 9/15/22, 9/23/22, 9/24/22, 9/25/22, and 9/29/22. Interview with the Administrator on 3/9/23 at 2:58 p.m., indicated there was not 8 hours of RN coverage on the above dates. This Federal tag relates to Complaints IN00391519. 3.1-17(b)(3)	F 0727	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The facility will have 8 consecutive hours of RN coverage 7 days a week. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. The facility will have 8 consecutive hours of RN coverage 7 days a week. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:**	04/08/2023

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			The facility will have 8 consecutive hours of RN coverage 7 days a week. Assistant Administrator and Administrative nursing staff in-serviced over regulation regarding required RN coverage. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator/Designee will monitor staffing on scheduled workdays daily ongoing to ensure appropriate daily RN coverage. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited			

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	to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to Pharmacy recommendations with no follow up for 1 of 5 residents reviewed for unnecessary medications. (Resident 2) Finding includes: Resident 2's record was reviewed on 3/6/23 at 2:41	F 0756	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 2 will not be affected by this alleged deficient practice. Resident 2's orders have been reviewed. **How Other Residents Having The Potential To Be Affected By The Same Deficient**	04/08/2023

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	p.m. Diagnoses included, but were not limited to, congestive heart failure and dementia. A Pharmacy Recommendation, dated 4/15/22, indicated the resident was due for consideration of a GDR (gradual dose reduction) of Celexa (an antidepressant). There was no response to the recommendation. A Pharmacy Recommendation, dated 6/16/22, indicated the resident received a number of Vitamin B supplements, and recommended to discontinue cyanocobalamin, thiamin, and pyridoxine, and start a Vitamin B complex. There was no response to the recommendation. A Pharmacy Recommendation, dated 9/14/22, indicated the resident had an order for as needed Haldol (an antipsychotic) and the medication had a 14-day time limit on use and should be discontinued. There was no response to the recommendation. Interview with the Director of Nursing, on 3/8/23 at 11:38 a.m., indicated she was unable to find additional information related to the above Pharmacy Recommendations. 3.1-48(a)(1) 3.1-48(a)(2)		**Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All licensed nursing staff will be educated over pharmacy recommendation policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor pharmacy recommendations monthly on-going to ensure they are followed up on timely and completely. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and plan adjusted accordingly.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to labs not completed as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 10) Finding includes: The record for Resident 10 was reviewed on 3/8/23 at 10:25 a.m. Diagnoses included, but were not limited to, seizures, hypertension, and tuberous sclerosis. The Annual Minimum Data Set (MDS) assessment, dated 12/19/22, indicated the resident was cognitively intact. He had received antipsychotic, anti-anxiety, antidepressant, anticoagulant, antibiotic, and diuretic medications	F 0757	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 10 will not be affected by this alleged deficient practice. Resident 10 will have ordered labs drawn. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into**	04/08/2023

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	during the assessment period. The Physician's Order Summary, dated 3/2023, indicated orders for Lamictal (lamotrigine, a seizure medication) 200 mg (milligrams) three times a day, Afinitor (everolimus, a cancer medication) 10 mg daily, and clorazepate dipotassium (tranxene, an anti-anxiety medication) 7.5 mg twice a day and 15 mg at bedtime. The Medication Administration Record, dated 3/2023, indicated the resident had received the medications as ordered. A Physician's Order, dated 5/28/22, indicated to obtain a CBC (complete blood count), BMP (basic metabolic panel), Lamictal level, everolimus level, and clorazepate level every 3 months. The CBC, BMP and Lamictal level had been completed on 6/28/22 and 12/27/22. A clonazepam (an anti-anxiety medication) level had been completed on 6/8/22. There was a lack of documentation the lab tests had been completed every 3 months as ordered. There was no documentation of any everolimus level being completed. Interview with the Director of Nursing (DON) on 3/9/23 at 10:30 a.m., indicated she was unable to provide any further documentation. 3.1-48(a)(3)		**Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All licensed nursing staff will be in-serviced over physician orders and lab draw policy and procedures. Lab monitoring schedule will be put in place for DON to monitor. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor physician lab orders on-going to ensure they are followed up on timely and completely. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and plan adjusted accordingly.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides-			

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	§483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs related to not following a recipe for pureed food. This had the potential to affect 1 resident who received a pureed diet. Finding includes: On 3/7/23 at 10:31 a.m., Cook 1 was observed preparing pureed food. She indicated one resident received a pureed diet. She added one Salisbury steak to the puree blender and started blending. She started to pour in milk and some gravy from the Salisbury steak. There was no recipe present. Interview with the Cook on how much she had to add to the Salisbury steak indicated she "eyeballed it". The Dietary Manager (DM) then brought out the recipe. The DM then told the Cook to add a piece of bread to the blender because that was "the way she was taught". She added the bread to the blender and then poured the Salisbury steak onto a plate. The steak was lumpy and a thin consistency. Interview with the Cook indicated she believed it was the right consistency. The DM told her it was not. The Cook then scooped it back into the blender and the DM told her to add thickener. The Cook then added the thickener, blended it and then poured it back out and it was smooth and a pudding consistency. The recipe for the Salisbury steak called for beef stock and food thickener. The recipe did not include milk or bread. The next pureed food the Cook made was green beans. The DM got the recipe out but the Cook	F 0805	**What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident referenced in 2567 (no number listed) will be affected by this alleged deficient practice. Cook 1 was in-serviced in regard to using recipe to properly puree food. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What Corrective Action(s) Will Be Taken:** All residents receiving meal trays have the potential to be affected, no other residents were affected by this alleged deficient practice. Cook 1 was in-serviced in regard to using recipe to properly puree food. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Recipes will be used and properly followed when pureeing food. All dietary staff will be in-serviced in regard to puree food policy and procedure.	04/08/2023

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	did not look at it. The cook took a scoop of green beans and added them to the blender and started to blend. Interview with the DM indicated the scooper was a half cup. The recipe called for 1 cup. The DM then told the Cook to put in another scoop. The DM then told her to add a tablespoon of thickener. The Cook added the thickener and then started to blend. Interview with the DM at the time regarding if that was the correct amount of thickener, she indicated "no, the recipe only called for 1 teaspoon of thickener per serving." The Cook poured the pureed green beans onto a plate. The green beans were smooth but unsure how thickened they were. Interview with the DM indicated the Cook was new and she would in-service her on reading the recipes, adding only ingredients in the recipe, and how to figure out measurements for when she does smaller servings than what the recipe indicated. 3.1-21(a)(3)		**How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Dietary Manager/Designee will monitor puree food preparation 3 times weekly at varying meals times 2 months, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0812 SS=F 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			

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	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 store and serve food under sanitary conditions related to canned foods with compromised seals. This had the potential to affect the 27 residents who received their meals from the kitchen. (The Main Kitchen) Finding includes: Observation during the initial kitchen tour on 3/5/23 at 12:50 p.m. with the Dietary Manager (DM), indicated the following: - In the dry storage area on shelves, there were multiple large cans of food that were dented, including 2 dented cans of sliced apples, 1 dented can of kidney beans, 1 dented can of applesauce, and 1 dented can of corn. Interview with the DM indicated the dented cans should not have been on the shelves to be served. The staff should have thrown them away. A facility policy titled, "Storage of Foods under Sanitary Condition" and received as current from the DM on 3/7/23, indicated, "...8. Canned goods with a compromised seal are discarded and/or removed from the kitchen for return to the vendor for credit...." 3.1-21(i)(3)	F 0812	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. Dented cans have been removed. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. Dented cans have been removed. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Dented have been removed. Dietary Manager and all other dietary staff will be in-serviced in regard to Food Storage policy and procedure.	04/08/2023

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			How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Dietary Manager/Designee will monitor storage for dented cans daily on scheduled workdays times 4 weeks, then weekly times 3 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident			

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	155743	A. BUILDING 00 B. WING	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, IN 47944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and			

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	community-based risk assessment, utilizing an all-hazards approach. Based on record review and interview, the facility failed to ensure the Facility Assessment was reviewed and updated yearly. This had the potential to affect all 27 residents residing in the facility. Finding includes: On 3/5/23 at 11:50 a.m., during the Entrance Conference with the Administrator, the facility assessment was requested. Interview with the Administrator on 3/7/23 at 5:13 p.m., indicated she was not aware the Facility Assessment had to be updated yearly. She was currently working on updating it. The Facility Assessment, provided for review by the Administrator on 3/8/23, indicated the date had been blacked out and 3/7/23 was written in. The Administrator indicated at that time it had last been updated in late 2021.	F 0838	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. Facility Assessment has been updated **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. The Facility Assessment has been updated. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Administrator to be in-serviced in regard to regulation over up-dating facility assessment. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator to monitor the Facility Assessment every 6	04/08/2023

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			months to ensure annual update occurs timely. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QA Committee monthly for a minimum of 12 months and plan adjusted accordingly.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;			

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	(ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			

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	Based on record review and interview, the facility failed to ensure a medical record was complete and accurately documented related to a resident death for 1 of 1 residents reviewed for death. (Resident 30) Finding includes: Resident 30's closed record was reviewed on 3/6/23 at 2:18 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, hypertension, and type 2 diabetes mellitus. An MDS (Minimum Data Set) assessment, dated 12/28/22, was completed for death in facility. A Progress Note, dated 12/28/22 at 3:09 a.m., indicated the resident's vital signs were within normal limits. She was in droplet isolation for COVID-19. She was resting in bed, her call light was in reach, and she was in no acute distress. There was a lack of any further documentation regarding the resident's status or the resident's death. Interview with the Administrator on 3/6/23 at 4:02 p.m., indicated the resident had passed away in the facility on 12/28/22. She had received a phone call on 12/28/22 saying that staff had found the resident unresponsive and attempted CPR, but the resident had passed away. 911 had been called and EMS (Emergency Medical Services) had responded. She was unsure why there was no documentation of the incident in the Progress Notes. Interview with LPN 1 on 3/7/23 at 12:47 p.m., indicated she had been working the morning of 12/28/22. The CNAs had yelled for her to come to	F 0842	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: Resident 30 was not affected by this alleged deficient practice. All residents' medical records will be complete and accurately documented. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing within the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All residents' medical records will be complete and accurately documented. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All residents' medical records will be complete and accurately documented. All licensed nursing staff will be educated in regard to proper documentation policies and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor	04/08/2023

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	the room as the resident was unresponsive. She went to the resident's room, checked for signs of life, and then began CPR. She instructed a CNA to call 911. EMS responded and took over when they arrived. They declared the resident dead. At that time, she had documented the incident in the Progress Notes and completed the death certificate. She was unsure why there was no documentation of the incident showing up in the Progress Notes. 3.1-50(a)(1)		completion of documentation on residents' medical records on varying shifts during scheduled workdays daily times 1 month, then weekly times 1 month, then every 2 weeks times 2 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19 related to not having a current COVID-19 policy pertaining to care and monitoring of residents with COVID-19, not monitoring a resident with COVID-19 every shift or daily for 1 of 3 residents reviewed for infection control (Resident 2), and not having a complete, functional infection surveillance program. The facility also failed to ensure infection control measures were followed related to staff not wearing proper personal protective equipment (PPE) in an isolation room and staff not completing proper hand hygiene during a wound treatment for 1 of 1 residents reviewed for pressure ulcers. (Resident B) Findings include: 1. The Infection Prevention and Control Program policies and procedures were reviewed on 3/7/23. The policy, "Exposure to Coronavirus (2019-nCov): Disease Response and Management", was dated 2/13/20. There was no indication the policy had been reviewed or updated with current guidance. Interview with the Administrator on 3/8/23 at 3:05 p.m., indicated she realized the policy was outdated but had not received a current one from corporate. 2. The record for Resident 2 was reviewed on	F 0880	**F880** **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Residents 2 and resident B were not affected by this alleged deficient practice. 1.) Policy and procedure for Exposure to Coronavirus disease response and management will be updated to reflect current guidance. 2.) Any COVID-19 positive residents will be monitored for worsening signs and symptoms along w/ vital signs every shift and a complete nursing assessment will also be done daily on those residents. 3.) The McGreer's criteria will be used to assess residents suspected to have an infection and will include results from any labs performed that support the use of an antibiotic. 4.) Hand hygiene will be performed when appropriate or indicated when performing wound care. Staff will DON the appropriate PPE when entering the room of a resident on isolation precautions. Staff will also ensure that the appropriate signage is present on the resident's door and	04/08/2023

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	3/6/23 at 2:41 p.m. Diagnoses included, but were not limited to, congestive heart failure and dementia. A Nurse Note, dated 12/17/22, indicated the resident had an occasional moist, productive cough. She tested positive for COVID-19 at that time. She was placed in isolation and medications were imitated. A Physician's Order, dated 12/17/22, indicated a Complete Nursing Assessment should be completed every evening shift. A Complete Nursing Assessment was completed on 12/20/22. There were no additional complete assessments documented. Nurse Notes that included an assessment of symptoms and vital signs were completed on 12/22/23, 12/23/22, 12/24/22 and 12/28/22. She was removed from isolation on 12/28/22. Interview with the Infection Prevention (IP) Nurse on 3/8/23 at 10:09 a.m., indicated residents who were COVID-19 positive should have been monitored for worsening symptoms and vital signs every shift, and a Complete Nursing Assessment should have been completed daily. She indicated there were missing assessments and vital signs. 3. The Infection Surveillance Program was reviewed on 3/8/23. The Director of Nursing (DON)provided the Infection Monitoring book. There was only information available for January and February 2023. The maps were blank, they were not completed to identify patterns of infections.		will ensure it remains there the entire isolation period. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. The COVID-19 policy and procedure will be updated, Hand hygiene will be performed when appropriate or indicated, appropriate PPE will be worn when required and signage posted on residents' door when warranted and McGreer's criteria used to assess residents when infection is suspected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Hand hygiene will be performed when appropriate or indicated and infection control logs have been updated. All staff will be in-serviced over "how to don/doff PPE with return demonstration, proper hand hygiene with return demonstration, including, but not limited to mask, respirator devices, gloves, gown, and eye protection. The facility LTC Infection Control Assessment has been completed (Attachment A).	

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	Three of the residents receiving antibiotics were not assessed using McGreers criteria for symptoms of a true infection. There were no lab results included in the monitoring. Interview with the DON on 2/8/23 at 3:40 p.m., indicated the maps should have been color coded to identify trends or patterns of infections in the building, and she was in the process of updating the program. Interview with the Administrator on 3/9/23 at 11:15 a.m., indicated she was not aware they should maintain infection tracking records and had removed the previous years and sent them to medical records. They were not available for review. 4. On 3/5/23 at 3:03 p.m., Resident B was observed lying in bed. The resident had an IV pump in his room. He indicated he was being administered an IV antibiotic due to having an infection in his urine and a wound. He was on isolation precautions for his infection at one time. No isolation signs were observed on the resident's door and there was no PPE (personal protection equipment) bin by the door. On 3/6/23 and 3/7/23, there were no isolation signs on the resident's door or PPE bin observed by the door. On 3/8/23 at 10:58 a.m., Resident B was observed lying in bed. There were no isolations signs on the resident's door. LPN 2 and the Director of Nursing (DON) were getting ready to complete a wound dressing change on the resident's sacral pressure ulcer. Neither the LPN nor the DON		A Root Cause Analysis (RCA) (Attachment B, C, D and E) for the facility has been conducted. **How The Corrective Action(s) Will Be Monitored to Ensure The Deficient Practice Will Not Recur:** ADON/Designee will complete IP rounds during scheduled workdays daily for a minimum of 12 weeks, then weekly times 12 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly. **Date of Completion: 4/8/2023**	

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donned any PPE. The LPN indicated that day was the last day of the resident's antibiotic for his infection. The LPN washed her hands, donned gloves, and removed the resident's dressing to his sacral area. She then changed her gloves and proceeded to cleanse the wound. After cleansing the wound she packed the wound with a medicated bandage and covered the wound. The LPN had not changed her gloves and washed her hands after cleansing the wound and before applying the clean bandage. Interview with the LPN at that time indicated she should have changed her gloves and washed her hands after cleaning the wound and before applying the clean medicated bandage.

Record review for Resident B was completed on 3/8/23 at 9:38 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, stage 4 pressure ulcer, wound infection, and UTI (urinary tract infection).

The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact. The resident had a stage 4 pressure ulcer on admission, had an indwelling urinary catheter and had received IV medications.

A Care Plan, dated 12/10/21 and revised on 3/7/23, indicated the resident had IV antibiotic therapy to treat a wound infection until 3/7/23. An intervention included to maintain contact isolation.

The Physician's Order, dated 2/7/23, indicated an order for contact isolation due to infection in sacral wound with CRPA: Carbapenem Resistant Pseudomonas (bacterial infection).

Interview with the DON on 3/8/23 at 3:58 p.m.,

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	indicated she had spoken to housekeeping and they said the isolation sign must have gotten knocked off of the resident's door. The resident should have been on contact precautions until 3/7/23 and was not. 3.1-18(b)			
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the			

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	transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on record review and interview, the facility failed to conduct COVID-19 testing per CDC guidance related to not completing routine	F 0886	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been**	04/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING 00 B. WING	03/09/2023

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	COVID-19 testing for unvaccinated staff for 1 of 4 staff reviewed (Housekeeper 1) and not completing facility wide COVID-19 testing during an outbreak until there were no additional positive residents. Findings include: 1. The Infection Prevention and Control Program was reviewed on 3/8/23. A list of employee COVID-19 vaccination status was provided. Housekeeper 1 was noted to have a medical exemption, and was not vaccinated for COVID-19. Testing logs from November 1, 2022 to March 2023, lacked documentation that the Housekeeper had been tested for COVID-19. Interview with the Administrator on 3/9/23 at 11:15 a.m., indicated unvaccinated staff were subject to COVID-19 testing three times a week. The housekeeper was currently on maternity leave since February, but had accidentally been omitted from testing during that time. A Facility Policy, titled "COVID-19 Vaccine Policies and Procedures", received as current from the Administrator, indicated, "...Staff who receive an exemption to the COVID-19 vaccine and staff who have not completed their primary vaccination series, will be subject to additional precautions to mitigate the transmission and spread of COVID-19, which includes: COVID-19 testing at least weekly..." 2. The resident COVID-19 testing logs were provided for review. The facility began outbreak testing on 12/12/22 after a staff member tested positive.		**Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. The facility will follow CDC guidelines for routine testing of staff and outbreak testing for staff and residents. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. The facility will follow CDC guidelines for routine testing of staff and outbreak testing for staff and residents. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will follow CDC guidelines for routine testing of staff and outbreak testing for staff and residents. Testing logs with accurate and timely testing will be maintained. Administrator, DON, and IP will be in-serviced in regard to the CDC guidelines for routine staff testing and outbreak testing guidelines. **How The Corrective Action(s) Will Be Monitored To Ensure**	

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	Residents were tested daily from 12/12/22 until 12/21/22. There was no additional testing after 12/21/22. During that period, 27 of 31 residents tested positive and 4 residents remained negative. Interview with the Administrator, on 3/9/23 at 11:15 a.m., indicated they had stopped testing because there were no residents left to test. She indicated she was unaware there were 4 residents that were negative and had misunderstood the CDC guidelines. The Center for Medicare and Medicaid (CMS) memo, revised 9/23/22, titled "Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements", indicated, "... As part of the broad-based approach, testing should continue on the affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days...."		**The Deficient Practice Will Not Recur:** IP Nurse/Designee will audit COVID-19 testing logs weekly for 6 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	
F 0921 SS=E 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 and interview, the facility failed to ensure the kitchen area was clean and in good repair related to a black substance on the wall and ceiling, gouged walls, chipped tiles, and missing weather stripping on the back door in 1 of 1 kitchens. (Kitchen) Finding includes: During the initial kitchen tour on 3/5/23 at 12:50	F 0921	**F921** **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** In kitchen 1 of 1 the black substance found on the corner wall by the back door and on the wall and ceiling were cleaned off	04/08/2023

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	p.m. with the Dietary Manager, the following was observed: a. The corner wall by the back door had a black substance on the wall and ceiling. b. The walls by the freezer were gouged. c. The tiles on the floor and bottom of the wall by the freezer were chipped and pulling away from the wall. d. The back door by the freezer had the weather stripping missing in places. There were visible holes from the missing weather stripping that you could see through to the outside. Interview with the Dietary Manager indicated the black substance was mold due to the ceiling leaking by the door. She indicated all areas were in need of cleaning and repair. This Federal tag relates to Complaint IN00391519. 3.1-19(f)		immediately. The gouges to the walls by the freezer have been repaired. The tiles on the floor and along the bottom of the wall by freezer have also been repaired. The weather stripping missing along the back door has been replaced and you can no longer see outside. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected. An audit of the kitchen will be conducted, and negative findings will be corrected. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Residents will be provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. All staff are expected to complete maintenance work orders when equipment/items need to be repaired or replaced. All staff will be in-serviced over Quality of Life-Homelike Environment and Maintenance Work Orders policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure**	

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			The Deficient Practice Will Not Recur: Maintenance Director/Designee will audit the kitchen weekly times 2 months, then every two weeks times 2 months, then monthly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly. **Date of Completion: 4/8/2023**	