STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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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 IN00388683, IN00394202, IN00394334, IN00394560 and IN00404072. Complaint IN00388683- Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00394202 - Federal/State deficiencies related to the allegations are cited at F686 and F921. Complaint IN00394334 - Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00394560 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00404072 - Federal/State deficiencies related to the allegations are cited at F921 Survey dates: March 13, 14, 15, 16, 17, 20, and 21, 2023 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicaid: 52 Other: 14 Total: 66	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Lewis	Administrator	04/21/2023

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reveiw completed 4/6/2023.			
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that			

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	is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. Based on record review and interview, the facility failed to ensure residents are able to withdrawal their money on weekends and evenings for 3 of 7 residents reviewed for personal funds. (Residents 43, 4 and 14) Findings include: 1. During an interview, on 3/13/2023 at 11:06 A.M., Resident 43 indicated he could not get money on weekends or holidays. A clinical record review was completed on 3/20/2023 at 9:25 A.M. Resident 43's diagnoses included diabetes, hypertension and arthritis. A Quarterly MDS (Minimum Data Set) assessment, dated 12/12/2022 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 14, cognition intact. 2. During an interview, on 3/13/2023 at 3:29 P.M., Resident 4 indicated she could only get money out during working hours. A clinical record review was completed, on 3/20/2023 at 3:25 P.M. Resident 4's diagnoses included heart failure, Parkinson's disease, depression and Schizophrenia. A Quarterly MDS, dated 1/18/2023, indicated her BIMS score was 13, cognition intact.	F 0567	It is the practice of this facility to ensure residents are able to withdraw funds from their resident accounts on holidays and weekends, in addition to normal business hours. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The residents identified in the 2567 are able to withdraw their funds on weekends and evenings. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents with facility accounts have the potential to be affected by the alleged deficit practice. A practice has been implemented to allow all residents with accounts to withdraw funds on evenings and weekends. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. A system for residents to withdraw funds outside of business hours including weekends has been implemented.	05/08/2023

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	3. During an interview, on 3/13/2023 at 10:29 A.M., Resident 14 indicated she could only get money out Monday through Fridays. A clinical record review was completed, on 3/16/2023 at 2:07 P.M. Resident 14's diagnoses included Hemiplegia and hemiparesis, aphasia, and major depressive disorder. A Quarterly MDS, dated 1/19/2023, indicated Resident 14 had a BIMS score of 13, cognition intact. During an interview, on 3/17/2023 at 1:13 P.M., the Business office Manager indicated the money is available during the week from 8:00 A.M. to 5:00 P.M. She indicated the activity staff will go around and ask the residents about needing money before the weekend, but does not do it all the time. On 3/20/2023 at 2:49 P.M., the Administrator provided the policy titled, "Resident Funds Distribution", undated and indicated the policy was the one currently used by the facility. The policy indicated"...To ensure timely distribution of resident funds, the resident's fund Petty Cash account will be maintained by the facility. The petty cash box for the resident funds will be reconciled on a routine basis. 1. sufficient funds will be available on site to meet the needs of the residents. 2. Banking Schedule will be posted in a prominent place with hours convenient for resident access...." 3.1-6(f)(1)		Resident fund balance statements and money have been made available and the charge nurse will have access to assist residents with their evening and weekend requests. The Business Office Manager and nursing staff have been in-serviced on the system for resident procurement of funds on evenings and weekends. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Business Office Manager / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans			

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	§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the			

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	details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to ensure a base line care plan for the use of a Foley catheter was initiated within 48 hours of admission for a resident using a Foley catheter in 1 of 2 residents reviewed for catheters. (Resident F) Finding includes: A clinical record review was completed, on 3/16/2023 at 1:49 P.M. Resident F's diagnoses included, but were not limited to hypertension, benign prostatic hyperplasia, neurogenic bladder, diabetes, hemiplegia and depression. An Admission MDS (Minimum Data Set) Assessment, dated 2/21/2023, indicated Resident F had moderate cognitive impairment and used a Foley catheter for elimination. The clinical record lacked a Base Line care plan for the use of the Foley catheter. During an interview, on 3/17/2023 at 11:24 A.M., the Director of Nursing indicated there should have been a base line care plan for the use of the catheter. On 3/21/2023 at 3:25 P.M. the Administrator provided the policy titled, "Care Plans- Baseline". The policy indicated "...1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission... 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan...."	F 0655	It is the practice of this facility to ensure baseline care plans include instructions to provide effective and person-centered care of the resident that meet professional standards of quality care. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident identified in the 2567 had a care plan for the foley catheter added. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents with foley catheters have the potential to be affected by the alleged deficit practice. Residents with a foley catheter have been reviewed and baseline care plans are developed within 48 hours of admission and include the use of a foley catheter when indicated. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Nursing will be trained to complete the baseline care plan upon admission and baseline care plans will be reviewed by MDS/designee within 48 hours of admission to ensure the use of foley catheter is included when appropriate.	05/08/2023

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	3.1-30(a)		How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the MDS Coordinator / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three to ensure foley catheters are included if indicated. Findings will be reported in QAPI quarterly.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and clinical record review, the facility failed to develop a comprehensive care plan for 1 of 22 residents whose care plans were reviewed. (Resident 63) Finding includes:During an observation, on 3/13/2023 at 11:33 A.M., Resident 40 was observe to have a scab to his right elbow, and dressings to the upper right arm and left wrist. A clinical record review was completed, on. 3/15/2023 at 6:10 A.M. Resident 40's diagnoses included, but were not limited to: Parkinson's disease, contracture of the lower leg, dementia, and protein malnutrition.	F 0656	It is the practice of this facility to develop a person-centered comprehensive care plan for each resident that includes measurable objectives and timeframes to meet needs identified in the comprehensive assessment. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident identified in the 2567 has had an updated skin assessment and problems and interventions have been updated in the care plan as indicated. How	05/08/2023

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	A Quarterly MDS (Minimum Data Set) Assessment, dated 3/9/2023, indicated the resident had intact cognition. A current care plan, dated 7/29/2022, indicated the resident had the potential for pressure ulcer/injury related to: incontinence of bowel/bladder; spends most of time in bed/chair; limited ability to change position; impaired nutritional intake; potential for friction/shear; and comorbidities: Parkinson's, dementia. Interventions, included, but were not limited to: observe skin daily during care for red, irritated or open area and report to charge nurse/NP/Physician. The clinical record lacked a person centered care plan for the skin issues to the residents' elbow, right arm and left wrist. During an interview, on 3/17/2023 at 2:45 P.M., the Director of Nursing indicated there should have been a care plan for the skin issue. On 3/20/2023 at 2:49 P.M., the Administrator provided the policy titled,"Care Plans, Comprehensive Person Centered", dated 9/2022, and indicated the policy was the one the facility currently uses. The policy indicated"... The comprehensive, person-centered care plan will ... b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being... h. Incorporate identified problem areas... l. reflect treatment goals, timetables and objectives in measurable outcomes...." 3.1-35(a)		other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the alleged deficit practice. Skin assessments have been completed on all residents care plans will be audited and updated appropriately with any findings. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to MDS, and nurses to reflect the appropriate care plan process. A Quality Assurance tool has been developed to monitor residents for new skin issues to ensure they have been added to the care plan. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the MDS Coordinator / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported quarterly in QAPI.	

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F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide showers for 7 of 7 residents reviewed for activities of daily living.(Residents 5, 14, 67, 3, 10, 39 and 40) Findings include: 1. During an observation, on 3/13/2023 at 10:26 A.M., Resident 5 was observed in her room and observed to have dried food on her face, shirt and pants. During an interview, on 3/13/2023 at 10:29 A.M., Resident 5 indicated she does not receive routine showers. A record review was completed, on 3/15/2023 at 11:35 A.M., diagnosis included but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes, chronic kidney disease, paranoid schizophrenia, cerebral infarction, hypertensive chronic kidney disease, major depressive disorder, cognitive communication deficit, muscle weakness, schizophrenia, delusional disorders, major depressive disorder and hemiplegia and hemiparesis following cerebral infarction. A Quarterly MDS (Minimum Data Set) assessment, dated 1/23/2023, indicated Resident 5 had intact cognition. Resident 5 required extensive assist with two staff members for transfers and required a full hoyer.	F 0677	It is the practice of this facility to ensure a resident who is unable to carry out activities of daily living receives the services necessary to maintain grooming and personal hygiene. What corrective action will be accomplished for those residents found to be affected by the deficit practice. Residents identified in the 2567 have been provided showers and appropriate care as indicated and desired. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents have the potential to be affected for the alleged deficit practice. All residents have been offered showers/bed baths per their preference. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Staff will be educated and a systematic process will be implemented that provides a multi-level check system to ensure showers are being offered and given. Individualized preferences will be honored and documentation will be reflected in	05/08/2023

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	A shower record was reviewed on 3/15/2023 at 12:15 P.M., and indicated Resident 5 had 2 bed baths and 1 shower between 2/15/2023 and 3/15/2023. During an interview, on 3/15/2023 at 2:34 P.M., CNA 5, indicated Resident 5 was to receive 2 showers a week. During an interview on 3/15/2023 at 2:46 P.M., the Director of Nursing indicated Resident 5 should be receiving 2 showers a week. 2. During an interview on 3/13/2023 at 11:10 A.M., Resident 14 indicated she does not receive 2 showers a week. A record review was completed for Resident 14 on 3/16/2023 at 2:07 P.M.. Diagnosis included but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, major depressive disorder, contracture to right elbow, contracture to right wrist, autonomic neuropathy, need for assistance with personal care, right foot drop and muscle weakness. A Quarterly MDS (Minimum Data Set) Assessment, dated 1/19/2023, indicated Resident 14 had intact cognition. A shower record was reviewed on 3/16/2023 at 2:21 P.M., and indicated Resident 14 received 4 showers between 2/15/2023 and 3/15/2023. During an interview, on 3/16/2023 at 3:10 P.M., the Director of Nursing indicated Resident 14 should be receiving 2 showers a week.		the record. A Quality Assurance tool has been developed to monitor that residents are clean and well-groomed and have been offered a bed bath/shower per their preference. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	3. During an interview, on 3/13/2023 at 2:17 P.M., Resident 67 indicated she does not receive routine showers. A record review was completed on 3/16/2023 at 10:49 A.M.. Diagnosis included but were not limited to, effusion of left knee, diabetes, muscle weakness, need for assistance with personal care, hypertensive heart disease, vertigo and blindness in one eye. An Admission MDS (Minimum Data Set) Assessment, dated 1/26/2023, indicated Resident 67 had intact cognition. A shower record was reviewed on 3/16/2023 at 11:03 P.M., and indicated Resident 67 received 2 showers and 1 bed bath between 2/15/2023 and 3/15/2023. During an interview, on 3/16/2023 at 3:10 P.M., The Director of Nursing indicated Resident 67 should be receiving 2 showers a week. 4. During an observation, on 3/13/2023 at 11:05 A.M., Resident 3 was laying in bed and observed to have whiskers on her chin, toenails were long, and toes and feet were dry with flaking skin. An Annual MDS (Minimum Data Set) Assessment, dated 8/18/2022, included, but was not limited to: Resident 3's preferences indicated it was very important to choose her clothing and somewhat important to choose between a tub bath, shower, bed bath or sponge bath. A Quarterly MDS Assessment for Resident 3, dated 3/17/2023, included, but was not limited to: moderate cognitive impairment. She felt down or depressed 7-11 days during the assessment period. Resident had verbal symptoms directed at			

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	155086	A. BUILDING 00 B. WING	03/21/2023

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	others 1-3 days during the assessment period. She required extensive assist of 2 staff persons for bed mobility, dressing, and toileting. She required total assist of 2 staff persons for transfers. Resident 3 was frequently incontinent of bowel and bladder. Diagnoses for Resident 3 included, but were not limited to: quadriplegia, unspecified brain damage due to birth injury, epilepsy, and morbid severe obesity. Resident 3's physician orders included, but were not limited to: on 2/10/2021, may use Hoyer lift with assist of two for transfers. A care plan problem for Resident 3, dated 12/7/2021 included, but was not limited to: she required assist with ADL's (activities of daily living) due to cognitive deficits, seizures, and quadriplegia. Interventions included, but were not limited to: assistive devices used: wheelchair, and bariatric bed, transfer with Hoyer lift and assist of two, prefers showers on Wednesday and Saturday evenings. The Task portion of Resident 3's clinical record indicated no bath or shower was done between 3/6/2023 and 3/20/2023. No documentation of refusals of baths or showers were documented in Tasks. On 3/17/2023 at 2:14 P.M., the DON (Director of Nursing) provided shower sheets completed by staff for March 2023, which indicated resident received a shower on 2/5/2023, 2/23/2023, and 3/5/2023. No shower sheets that indicated refusals were provided. During an interview, on 3/21/2023 at 10:24 A.M., QMA 13 indicated residents are supposed to get showers twice a week, but sometimes they refuse.			

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	5. During an observation, on 3/13/2024 at 11:27 A.M., Resident 10 was found still in bed with a hospital gown that had food on it. He had long whiskers on his face and his fingernails had dark brown matter underneath and they had grown past his fingertips. A record review was conducted for Resident 10 on 3/15/2023 at 9:13 A.M. The Admission MDS, dated 5/25/2022, indicated preferences that included, but were not limited to: choosing between a shower, tub bath, or bed bath was very important. The Quarterly MDS Assessment, dated 3/15/2023, included, but was not limited to: severe cognitive impairment. No behavior issues were noted. He required extensive assistance of 1 staff person for bed mobility, extensive assistance of 2 staff persons for transfers, dressing, and toileting. Resident was always incontinent of bowel and bladder. Active diagnoses included, but were not limited to: Non-Alzheimer's dementia, depression, and schizophrenia. Resident 10's diagnoses included, but were not limited to: unspecified schizophrenia, unspecified dementia with unspecified severity without behavioral disturbance and anxiety; obsessive compulsive disorder, and schizoaffective disorder. Physician orders for Resident 10 included, but were not limited to: on 5/22/2022 buspirone 10 mg (milligrams) for anxiety, on 1/12/2023 clozapine 200 mg for schizophrenia, and on 1/12/2023 galantamine 4 mg for unspecified dementia. A care plan for Resident 10 included, but was not limited to: a problem, dated 5/22/2022, that indicated resident has an ADL (activity of daily living) deficit related to dementia and schizophrenia. Interventions included, but were			

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	not limited to: resident requires 2 staff persons for transfers, and is totally dependent on staff to provide a bath or shower weekly and as necessary. The Task portion of Resident 10's clinical record over the last 30 days indicated showers were given on 2/20/2022 and 3/2/2022. No documentation of refusals was noted in Tasks. An observation, on 3/17/2023 at 1:54 P.M., indicated Resident 10 was unshaven and his hair appeared greasy and disheveled. On 3/17/2023 at 2:14 P.M., the DON provided shower sheets that indicated resident received showers on 2/4/2022 and 2/20/2022. No shower sheets that indicated refusals were provided. During an interview, on 3/21/2023 at 10:24 A.M., QMA 13 indicated residents were supposed to get showers twice a week, but sometimes they refuse.6. During an interview, on 3/13/2023 at 10:45 A.M., Resident 39 indicated he does not get showers. A clinical record review was completed on 3/15/2023 at 6:00 A.M. Resident 39's diagnoses include, but were not limited to: diabetes, hypothyroidism, dementia, anxiety, and depression. A Quarterly MDS (Minimum Data Set) Assessment, dated 2/2/2023, indicated Resident 39 had no cognitive impairment. Required supervision of 1 staff for bed mobility, transfers, dressing, eating, toilet use and bathing. A current care plan, dated 4/12/2021, indicated the resident required assist with ADL's(activities of			

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	daily living) due to dementia, diabetes, falls, and history of traumatic brain injury. Interventions included, but were not limited to: the resident prefers to complete bathing with assist and supervise the resident with bathing. Resident 39's shower documentation from 1/30/2023 to 3/10/2023, indicated Resident 39 had received a bed bath on 2/10/2023, a shower on 2/13/2013, and refused 1 time on 3/10/2023. There were no other showers and or bathing types documented. A shower schedule indicated the resident was to receive showers on Tuesdays and Fridays. No showers had been documented on 1/31, 2/3, 2/7, 2/17, 2/21, 2/24, 2/28, 3/3, 3/7, 3/14, and 3/17/2023. During an interview, on 3/15/2023 at 2:26 P.M. CNA 5 indicated they document the showers in the computer, complete a shower sheet, and turn them into the Director of Nursing. She indicated the shower sheet should be done every time the resident gets a shower, bed bath or refused, and indicated the residents should get 2 showers a week. 7. During an interview, on 3/13/2023 at 11:23 A.M., Resident 40 was observed with whiskers all over his face, yellow teeth with debris and his hair was disheveled. Resident 40 questioned as to when his shower was scheduled. A clinical record review was completed on 3/15/2023 at 6:10 A.M. Resident 40's diagnoses included: Parkinson's disease, contracture of the lower leg, dementia, kyphosis and osteoarthritis. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/9/2023, indicated Resident			

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	40's cognition was intact. Required extensive assist of 2 staff for bed mobility, transfers, 1 assist for dressing, eating and toilet use. Was incontinent of bladder and bowels and required total assist with bathing. A current care plan, dated 9/24/2020, indicated the resident required assist with ADL's(activities of daily living) due to Parkinson's diagnosis and poor mobility. Interventions included, but were not limited to: he preferred to complete bathing with one person assist and assist him with bathing body parts that he was unable to do. Lower body and back. A current care plan, dated 7/24/2021, indicated the resident will refuse showers at times. Interventions included, but were not limited to: explain importance of good personal hygiene. Notify family and doctor of refusals. Offer shower and when refusing offer bed bath. Re-approach with a different staff member. The shower schedule indicated Resident 40 was to receive showers on Wednesdays and Saturdays. The computer shower documentation for Resident 40, from 2/13/2023 to 3/20/2023, indicated the resident had received bed baths on 2/18, 2/25 and 3/4/2023. A paper shower sheet was provided and indicated the resident had received a shower on 1/5/2023. No other shower documentation was provided for 1/7, 1/11, 1/14, 1/18, 1/21, 1/25, 1/28, 2/1, 2/4, 2/8, 2/11, 2,15, 2/22, 3/1, 3/8, 3/11, 3/15 and or 3/18/2023. During an interview, on 3/17/2023 at 2:49 P.M.,the Director of Nursing indicated she had no other documentation of the resident receiving showers.			

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	On 3/20/2023 at 8:45 A.M., the Administrator provided the policy titled, "Shower/Bathing Policy", with a revision date of 8/2018. The policy indicated"...Resident's preferences will be considered and shower/bath/bed bath shall be provided at least weekly...." 3.1-38(a)(b)(2)			
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, encouraging both independence and interaction in the community. Based on interview, observation and record review the facility failed to implement an activities program that incorporated the resident's interest and hobbies for 1 of 1 resident reviewed for activities. (Resident 5) Finding includes: During an interview, on 3/13/2023 at 10:40 A.M., Resident 5 indicated she watched television in her room and has nothing else to do. During an observation, on 3/13/2023 at 10:41 A.M., Resident 5 was observed to be sitting in her dark room with no activity going on in the room. Television was on but sound turned off.	F 0679	Activities Meet Interest/Needs Each Resident It is the practice of this facility to provide an ongoing program of activities to support resident choice designed to meet the needs of each resident. What corrective action will be accomplished for those residents found to be affected by the deficit practice. Resident # 5 has been interviewed on activities that meet her interest and activities have been provided. The care plan was updated to reflect activities of current interest. How other residents having the potential to	05/08/2023

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	During an observation, on 3/14/2023 at 10:08 A.M., Resident was noted sitting in her room watching television. During an observation, on 3/14/2023 at 2:13 P.M., Resident was noted laying in her bed asleep, television on but sound turned off. During an afternoon activity in the dining room on 3/15/2023 at 2:00 P.M., Resident 5 was observed in her room sitting in a chair looking out the door. During a morning activity in the dining room on 3/16/2023 at 9:07 A.M., Resident 5 was noted in her room sitting in her chair. During a morning activity in the dining room on 3/17/2023 at 9:00 A.M., Resident 5 was noted in her room sitting in her chair. A record review was completed on 3/17/2023 at 11:35 A.M., Diagnosis included but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, chronic kidney disease, paranoid schizophrenia, cerebral infarction, hypertensive chronic kidney disease, major depressive disorder, cognitive communication deficit, muscle weakness, schizophrenia, delusional disorders, major depressive disorder and hemiplegia and hemiparesis following cerebral infarction. A Quarterly MDS (Minimum Data Set) Assessment dated 1/23/2023, indicated Resident 5 was cognitively intact. A Significant change MDS Assessment, dated 4/15/2023, indicated Resident 5 stated it was very important to have books, newspapers and magazines to read, listening to music, keeping up		be affected by the same deficit practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the alleged deficit practice. Resident activities will be audited to ensure they are provided opportunities to participate in activities that incorporate their interests and hobbies. Care plans will be updated as indicated. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. The Activity Director was in-serviced on providing activities that meet each resident's interest and documenting participation in those activities. A quality assurance tool has been developed to monitor that the activity schedule includes programs that meet residents interests, residents are invited to attend and documentation is completed. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Activity Director / Designee on 5 residents weekly for three weeks, then monthly for three months, then quarterly x three. Findings will be reported quarterly in QAPI.	

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	with the news, go outside when the weather is good, religious services and to receive snacks between meals. During an observation of Resident 5's room, on 3/17/2023 at 2:34 P.M., Resident 5 did not have any books, magazines, pictures, music, newspaper or radio. A current activity careplan was reviewed on 3/17/23 at 3:06 P.M., and indicated Resident 5's personal preferences included but were not limited to: group and independent activities such as food/cooking, conversation, games, nailcare, church, staff visits, salon, karaoke, watching tv, music, reading books, newspapers and magazines Her careplan indicated she would like to get fresh air and be invited to activities such as bingo, going outside, pet therapy, and using the telephone. During an interview, on 3/20/2023 at 1:38 P.M., the Activity Director indicated Resident 5 does not have books, magazines and other items that are listed in her careplan that she enjoys. Activity Director indicated she would start inviting Resident 5 to activities. There was no documentation to indicate Resident 5 was receiving any structured 1:1 programming and none was observed throughout survey. A policy was provided, on 3/21/2023 at 10:09 A.M., titled "Activity Recreation Programs", by the Executive Director. The policy indicated, "...The facility recreation programs are designed to meet the individual needs of each Resident...." 3.1-33(a)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to follow physician orders to hold insulin; failed to use a foot buddy (positioning devise) and failed to follow physician orders for the use of Ted Hose (compression stockings) for 3 of 24 residents whose physician orders were reviewed. (Residents 19, 5 & 22) Findings include: 1. During an interview, on 3/13/2023 at 2:22 P.M., Resident 19 indicated she had received her insulin's after she had a meal. A clinical record review was completed, on 3/15/2023 at 2:33 P.M. Resident 19's diagnoses included, but were not limited to: diabetes, seizures, and chronic kidney disease. A current care plan, dated 6/8/2022, indicated the resident had a diagnosis of diabetes mellitus Type 1 and is dependent on insulin and continues to be at risk for altered blood sugars. Interventions included, but were not limited to: blood sugar checks as ordered and medications as ordered by physician. Resident 19's current physician orders included:	F 0684	It is the practice of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice What corrective action will be accomplished for those residents found to be affected by the deficit practice. The residents identified in the 2567 have been reviewed and discussed with the medical director. The provider has been notified of blood sugars and has updated orders related to long-acting insulin. (resident 19). Resident 5 has been reassessed by therapy and appropriate positioning device has been implemented as ordered. Resident 22 orders were updated to task the nurse to ensure Ted hose are applied as ordered. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. Residents with orders for long-acting insulin, positioning devices or Ted hose have the	05/08/2023

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	Levemir Solution (Insulin Detemir)--Inject 30 unit subcutaneously one time a day for diabetes. Hold insulin if blood sugar is less than 100 and notify the physician. The MAR (Medication Administration Record) dated March 2023, indicated Resident 19's blood sugar results on 3/3/2023 was 94 and on 3/17/2023 it was 89. The clinical record lacked the documentation to show the MD had been notified of the blood sugars below 100 and the insulin was not held per the physicians order. During an interview, on 3/17/2023 at 11:22 A.M., the Director of Nursing indicated the insulin was not held when the blood sugar was lower than 100, the physician should have been notified. On 3/20/2023 at 8:45 A.M., the Administrator provided the policy titled, "Medication Administration General Guidelines", dated 5/20/2020. The policy indicated "...e. Be sure to read thee label at least three (3) times, comparing label to the MAR/eMAR before administering medications...."2. During an observation, on 3/14/2023 at 12:01 P.M., Resident 5 was observed sitting in her wheelchair leaning to the right side without support, and not provided with foot pedals on her wheelchair and bilateral legs were dangling. During an observation, on 3/15/2023 at 12:06 P.M., Resident was seated in her wheelchair in the dining room leaning to her right side without support. Resident was without foot pedals and bilateral legs were dangling. During an observation, on 3/16/2023 at 11:58		potential to be affected by the alleged deficit practice. Resident charts have been audited and orders reviewed and updated as indicated for residents with long-acting insulin, positioning devices and Ted hose. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education has been provided to nurses and providers regarding order entry including appropriate task for nurses and care givers. Education provided to nurses for provider notifications as ordered. IDT will review new orders and ensure appropriate implementation of orders. A quality assurance tool has been developed to monitor residents to ensure physicians orders are followed for the administration of insulin, positioning devices and compression stockings. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	A.M., Resident was seated in her wheelchair in the dining room leaning to her right side without support, no foot pedals and bilateral legs were dangling. During an observation, on 03/17/2023 12:06 P.M., Resident was seated in her wheelchair, leaning over on her right side without support, no foot pedals provided and bilateral legs dangling. During an observation, on 3/20/2023 at 10:47 A.M., Resident was in the dining room, Resident leaning to right side in her wheelchair without support and bilateral legs dangling from wheelchair. During an observation, on 03/20/2023 at 11:56 A.M., Resident was observed asleep in the hall, slumped over on her right side in her wheelchair. A record review was completed on 3/15/2023 at 11:35 A.M. Diagnoses included but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, depressive disorder, cognitive communication deficit, muscle weakness, schizophrenia, delusional disorders, hemiplegia and hemiparesis following cerebral infarction. A Quarterly MDS (Minimum Data Set) Assessment, dated 1/23/2023, indicated Resident 5 had intact cognition. Total severity score for section D is 00. E0200 behavior not exhibited. Section G indicated Resident requires extensive assist x 2 for bed mobility and transfers. Range of motion no impairment to upper or lower extremities, no falls since admission. A current order for a high back chair with foot buddy initiated on 7/27/2021 was reviewed.			

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	During an interview, on 3/20/2023 at 12:32 P.M., LPN 11 indicated Resident 5 has a foot buddy for her wheelchair and she should have it when she is in her wheelchair. During an interview, on 3/20/2023 at 2:10 P.M., the Director of Nursing indicated Resident 5 has an order for a foot buddy to be worn when in her wheelchair and it should be on at this time.3. During an observation, on 3/13/2023 at 3:01 P.M., Resident 22's feet and lower legs were swollen. A record review was completed on 3/16/2023 at 10:36 A.M. Resident 22's diagnoses included, but were not limited to: unspecified combined systolic and diastolic heart failure, hypertensive heart disease with heart failure, and chronic atrial fibrillation. A Quarterly MDS (Minimum Data Set) Assessment, dated 12/15/2023, included, but was not limited to: severe cognitive impairment. He required extensive assistance of 1 staff person for bed mobility, transfers, dressing, and toileting. Active diagnoses included, but were not limited to: cardiorespiratory conditions, heart failure, hypertension, diabetes mellitus, and Non-Alzheimer's dementia. Resident 22's medications included, but were not limited to: diuretics taken 7 out of 7 days. Physician orders for Resident 22 included, but were not limited to: furosemide, a diuretic, 20 mg (milligrams) daily, metolazone, a diuretic, 5 mg at bedtime, and TED (thrombo-embolic deterrent) hose to be on in the morning and off at bedtime. When reviewed, neither the MAR (Medication Administration Record) nor the TAR (Treatment Administration Record) for Resident 22 included			

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	entries to apply TED hose. A care plan for Resident 22 dated 10/21/2022, included, but was not limited to: the resident was on diuretic therapy related to benign prostatic hypertrophy intervention. The interventions included, but were not limited to: administer medication as ordered and observe for, document, and report to MD (Medical Doctor) dizziness, postural hypotension, fatigue, and an increased risk for falls. There was no intervention noted for the TED hose. During an observation, on 3/16/2023 at 2:55 P.M., Resident 22 was not wearing TED hose. During an interview, on 3/16/2023 at 3:01 P.M., QMA 9 indicated she did not know anything about the resident wearing TED hose and the nurses apply TED hose. She also indicated she usually worked on the unit where the resident resides. She indicated LPN 8 was the nurse in charge of the unit on 3/16/2023. During an interview, on 3/16/2023 at 3:06 P.M., LPN 8 indicated she did not know about putting his TED hose on. During an interview, on 3/17/2023 at 9:13 A.M., the ADON (Assistant Director of Nursing) indicated the order for the TED hose was not included on the MAR but has now been added. She also indicated his legs were measured and the TED hose have been ordered. On 3/17/2022 at 11:22 A.M., a policy for following physician orders was requested from the DON (Director of Nursing) but one was not provided before survey exit.			

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F 0686 SS=D Bldg. 00	3.1-37(a) 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview the facility failed to provide appropriate timely skin treatment for a resident with a stage 2 pressure ulcer development for 1 of 1 resident reviewed for skin condition. (Resident B) Finding includes: A clinical record review of Resident B was completed on 3/16/2023 at 9:35 A.M. Diagnoses included, but were not limited to: dementia, convulsions, congestive heart failure, chronic obstructive pulmonary disease (COPD), and depression. An Admission Minimum Data Set (MDS) Assessment, dated 8/31/2022, indicated Resident B had moderate cognitive impairment. He required limited assistance with one staff member for bed mobility and toileting. He was occasionally	F 0686	It is the practice of this facility to ensure a resident receives care consistent with professional standards of practice to prevent pressure ulcers and receives treatment and services to promote healing. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident in the 2567 was not a resident at the time of survey. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. Residents with skin impairment have the potential to be affected by the alleged deficit practice. Residents with skin impairments	05/08/2023

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	incontinent of bladder and frequently incontinent of bowel. Resident B had moisture associated skin damage with application of a nonsurgical dressing and application of ointment and/or medication. The preventative measures in place included a pressure reducing device for the bed. An Admission Nursing Evaluation, dated 8/26/2022, indicated the resident had a sacrum pressure ulcer, stage 2. The assessment indicated the area was newly dressed with a Mepilex border (a dressing to absorb and retain exudate), and an assessment would be completed on the next shift. A Weekly Skin Review, on 8/28/2022, indicated mild excoriation to the gluteal cleft and peri-area. On 9/4/2022, a Weekly Skin Assessment indicated no new area of concern noted or reported. Resident B continues with excoriation to bottom. On 9/11/2022 and 9/18/2022, a Weekly Skin Assessment indicated the residents redness of pre-existing origin. A Braden Scale for Predicating Pressure Score Risk was completed on 9/29/2022. The score indicated; Resident B was at risk for pressure ulcer development. The Weekly Skin Review indicated redness, but had not indicated a location. A Nurse's Note, on 9/30/22 at 11:49 P.M., indicated an open area was found to the left and right buttocks. A new order was obtained for Duoderm (a dressing used for stage 2-4 pressure ulcers) to the left and right buttock to be changed every 72 hours. On 10/2/2022 at 2:03 A.M., a Skilled Nursing Note		have been audited and orders and care plans updated as needed to ensure appropriate and timely skin treatment. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nurses on pressure ulcer prevention and appropriate treatment policies and documentation. Residents with skin impairment will be assessed by wound doctor to ensure proper treatment. A quality assurance tool has been developed to identify residents with skin issues and ensure treatment are appropriate and have been initiated timely. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Wound Nurse / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	indicated, " ...New open area to Lt buttocks observed and the start of an open area on the Rt buttocks. Duoderm in place ...." A Skin and Wound Note on 10/3/2022 at 12:15 P.M., indicated, " ...This writer assessed area to coccyx, area is MASD, 5.5 cm x 2.0 cm x 0.1 cm ...." New order was received for Triad Paste received for the midline at the top of the buttocks, and to discontinue the Duoderm. A Wound Evaluation Flow Sheet was initiated on 10/3/2022. The assessment indicated moisture associated skin damage to the top midline buttocks and sacrum. The area measured 5.5 cm (centimeters) by 2 cm by 0.2 cm. The current preventative interventions included a pressure redistribution mattress and a wheelchair cushion. On 10/3/2022 at 12:32 P.M., a Skin and Wound Note addendum was placed that revised the area assessed to the sacrum. An outside clinical assessment group evaluated Resident B on 10/3/2023. The assessment indicated, " ... [Resident's name] was seen today for wound follow-up. He has a midline pressure sore to his sacrum that he is currently being treated per wound doctor. Today, treatment was changed. We will do DC [discontinue] and Triad paste twice daily and as needed was started. He declined assessment of area at this time, reported comfortable in chair ... MASD: Continue with Triad paste twice daily and as needed; continue with treatment plan per facility Dr. [doctor] And notify of any needs/concerns ...." A Care Plan was initiated on 10/3/2022, indicated Resident B had the potential or actual impairment to skin integrity related to moisture associated			

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	skin damage. The goals included to encourage good nutrition and hydration, monitor skin injury, report abnormalities, and to treat as ordered. During an interview on 3/20/2023 at 1:46 P.M., the Director of Nursing (DON) indicated Resident B was not followed by wound care. While on the phone with Assistant Director of Nursing, the DON indicated, " ...We need to mitigate the pressure [ulcer] versus excoriation ...." The Don indicated Resident B did not have any orders for the excoriation or MASD unless the staff had used house barrier cream. There was no documentation that house barrier cream was in use. On 3/20/23 at 3:50 P.M., the Administrator provided the policy titled, "Skin and Wound Management System". The policy indicated, " ...It is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing and/or skin integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes ...An assessment of skin integrity is to be performed on each resident upon admission to the center by completing: a. a head-to-toe physical assessment of skin condition, and b. A risk evaluation for predicting pressure will be used to determine risk status, such as the Braden Scale ...4. Preventative interventions will be implemented for residents identified at risk as appropriate ...5. Residents with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Wound location, characteristics and a physician's order for treatment are documented in the medical			

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	record. Wound status will be evaluated and documented in [electronic medical record name] on the "Wound Evaluation Flow Sheet" form ...." This Federal tag relates to Complaint IN00394202. 3.1-40(a)(2)			
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 record review an interview, the facility failed to identify a Residents risk for falls for 1 of 4 residents reviewed for falls. (Resident F) Findings include: A record review for Resident F was completed on 3/17/2023 at 1:40 P.M. Diagnoses included, but were not limited to: hemiparesis and hemiplegia following a cerebral infarction (stroke) affect the right dominant side, diabetes mellitus type 2, and cognitive communication deficit. An Admission Nursing Evaluation on 2/10/2023, was not completed to determine fall risk. An Admission MDS (Minimum Data Set) Assessment, dated 2/10/2023, indicated Resident F had moderate cognitive impairment. He required extensive assistance with two or more staff	F 0689	It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident in the 2567 had been discharged at the time of survey. A fall risk assessment was completed on his return and a care plan for fall risk has been implemented. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents	05/08/2023

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	members for transfer, bed mobility, and toileting. He had a Foley catheter and was always continent of bowel. Resident F had a fall in the previous month. A late entry Nursing Note, on 2/11/2023 at 9:30 A.M., indicated Resident F attempted to transfer self to the bathroom and fell. No injuries were noted at the time, and Resident F denied pain or discomfort. On 2/12/2023 at 7:32 P.M., a Nurse's Note indicated that Resident F denied pain or discomfort in the morning. Family approached the nurse and stated Resident F had complained of pain to the right chest when taking a deep breath. Light bruising was observed measuring 4 cm (centimeters) by 2 cm at the site Resident F complained of pain. A new order was obtained for a 2-view chest x-ray. On 2/12/2023 at 8:33 P.M., a Nurse's Note indicated the nurse received a call from the Power of Attorney (POA). The POA indicated Resident F had discomfort with breathing and soreness to the chest and flank. The POA requested Resident F be sent to the Emergency Department for evaluation. A Care Plan for falls was initiated on 2/12/2023. An Emergency Department History and Physical on 2/13/2023 at 12:25 A.M., indicated, " ...Patient reports that he has been mostly wheelchair-bound at the nursing facility, while attempting to transfer from wheelchair to bed he fell and landed on his right side. He reports that this happened a couple of days ago. On Saturday patient was again attempting to transfer from the wheelchair to the bed and fell landing on his right side. He did [sic]		have the potential to be affected by the alleged deficit practice. An audit was completed on all residents to ensure a fall risk assessment has been completed with no negative findings. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. All residents will be assessed for fall risk and residents at risk for falls will have interventions in place to prevent accidents. Education will be provided to staff related to accident prevention. A quality assurance tool has been developed to monitor residents that fall risk assessments have been completed, a care plan in place if determined to be at risk for falls and appropriate interventions are in place. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	initially have pain but did not want to be seen at the hospital as he thought the pain would resolve on its own, however the pain in his right side of his chest continued. He describes the pain as sharp and stabbing 8 out of 10 in severity at worst. He has significant pain with deep breath or cough ...Patient will be admitted for further evaluation and treatment of right-sided rib fracture, pulmonary toilet, and pain control ...Assessment and Plan: Rib fractures. CT of the chest fields nondisplaced right lateral ninth rib fracture and minimally displaced right posterior lateral 10th rib fracture ...." On 2/13/2023 at 12:00 P.M., a Nurse's Note indicated Resident had been admitted to the hospital for rib fractures. During an interview on 3/20/2023 at 1:31 P.M., the Director of Nursing (DON) indicated nursing evaluations, including fall risk, should be completed upon admission. On 3/20/2023 at 3:50 P.M., the Administrator provided a policy titled, "Falls Management System". The policy indicated, " ...It is the policy of this center to provide each resident with appropriate evaluation and intervention to prevent falls and to minimize complications of a fall occurs. Additionally, all resident falls in this center are analyzed and trended through the Performance Review process to maintain a safe environment ...a. At the time of admission, each resident is evaluated to determine his/her risk for sustaining a fall ...." This Federal tag relates to Complaint IN00394560. 3.1-45(a)(2)			

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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 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, record review and interview, the facility failed to prevent residents from getting a urinary tract infection related to	F 0690	It is the practice of this facility to ensure that residents receive treatment and care in accordance	05/08/2023

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	having a drainage bag at the waist level and not having documentation to show catheter care had been provided for 2 of 2 residents reviewed for catheter use. (Resident 38 & F) Findings include: 1. During an observation, on 3/13/2023 at 2:38 P.M., Resident 38 was observed with a urinary drainage bag hanging on the side of his pants at the waist band. A clinical record review was completed, on 3/20/2023 at 10:48 A.M. Resident 38's diagnoses included, but were not limited to: congestive heart failure, benign prostate hypertrophy, dementia, and obstructive uropathy. An Annual MDS (Minimum Data Set) Assessment, dated 2/23/2023, indicated Resident 38 required limited assist of 1 staff for bed mobility, transfers, dressing, eating and toilet use. Required the use of a Foley Catheter and was occasionally incontinent of bowels. A current care plan, dated 2/15/2022, indicated the resident had an Indwelling Catheter. Interventions included, but were not limited to: catheter care every shift and PRN (as needed) for soilage. Catheter drainage bag to drain to gravity. Position catheter bag and tubing below the level of the bladder. Change catheter bag on shower day and PRN. Check tubing for kinks each shift/per policy. Current physician orders for March included: 16 French Foley catheter with a 10 cc balloon to straight drainage for urinary retention. Catheter drainage bag to gravity - check every shift. Catheter care every shift for preventative and as needed for soilage.		with professional standards of practice by receiving services and assistance in the maintenance of urinary catheters. What corrective action will be accomplished for those residents found to be affected by the deficit practice. Resident F identified in the 2567 was not in the facility during the survey. On his return, monitoring is being completed to ensure the drainage bag is below the waist level and documentation on the EMR is being completed for catheter care. Resident #38 is being monitored to ensure the drainage bag is below the waist level and documentation on the EMR is being completed for catheter care. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents with foley catheters have the potential to be affected by the alleged deficit practice. An audit of orders for residents with foley catheters has been completed and updated as indicated. Monitoring is being conducted to ensure that drainage bags are below waist level. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nursing staff to ensure residents with foley catheters have appropriate orders and care plans	

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	A Nurses Note, dated 11/2/2022 at 6:24 A.M., indicated an additional 350 ml (milliliters) of clear, yellow urine emptied out of overnight bag. This is an addition to the 650 ml this nurse emptied out of bag on second shift. A Nurses Note, dated 11/4/2023 at 4:30 P.M., indicated Management staff reported the resident was noted on floor, laying on his right side. The resident had a skin tear to his right hand, was not able to move fingers and complained of numbness. Had a hematoma to right side of forehead and an abrasion to the left knee. New order was received to send the resident to the hospital emergency room for evaluation and treatment. A Nurses Note, dated 11/4/2023, indicated the hospital was called for and update. Resident still in the ER at this time but is being admitted with diagnosis of UTI (urinary tract infection). Resident 38 returned to the facility on 11/7/2023. A Nurses Note, dated 11/10/2023, indicated UA (urinalysis) with C&S (culture and sensitivity) if indicated one time only for 1 Day. Unable as no UA cups available. A Nurses Note, dated 11/21/2022 at 8:30 A.M., indicated the physician was notified, and a new order was received for a UA and C and S if indicated. A Nurses Note, dated 11/22/2022 at 5:04 A.M., indicated the UA was collected via Foley for specimen, lab notified for pick up, specimen on ice.		to prevent infection and provide appropriate catheter care. A quality assurance tool has been developed to monitor that urinary catheters have preventative maintenance being completed. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	A Nurses Note, dated 11/22/2022 at 10:24 P.M., indicated the catheter had clear amber urine to gravity in overnight bag. A Nurses Note, dated 11/25/2022 at 10:32 A.M., indicated the urinalysis results were received and reported to NP (Nurse Practitioner). New order received for Cipro (antibiotic) 250 mg (milligrams) two (2) times a day for 7 days. On 2/25/2023 an order was received for Macrobid Capsule (antibiotic) 100 mg, give 1 capsule two (2) times a day for enterococcus faecalis for 7 days. During an observation, on 3/20/2023 at 1:18 P.M., Resident 38 was sitting in his wheelchair with the drainage bag uncovered. The drainage tube had a large amount of sediment and was not draining into the bag. During an observation, on 3/20/2023 at 1:32 P.M., with LPN 3, Resident 38's catheter was not draining into the drainage bag. She indicated she was not sure why he did not have a leg bag on, and indicated the tubing was full and could not drain properly, and indicated the bag should be below the bladder. 2. During an observation, on 3/14/2023 at 9:27 A.M., Resident F's catheter drainage bag was not covered. During an interview, on 3/14/2023 at 2:06 P.M., the residents son indicated took almost a week to get the results. A record review was completed, on 3/16/2023 at 1:49 P.M. Resident F was admitted on 2/10/2023, discharged to the hospital on 2/12/2023 and returned to the facility on 2/15/2023. His			

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	155086	A. BUILDING 00 B. WING	03/21/2023

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	diagnoses included, but were not limited to: benign prostatic hyperplasia, neurogenic bladder, diabetes, hemiplegia and depression. An Admission MDS (Minimum Data Set) Assessment, dated 2/21/2023, indicated Resident F had moderate cognitive impairment. Required extensive assist of 2 staff for bed mobility, transfers, dressing, and toilet use, and limited assist for eating. Used an indwelling catheter and was incontinent of bowels. A current care plan, dated 2/16/2023, indicated the resident had an Indwelling Catheter related to a neurogenic bladder. Interventions included, but were not limited to: has 14 french Foley 10 cc balloon. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Check tubing for kinks each shift/per policy. Observe for/document/report to physician for signs & symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Provide catheter care every shift. A Nurses Note, dated 3/10/2023 at 12:53 P.M., indicated an order was received for urinalysis, culture and sensitivity if indicated per NP (Nurse Practitioner) for cloudy urine. A Nurses note, dated 3/10/2023 at 3:47 P.M., indicated the urine had been obtained for urinalysis. Laboratory was called for a STAT pick up. A new physician's order was received on 3/14/2023 to start Macrobid (antibiotic) 250 mg			

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	(milligrams) twice a day for 7 days. Resident F's admission orders, for 2/10/2023, lacked any Foley catheter orders for catheter care, drainage bag changes, flushes, as needed catheter changes, or to monitor outputs. The Medication and Treatment Administration Records for February 2/2023 lacked the documentation to show that catheter care had been completed. During an interview, on 3/17/2023 at 10:57 A.M., QMA 13 indicated they complete catheter care on Resident F, then they will tell the nurse and the nurse will document it, because we (the aides) have no place to document it. During an interview, on 3/17/2023 at 11:24 A.M., the Director of Nursing indicated there should have been catheter orders. She indicated the catheter care was done, and should have been documented on the MAR (Medication Administration Record) or TAR (Treatment Administration Record). On 3/21/2023 at 12:30 P.M., the Director of Nursing provided the policy titled,"Catheter Care, Urinary", dated 2014. The policy indicated"...The purpose of this procedure is to prevent catheter-associated urinary tract infections. ... 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder... 19. Check drainage tubing and bag to ensure that the catheter is draining properly... Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title			

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	of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction... 9. The signature of and title of the person recording the data...." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to follow a dietary recommendation for changing a diet for 1 of 4 residents reviewed for nutrition. (Resident 66)	F 0692	Nutrition/Hydration Status Maintenance It is the practice of this facility to ensure that residents receive treatment and care in accordance with	05/08/2023

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	Finding includes: A clinical record review was completed on 3/17/2023 at 9:55 A.M. Resident 66's diagnoses included, but were not limited to: depression, diabetes, hemiplegia, gastro and heart failure. An Admission MDS (Minimum Data Set) Assessment, dated 12/23/2022, indicated Resident 66 required supervision for eating, received insulin and antidepressant medications. Resident 66's current diet order included: regular texture NAS (no added salt) ground meat and double portions. A current care plan, dated 2/19/2023, indicated the resident is at risk for impaired nutrition related to dysphagia, history of variable intakes. Has diagnoses of diabetes type 2, congestive heart failure, chronic kidney disease and gastro esophageal reflux disease. The resident has desired weight loss by limiting intake and increased physical activity. An Interdisciplinary Note, dated 1/11/2023 at 4:32 P.M., indicated the IDT team is monitoring for weight variance. Has dysphagia, status post CVA (cerebral vascular accident) and adjustment to facility. Weight loss appears verified. Nursing reports resident increased exercise and activity along with limiting intake with goal to lose weight; usual weight 180-190. 12/29/2022 Vitamin D with in normal limits. Plan liberalized diet and increase portions to stabilize weight and support activity. Continue to monitor. A Medical Nutrition Therapy Recommendation form, provided by LPN 10 indicated for the week of 1/4/2023 the Registered Dietician recommended		professional standards of practice by offering a therapeutic diet when there is a nutritional problem and the health care provider recommends a diet change. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident identified in the 2567 diet ordered was updated as recommended. This resident has discharged from the facility. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. Residents with nutrition recommendations have the potential to be affected by the alleged deficit practice. All dietary recommendations will be addressed upon receipt by the dietician. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nurses in coordination with dietician to ensure dietary recommendations are addressed appropriately. An audit of dietary recommendations will be completed and orders updated as indicated. A quality assurance tool has been developed to monitor that all dietary recommendations have been addressed by the provider. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e.,	

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	a reweigh and discontinue the NAS regular thin liquids related to low blood pressure. During an interview, on 3/21/2023 at 11:11 A.M., LPN 10 indicated the resident's diet had not been changed from the RD recommendations and should have been. On 3/21/2023 at 3:30 P.M. a policy for Following Registered Dietician recommendations was requested, but on was not provided. 3.1-46		what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review and interview, the facility failed to ensure ordered medications were administered per physician orders for 1 of 9 residents observed for medication administration. (Resident 14) Finding includes: On 3/15/2023 at 8:29 A.M., LPN 2 pulled Resident 14's medications from the medication cart. LPN 2 indicated she did not have the ensure (supplement drink) to give to her and did not have the Lidoderm patches. She stated the patches had been ordered. A clinical record review was completed on 3/15/2023 following the medication pass. The MAR (Medication Administration Record) had been documented with the code (16) "held and see nurses notes". Resident 14's current medication orders included: Lidoderm Patch 5% (Lidocaine) apply to right ankle topically every 12 hours for primary osteoarthritis and Lidoderm Patch 5% (Lidocaine) apply to right shoulder topically in the morning for primary osteoarthritis, 1 patch up to 12 hours remove at 6:00 P.M. No nurses notes were documented in the chart for	F 0755	Pharmacy Services/Procedures/Pharmacist Records It is the practice of this facility to follow professional standards of practice by ensuring ordered medications are administered as per physicians orders What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident #14 identified in the 2567 was provided medications as ordered. Physician was notified of any missed doses or medications. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents that take medications have the potential to be affected by the alleged deficit practice. An audit will be completed on all medication carts to ensure medications are available. Medications will be available as ordered or medical provider and pharmacy will be notified. What measure will be put into place and	05/08/2023

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	the reason why the patch was not given, or if the physician had been notified. On 3/17/2023 at 2:43 P.M., the Director of Nursing provided the policy titled,"Emergency Pharmacy Service and Emergency Kits", dated 5/20/2020. The policy indicated"...Emergency pharmacy service is available on a 24 hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances and products for infusion are supplied by the pharmacy in limited quantities, in portable, sealed containers, in compliance with applicable state regulations. ...5. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or from the pharmacy...." 3.1-25(a)		what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nurses and QMAs including ordering, use of the EDK, and notification to provider. Medications available in the EDK have been listed in the binder on each medication cart to increase nursing efficiency. A quality assurance tool has been developed to monitor that medications are available, and if unavailable, pharmacy and physician have been notified. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported quarterly in QAPI.	
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.			

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	§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 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 observations, interviews, and record reviews the facility failed to ensure that the physician was aware of, and documented in the clinical record, any action taken, or if no action was taken, the rationale, for 3 out of 5 residents reviewed for unnecessary medications and	F 0756	Drug Regimen Review It is the practice of this facility to ensure pharmacy medication reviews are reviewed by the physician and results of the review are documented in the clinical record.	05/08/2023

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	medication regimen review. (Residents 22, 31, and 39) Findings include: 1. During a record review for Resident 22, on 3/16/2023 at 10:36 A.M., a Quarterly MDS (Minimum Data Set) Assessment, dated 12/15/2022, included but was not limited to: indication of severe impairment, feeling down or depressed, trouble sleeping, and feeling bad about himself 7-11 days during the assessment period. Resident 22 exhibited physical and verbal behavior symptoms daily during the assessment period. He also exhibited other behavior symptoms toward others daily during the assessment period. Resident 22 required extensive assistance of 1 staff person for bed mobility, transfers, dressing, and toileting. Active diagnoses included, but were not limited to: Non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. other than schizophrenia. Medications included, but were not limited to: antipsychotic, antianxiety, antidepressants for 7 out of 7 days during the assessment period. A GDR (Gradual Dose Reduction) had not been attempted. Diagnoses for Resident 22 included, but were not limited to: vascular dementia unspecified severity with other behavioral disturbance, psychotic disorder with delusions due to known physiologic condition, major depressive disorder, and unspecified psychosis not due to a substance or physiologic condition. Resident 22's physician orders included, but were not limited to: on 10/18/2021 behavior monitoring for resisting or refusing care. On 10/26/2021 behavior monitoring for refusing meds. On		What corrective action will be accomplished for those residents found to be affected by the deficit practice. Residents identified in the 2567 pharmacy recommendations were reviewed by provider and orders have been updated accordingly. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents with pharmacist recommendations have the potential to be affected by the alleged deficit practice. Pharmacist recommendations have been reviewed and given to providers. Documentation has been added to the record. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. The DON, ADON, MDS and Unit Manager have been educated on pharmacy review process and have electronic access to recommendations and reviews. Nurses and QMAs have been educated on pharmacy recommendation process. A quality assurance tool has been developed to monitor that pharmacy recommendations have been completed and documentation is present in the EMR. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program	

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	9/16/2022 monitor side effects of antipsychotic medications. On 12/5/2022 monitor for side effects of antidepressant and antianxiety medications. On 10/21/2021 Aricept 10 mg (milligrams), on 4/23/2022 Namenda 20 mg for vascular dementia. On 4/5/2022 Risperdal 0.5 mg for unspecified psychosis. On 8/1/2022 sertraline 100 mg for vascular dementia. On 11/6/2022 lorazepam 1 mg for general anxiety disorder. A care plan for Resident 22 included, but was not limited to: a problem, dated 10/12/2021, indicated the resident on antipsychotic medications related to behavior management and psychosis. Interventions included, but were not limited to: administer medications as ordered, observe and document for side effects and effectiveness, consult with pharmacy and medical doctor to consider dosage reduction when clinically appropriate. A problem dated 10/28/2022, indicated the resident uses antianxiety medications related to psychotic disorder and agitation. Interventions included, but were not limited to: give meds as ordered, and observe for and record occurrence of target behavior symptoms. A problem dated 11/19/2022 indicated the resident uses antidepressant medications related to depression. Interventions included, but were not limited to: give medications as ordered, monitor, document, and report to MD (medical doctor) side effects and effectiveness, and monitor, document, and report to MD ongoing symptoms of depression. A pharmacy recommendation for Resident 31, dated 10/29/2022, indicated discontinue donepezil. No signature or note from the physician was noted on recommendation form. During an interview, on 3/16/2023 at 11:24 A.M.,		will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all new admissions weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported quarterly.	

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	the DON (Director of Nursing) indicated the physician notes regarding pharmacy recommendations would be in the Progress Notes unless the nurse practitioner made the note, then it would be in the Forms section of the electronic medical record. No documentation was found in either the Progress Notes or Forms. During an interview, on 3/17/2023 at 9:20 A.M., the ADON (Assistant Director of Nursing) indicated that she will find the pharmacy recommendation forms that the physician or nurse practitioner documented on. No forms were provided. 2. A record review was completed for Resident 31 on 3/15/2023. The Quarterly MDS Assessment dated 3/9/2023 included, but was not limited to: severe cognitive impairment. Resident 31 showed little interest in doing things for 7-11 days during the assessment period, felt down or depressed, tired with little energy, and felt bad about herself for 12-14 days during the assessment period. She exhibited delusions and rejected care 1-3 days during the assessment period. Resident 31 required limited assistance of 1 staff person for bed mobility and transfers, and extensive assistance of 1 staff person for dressing and toileting. Her active diagnoses included, but were not limited to: progressive neurological conditions, late onset Alzheimer's, Non-Alzheimer's dementia, anxiety disorder, depression, and PTSD (post-traumatic stress disorder). Medications included, but were not limited to: antipsychotic and antidepressant for 7 out of 7 days. Diagnoses for Resident 31 included, but were not limited to: Alzheimer's with late onset, PTSD, and recurrent major depressive disorder.			

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	Physician orders for Resident 31 included but were not limited to: on 8/9/2021 behavior monitoring for wandering into other's rooms, yelling and cussing at staff, hitting staff, and refusing medications and care. On 11/29/2021 Guidestar Psych Services to eval and treat. On 12/5/2021 monitor side effects of antidepressant medications. On 1/6/2023 monitor side effects of antipsychotic medications. On 1/12/2023 Risperdal 0.25 mg with 0.5 mg related to dementia, unspecified severity, with other behavioral disturbances. On 8/10/2021 memantine 28 mg related to Alzheimer's Disease. On 3/4/2022 mirtazapine 7.5 mg related to major depressive disorder. On 4/4/2022 Aricept 10 mg related to Alzheimer's Disease. On 8/25/2022 Zoloft 100 mg, give 1.5 tablets. A care plan for Resident 31 included, but was not limited to: a problem, dated 8/5/2022 indicating short term memory impairment related to Alzheimer's and depression. Interventions included, but were not limited to: administer medications per MD (medical doctor). A problem, dated 9/6/2022, indicated the resident uses psychotropic medications related to dementia. Interventions included, but were not limited to: administer medications as ordered, monitor and document for side effects and effectiveness, and monitor, record, and report to MD side effects and adverse reactions to antipsychotic medications, and observe and report any change in mental status. A pharmacy recommendation for Resident 31, dated 10/29/2022, indicated discontinue Aricept and Namenda. No signature or note from the physician was noted on recommendation form.			

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	155086	A. BUILDING 00 B. WING	03/21/2023

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	During an interview, on 3/16/2023 at 11:24 A.M., the DON indicated the physician notes regarding pharmacy recommendations would be in the Progress Notes unless the nurse practitioner made the note, then it would be in the Forms section of the electronic medical record. No documentation was found in either the Progress Notes or Forms. During an interview, on 3/17/2023 at 9:20 A.M., the ADON indicated that she will find the pharmacy recommendation forms that the physician or nurse practitioner documented on. No forms were provided.3. A clinical record review was completed on 3/15/2023 at 6:00 A.M. Resident 39's diagnoses include, but were not limited to: diabetes, hypothyroidism, dementia, anxiety, and depression. A Quarterly MDS (Minimum Data Set) Assessment, dated 2/2/2023, indicated Resident 39 had no cognitive impairment. Required supervision of 1 staff for bed mobility, transfers, dressing, eating, toilet use and bathing. Received an antidepressant medication A Note to Attending Physician/Prescriber, dated 2/28/2022, indicated Resident 39 received the following pertinent medication: Pantoprazole 40 mg (milligrams) daily that was started on 8/11/2021. Please consider one of the following to re-evaluate the continued need for therapy. Discontinue Pantoprazole or Discontinue Pantoprazole and Start Famotidine 20 mg daily PRN (as needed) indigestion or Discontinue Pantoprazole and start Famotidine 20 mg daily. The note lacked a Physicians response to agree, disagree and or other and lacked a date or signature of the physician. A Consultant Pharmacist Recommendation to			

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	DON/Medical Director, dated 9/30/2023, indicated the Pharmacist had recommended Resident 39 was currently receiving the following pertinent medication: Pantoprazole 40 mg daily and Famotidine 20 mg daily. Pantoprazole (PPI) blocks 2 of 2 possible pathways of acid secretion. Famotidine (H2 Antagonist) blocks 1 of 2 possible pathways of acid secretion. Please consider the following: Discontinue the Famotidine or decrease the Famotidine to 20 mg daily PRN (as needed) for Indigestion. A Note to Attending Physician/Prescriber, dated 11/30/2022, indicated Resident 39 had the following pertinent medication order: Promethazine 25 mg every 6 hours PRN and Ondansetron 4 mg every 4 hours PRN. Promethazine is considered an antipsychotic (phenothiazine type) and its use scrutinized due to more safe alternatives being available. Please consider the following: Discontinue the as needed Promethazine in favor of as needed Ondansetron. The note lacked a Physicians response to agree, disagree and or other and lacked a date or signature of the physician. A Note to Attending Physician/Prescriber, dated 1/31/2023, indicated Resident 39 had the following pertinent medication order: Promethazine 25 mg every 6 hours PRN and Ondansetron 4 mg every 4 hours PRN. Promethazine is considered an antipsychotic (phenothiazine type) and its use scrutinized due to more safe alternatives being available. Please consider the following: Discontinue the as needed Promethazine in favor of as needed Ondansetron. The note lacked a Physicians response to agree, disagree and or other and lacked a date or signature of the physician.			

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	A Note to Attending Physician/Prescriber, dated 1/31/2023, indicated Resident 39 was receiving the following pertinent medications: Pantoprazole 40 mg daily and Famotidine 20 mg every night. Pantoprazole (PPI) blocks 2 of 2 possible pathways of acid secretion. Famotidine (H2 Antagonist) blocks 1 of 2 possible pathways of acid secretion. Please consider the following: Discontinue the Famotidine and if additional therapy necessary consider: Change Pantoprazole to 40 mg every night or change Pantoprazole to 20 mg every 12 hours. The note lacked a Physicians response to agree, disagree and or other and lacked a date or signature of the physician. Current medications for Resident 39 included: Famotidine 40 mg 1 tablet at bedtime, Pantoprazole Sodium Tablet Delayed Release 40 mg 1 tablet in the morning and Promethazine 25 mg 1 tablet every 6 hours as needed. During an interview, on 3/17/2023 at 11:22 A.M., the Director of Nursing indicated there was a lack of follow through and she would have to get in touch with his GI doctor about the recommendations. On 3/20/2023 at 11:50 A.M., the Administrator provided the policy titled, "Pharmacy Recommendations- Facility Communication Policy And Procedure", dated 6/8/2018. The policy indicated"...4. The reviewing pharmacist will submit the Pharmacist Recommendation report with recommendations for identified irregularities, including previously communicated urgent irregularities to the attending physician, to the DON, and the Medical Director. 5. After receiving the Pharmacist Recommendation report the DON, or his/her designee, will: a. Notify the appropriate physician of the pharmacist recommendations in			

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	the method preferred by the physician. Note the date and time of initial physician notification. b. Urgent irregularities will result in immediate notification of physician. c. For non-urgent recommendations, the recommendations will be forwarded to the physician upon receipt. d. For non-urgent recommendations, the physician may address at the nest visit in the facility per the physician discretion. e. The DON, or his/her designee, will track the physician's response to the pharmacist recommendations.... 3.1-25(i)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 1 of 9 residents observed during medication pass. Two (2) medication errors were observed during 29 opportunities for error in medication administration. This resulted in a medication error rate of 6.9 %. The errors involved 1 resident (Resident 14) in a sample of 9. Finding includes: On 3/15/2023 at 8:29 A.M., LPN 2 pulled Resident 14's medications from the medication cart. LPN 2 indicated she did not have the ensure (supplement drink) to give to her and did not have the Lidoderm patches. She stated the patches had been ordered.	F 0759	It is the practice of this facility to ensure that medication error rates are not 5 percent or greater. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The resident #14 identified in the 2567 has been provided medications as ordered. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents that receive medications have the potential to be affected by the alleged deficit practice. Medication administration has been observed with all qualified personnel to	05/08/2023

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	A clinical record review was completed on 3/15/2023 following the medication pass. The MAR (Medication Administration Record) had been documented with the code (16) "held and see nurses notes". Resident 14's current medication orders included: Lidoderm Patch 5% (Lidocaine) apply to right ankle topically every 12 hours for primary osteoarthritis and Lidoderm Patch 5% (Lidocaine) apply to right shoulder topically in the morning for primary osteoarthritis, 1 patch up to 12 hours remove at 6:00 P.M. On 3/17/2023 at 2:43 P.M., the Director of Nursing provided the policy titled, "Adverse Consequences and Medication Errors", dated 4/2014. The policy indicated"... 5. A "medication error" is defined as the preparation or administration of drugs or biological's which are not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication errors include: a. Omission - a drug is ordered but not administered...." 3.1-48(c)(1)		ensure error rate is less than 5%. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nurses and QMAs with a focus on drugs ordered but not administered. Medication pass will be monitored by DON/designee and continuing education will be provided as identified. A quality assurance tool has been developed to monitor medication administration to ensure error rate is less than 5%. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on 5 residents weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported quarterly in QAPI.	
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			

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	§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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, and record review, the facility failed to ensure medication carts were locked when unattended; failed to ensure medication storage areas were free from loose medications; failed to date medications when opened; failed to have medications labeled with resident identifiers during medication storage reviews for 2 of 2 medication carts and 1 of 1 medication rooms observed. (300 hall medication cart, 100 hall medication cart, and 100 hall medication room) Findings include: 1. During a random medication cart observation, on 3/14/2023 at 1:53 P.M., the medication cart on the 300 hall was unlocked with no staff in attendance of the cart. During an interview, on 3/14/2023 at 1:55 P.M. RN 10 indicated the cart should not be unlocked.	F 0761	It is the practice of this facility to label drugs and biologicals in accordance with currently accepted professional standards. What corrective action will be accomplished for those residents found to be affected by the deficit practice. Deficit findings identified in the 2567 have been corrected. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents receiving medications have the potential to be affected by the alleged deficit practice. Medication carts and medication rooms will be audited for loose pills, expired or improperly labeled medications. Carts and medication rooms will be cleaned. What measure will be	05/08/2023

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	2. On 3/16/2023 at 10:46 A.M., a medication cart storage observation on the 100 hall cart was completed with LPN 2. The following was observed: In the top drawer were 3 medication cups with pills in them. LPN 2 indicated that resident refused and I should destroy them. An opened bottle of Systane eye drops, an opened bottle of Refresh eye drops with no resident labels or a date when opened. An opened and undated bottle of Polyvinyl 1.4 % eye drops. An opened tube of refresh eye ointment with no date opened. Two (2) opened tubes of refresh eye ointment dated 6/1/2022. An opened bottle of Akwa tear with a date opened 10/20/2022. An opened bottle of nose spray with no dated opened. An unopened container of Triad hydrophilic wound dressing in with the eye drops. An opened multi dose vial of Humalog insulin with no resident identifiers. An opened vial of Lispro insulin dated 1/25/2023..A Lantus insulin injector pen with no resident identifier. An opened Humalog insulin pen with no date opened and or resident identifiers. An open date of 12/31/2022 Humalog insulin pen with no resident identifiers. A albuteral inhaler with no date opened. In the top drawer were 3 loose pills, an expired bottle of sodium chloride. An opened container of antacid tablets with no resident identifiers. An opened bottle of liquid antacid with no date or resident identifiers. An opened bottle of Guinfenassin Liquid with no resident identifiers. An opened bottled of Milk of Magnesium with no date opened. An opened bottle of Milk of Magnesium with no resident identifiers. An opened container of antacid tablets with no opened date. An Ellipta Inhaler with the resident label removed. An opened bottle of valporic acid with no date opened. An opened bottle of Lactulose with no date opened. A small plastic bag with small white paper packages		put into place and what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to nurses and QMAs on proper medication label and storage practices, including locking medication carts when unattended, maintaining temperature control logs and storing wound supplies. A quality assurance tool has been developed to monitor that medications are labeled and stored properly. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing / Designee on all medication storage areas weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	ripped that contained 17 different pills for a resident who had gone LOA. An advair inhaler, Albuterol inhaler, and Ellipta Inhaler with no resident identifiers. During an interview, on 3/17/2023 at 2:15 P.M., LPN 2 indicated the medications should be labeled, have a date when opened, no loose pills in the drawers and the wound cleanser should not be in the medication cart. 2. During a medication room observation of the 100 hall, on 3/16/2023 at 11:15 A. M., with LPN 3 the following was observe: In the cabinet an opened bottle of vitamin D3 with no resident identifier. An opened bottle of Biotene spray with no open date. An opened bottle of Milk of Magnesium with the resident label peeled off and no open date An open bottle of cranberry pill that expired 12/2022 with no resident identifiers. In the medication refrigerator there was an opened vial of Tubersol (for tuberculin testing) with no date opened. The thermometer indicated the fridge temperature was 50 degrees. The temperature log sheet affixed to the front of the refrigerator lacked the documentation to show the temperature had been taken in the last 8 days from 3/9/2023 to 3/16/2023. During an interview, on 3/16/2023 at 11:23 A.M., LPN 3 indicated the medications should be labeled, have a date opened on them, and a resident label. During an interview, on 3/16/2023 at 11:29 A.M., LPN 3 indicated the fridge temperature log sheet should have been completed every day and was not.			

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	On 3/20/2023 at 8:45 A.M., the Administrator provided the policy titled,"Medication Administration General Guidelines", dated 5/20/2020. The policy indicated..." t. Medication carts are kept locked at all timesm when not in sight of the licensed personnel passing medications... v. If a resident is not available, flag MAR/TAR, and return to that resident later.... On 3/20/2023 at 2:49 P.M., the Administrator provided the policy titled,"Storage of Medications and Biologicals", dated 5/20/2020. The policy indicated "...2. The facility is required to secure all medications in a locked storage area... 7 Medication(s) labeled for individual residents are stored in separately than floor stock medications when not on the medication cart... 11. Medication(s) requiring storage in a refrigerator are kept at temperature maintained between 2 and 8 C (36 and 46). 12. Medication(s) requiring strorage in cold are kept at temperatures not exceeding 46 degrees F. 3.1-25(j)(m)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	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 clinical record review, the facility failed to store and prepare food in a sanitary manor in the kitchen,and resident pantries for 5 of 5 observations of food storage. (Unit 100/200, 300, and 400) Findings include: 1. During an observation of the kitchen with the Dietary Manager, on 3/13/2023, the following was observed: the doorway to the kitchen has a large chunk of plaster missing with cracks and missing plaster above the door, floor tiles around the handwashing sink were broken and missing pieces. On the inside of the door paint was peeling on the right side. A device on the same wall did not have a cover and the inner workings were exposed. Part of the wall behind the ice machine was falling off and the wall was dirty. The microwave had dried food particles on the walls and door. A cold air blower in the food preparation area had dark brown grime and dust. Paint on the ceiling around the blower was peeling. In general the walls were dirty with dried brown liquid dripping down. The dry storage room vent was dusty and crusted with brown dirt. The clasp for the lock on the door was rusty.	F 0812	It is the practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. What corrective action will be accomplished for those residents found to be affected by the deficit practice. Specific items identified in the 2567 have been quoted and awaiting scheduling of contractor projection in second week of May for wall repair, missing plaster, and area around the blower in the ceiling; all other items have been cleaned, replaced, and corrected. Pantry refrigerators and pantries have been cleaned. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the alleged deficit practice. An audit has been completed of all kitchen and pantry areas and all areas identified not being in compliance have been corrected. What measure will be put into place and	05/08/2023

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	The walk in cooler had left over pot roast left over from supper the night before that was not dated. An open bag of cubed turkey ham was open and not sealed or dated. The walk in freezer had an open container of ice cream that was not dated. An open bag of cookie dough that was not sealed or dated and an open bag of pancakes that was not sealed or dated. Wire metal shelves in the food preparation area were rusty, had brown grime, and dust over all the wires. The floor was dirty, sticky, and had food and paper debris scattered around. 2. During an observation on 3/15/2023 at 11:15 A.M., Cook 15 washed the bowl for the food processor by hand and swished it through the sanitizer sink for less than 10 seconds. The procedure sign on the wall by the sink indicated that items should be left in the sanitizer for 1to2 minutes. During an interview at that time Cook 15 indicated that he normally does it for about 10 seconds, but it should have been left in the sanitizer for 1to2 minutes. 3. An observation of unit pantries was completed on 3/20/2023 at 2:08 P.M. A drawer in the pantry for the 100/200 unit contained tourniquets, vacutainers, and small gauze packets. LPN 11 indicated that those items should not be there. 4. The unit 300 refrigerator temperature was 44 degrees and there was no temperature log was with the refrigerator. During an interview with LPN 12 she indicated she could not find the temperature logs but there should be a log with		what systematic changes will be made to ensure the deficit practice does not recur. Education will be provided to staff for storing, preparing and serving food. A quality assurance tool has been developed to monitor areas in the kitchen and pantry that need repair, areas that require cleaning, food storage, dish sanitizing and refrigerator temperatures. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Dietary Director / Designee on 5 kitchen/pantry areas weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily entries. 5. The unit 400 refrigerator was 42 degrees. Temperature logs indicated temperatures were done in January but not February or March. There were 2 bottles of juice opened but no date was found. A resident snack brought in by a family member did not have a date. The freezer had a thick layer of frost and there was no thermometer. A spill of a yellow/white liquid was noted on the bottom of the freezer. During an interview, QMA 13 indicated that the snack and juice should be dated. She also indicated that night shift does the temperatures, so she does not know about the logs. During an interview, on 3/21/2023 at 1:03 P.M., the Administrator indicated that temperatures of pantry refrigerators and freezers should be taken daily, and each refrigerator and freezer should have a thermometer. A policy provided by the Administrator, on 3/20/2023 at 3:50 P.M., titled, "Food Storage" and dated 3/26/2020, indicated, " ...A thermometer is available in all storerooms, freezers, and refrigerator units ...." It also indicated, " ...Un-served leftovers shall be labeled, dated, and stored for a period of time not to exceed three days ..." and " ...The Culinary & Nutrition Services Manager, Cook or designee, will check refrigerator, freezers, and storerooms twice daily for proper temperature maintenance. The Culinary & Nutrition Services Manager maintains records of such information ...." 3.1-21(i)(3)			
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	03/21/2023

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Bldg. 00	§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 a safe, clean and comfortable environment was maintained, related to a low temperature in a shower room, clogged sink, stains and gouged areas on walls, dirty floors, missing call light covers, a broken electrical box, chipped paint, metal, missing floor tiles, faucets that continuously run, leaking toilets, broken ceiling tiles and black/rust colored substances around the bases of toilets in 3 of 4 units observed and 2 of 3 shower rooms. (100, 300 & 400 halls) Findings include: During an environmental observation, on 3/21/2023 at 12:09 P.M. to 12:53 P.M., with two (2) Administrators, and the Maintenance director, the the following was observed: 1. On 3/21/2023 at 12:16 P.M., on the 300 hall: the shower room temperature was 70.6 degrees, the sink was filled with a tan colored water and was not draining. The Maintenance Director indicated it should be 71 degrees and the sink will be fixed today. The resident bathroom in the shower room had a orangish stain along the back wall behind the toilet and beside the sink. Room 305 had an electrical outlet behind the bathroom door that did not have a cover and there were 2 dirty heater knobs/cover on the window seal with the window cracked along the left side. In Room 314 the faucet would not stop running, and the closet doors were broken and not hung up. 2. On the 400 hall (locked unit) the following was	F 0921	It is the practice of this facility to provide a safe, functional, sanitary, comfortable environment. What corrective action will be accomplished for those residents found to be affected by the deficit practice. The items identified have been corrected and stained ceiling tiles have been replaced in resident care areas. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken. All residents have the potential to be affected by the alleged deficit practice. A walk-through audit was conducted in the facility and all areas that were identified have been corrected. What measure will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. All staff were in-serviced on how to report items in need of repair. Maintenance in-serviced on work order completion expectations. A quality assurance tool has been developed to monitor environmental areas as identified during the survey that areas are in good repair. How the corrective action will be monitored to ensure the deficit	05/08/2023

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	observed: In room 402 an electrical outlet next to a residents bed had a broken cover, the closet doors would not close due to numerous clothing items. There were 3 dirty glass vases on the floor in the bathroom. A ceiling tile in the hallway by room 403 was stained, there was an odor of urine, missing floor tiles and the faucet was running. Room 406 had a dirty substance around the toilet base. Room 409 the baseboard was coming off under the sink and the room smelled musty. 3. On the 100 hall the following issues were observed: A light cover by the nurses station was missing. Light cover by room 116 broken. The shower room had a dirty floor. Room 100 had a towel wrapped around the base of the toilet that was stained yellow along with the floor. Room 112 had large scrapes on the wall by bed 2 with no call light cover outside the room. Rooms 106, 107, and 108 did not have call light covers outside the rooms. During an interview, on 3/21/2023 at 1:03 P.M., the Administrator indicated all the items should have been fixed with preventative maintenance. On 3/21/2023 at 1:02 P.M., the Administrator provided the policy titled," Maintenance Administration", dated 3/2015. The policy indicated"... 4. Maintains documentation of functionality/compliance for: d. Call Bells... j. Heating/cooling systems...16. Makes rounds daily...." On 3/21/2023 at 1:25 P.M., the Director of Nursing provided the policy titled,"Housekeeping Administration", dated 3/2015. The policy indicated"...3. Assuring the clean and sanitary condition of the facility to provide a safe and		practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee weekly for three weeks; then monthly for three months, then quarterly x three. Findings will be reported in QAPI quarterly.	

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	hygienic environment for residents and staff... 1. Conducts rounds daily for identification of areas of improvement... 5. Proactive awareness of admissions, room changes and discharges for terminal cleaning process to be completed. ...8 Implements a procedure for housekeeping emergencies when housekeeping in not available. 9. Provides individualized services where practical to meet the needs of the residents...." This Federal tag relates to Complaints IN00388683, IN00394202, IN00394334 and IN00404072. 3.1-19(f)			