STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 2, 3, 4, 5, 6, and 10, 2023 Facility number: 000044 Provider number: 155106 AIM number: 100274940 Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicare: 2 Medicaid: 74 Other: 35 Total: 111 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 13, 2023.	F 0000	Please consider this plan of correction as our credible allegation of compliance to the annual survey conducted from 10/2/23- 10/10/23. We respectfully request desk review for this plan of correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

keith davis | Senior Executive Director | 10/27/2023

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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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on interview, observation, and record review, the facility failed to ensure prompt wound care was provided in a manner to promote resident dignity for 1 of 1 residents reviewed for dignity. (Resident 5) Findings include: During an interview on 10/6/23 at 11:37 a.m., Resident 5 indicated when the wound physician	F 0550	**We respectfully request desk review in this matter. Thank you for your consideration.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	10/27/2023

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	came to evaluate his bilateral leg wounds, he would be asked to sit on the edge of the bed, since that position made it easier for the physician to view his bilateral lower extremities. The physician would remove his dressings, take measurements, and advise him a facility nurse would be in shortly to apply new, clean dressings. There were times where he waited 2 to 3 hours, sitting on the edge of the bed, before the nurse had time to do to his dressings. His wounds were open and "stung" when left uncovered. He was uncomfortable, but unable to climb back into bed as the open wounds were weeping and bloody, which made a mess of his bedding and his clothing. The contractures in his legs prevented other positions from being manageable for the wound dressing treatments or the time he waited for the dressing to be reapplied. He felt this situation was inappropriate and he should not be asked to deal with multiple visits that caused him pain, since the staff were aware of how much pain he was in. The pain caused from his leg wounds, and these situations with the dressing changes made it difficult to do any activities for himself, such as washing his face or hair. During a wound observation on 10/05/23 at 1:42 p.m., Resident 5 moved to hang his legs off the left side of his bed. The MD removed his dressing to the left leg. Resident 5 asked the MD and DON to reapply his dressing on this leg prior to removing the dressing on the other leg. He indicated his pain was extreme. The MD indicated the ADON would do this as he proceeded to visit the other residents needing wound treatments. The MD indicated he would return to do the right leg. The ADON stayed with the resident to reapply the dressing to his left leg. The clinical record for Resident 5 was reviewed on		Resident 5 dressing was replaced immediately following removal and assessment. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents seen on wound rounds have the potential to be affected by the alleged deficient practice. All licensed staff have been educated per ED/Designee by 10/27/23 on timeliness of dressing changes following wound assessments. (See Attachment A) Dressing changes to be completed immediately following assessment by Charge Nurse. If Charge Nurse is not available wound team will change dressing. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All licensed staff have been educated per ED/Designee on timeliness of dressing changes following wound assessments. (See Attachment A) Dressing changes to be completed immediately following assessment by Charge Nurse. If Charge Nurse is not available wound team will change dressing.	

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	10/4/23 at 3:39 p.m. Diagnoses included recurrent cellulitis of the bilateral lower extremities, contractures of the muscle at multiple sites, chronic pain due to trauma, and unspecified anxiety disorder. Resident 5's current physician order, dated 10/2/23, indicated to cleanse left lower extremity including foot with Dakins 0.25% solution, (a solution to clean wounds), one application. Apply Versatel (a wound dressing), cut to fit to wound beds, cover with super absorbent dressing and secure with rolled gauze. Change daily between 2:00 p.m. and 10:00 p.m., and cleanse right lower extremity including foot with Dakins 0.25% solution, one application. Apply Versatel, cut to fit to wound beds, cover with superabsorbent dressing, secure with rolled gauze. Change daily between 2:00 p.m. to 10:00 p.m. A current care plan, revised on 10/2/23, indicated he admitted with venous ulcers to his bilateral legs and to top of feet and to encourage resident to elevate lower extremities as often as possible. An Inter Disciplinary Team (IDT) Weekly Wound Review Note, dated 9/29/23 at 3:44 p.m., indicated Resident 5 had arterial ulcers to his bilateral lower extremities and reported a continuous pain rating of 5 to 7 out a scale of 10. A progress note, dated 10/4/23 at 10:31 a.m., indicated Resident 5 had refused to go to dental appointment scheduled for 10/4/23 due to pain. During an interview on 10/4/23 at 2:23 p.m., Resident 5 indicated he was in pain and his dressing had not been changed yet today. Sometimes it was done so late on second shift, it affected his ability to sleep. He felt the nurses		**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The POC QAPI Tool Wound Rounds (See Attachment 1) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23	

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	were in a rush and sometimes didn't have the correct materials to do his dressing changes. He thought these should have healed by now and he could have been placed into an assisted living facility. He could not take care of himself like this and it was torture. During an interview, at the bedside on 10/5/23 at 10:48 a.m. with Resident 5 and LPN 12, Resident 5 indicated he would like to prevent a repeat of last week where he waited for hours until a nurse was able to come redress his wounds. LPN 12 indicated the wound team did not reapply the dressing, and she or the ADON would come as quickly as possible to redress his wounds. During a follow-up interview on 10/6/23 at 12:36 p.m., the ADON indicated the wound round process was set by the previous provider. The current MD was an interim team following the practice in place, and the facility nursing staff were aware of the residents being visited during these treatment rounds and should be prepared to follow behind and complete dressings applications as needed. Once her duties with the wound team were completed, she would follow up with the residents to ensure dressings had been replaced. The average time she felt a resident waited was no more than 30 minutes. 3.1-3(t)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval			

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	of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on interview and record review, the facility failed to resolve resident council concerns related to long call light wait times and missing clothing items. (Residents 5, 47, 4, 87, 59) Findings include:	F 0565	**We respectfully request desk review in this matter. Thank you for your consideration.** **What corrective action(s) will be accomplished for those**	10/27/2023

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	1. During the Resident Council meeting on 10/4/23 at 11:00 a.m., residents present indicated there were long call light wait times, especially on second shift, and the wait was approximately an hour. There were times when staff members would wear ear buds/headphones while on duty, or turn off the call light without completing care, and this caused continued waiting. Resident 5 indicated during an incident last week, he was left on the toilet for 40 minutes. He could see the clock from the bathroom, since the door was left open. The J Hall staff assigned to his room on H hall were unable to see his call light past the large fire doors. Resident 47 indicated during an incident last week, she was left in a wet brief for approximately one hour. She could see the clock from her bed. Resident 4 indicated during an incident last week, she was left sitting on her bedside commode for approximately one hour. She required staff assistance for this transfer and could see the clock from her bedside commode. During record review on 10/2/23 at 1:47 p.m., the resident council minutes indicated the following: The 6/27/23 minutes indicated residents were concerned about staff use of headphones/ear buds while on duty, agency staff turning call lights off prior to care, and long call light wait times. The included facility follow up, dated 7/3/23, indicated staff education was provided to focus on customer service. The 7/25/23 minutes indicated residents were concerned about agency staff turning call lights off prior to providing care, long call light wait		**residents found to have been affected by the deficient practice?** ED has met individually with Residents 5, 47,4,87,59 related to missing items and/or call light response times to ensure resolution. ED educated staff related to call light response time, turning call light off and use of cell phones and monitoring missing clothing How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. With the permission of the residents, ED attended residents' council meeting to hear their concerns. ED/Designee to educate department leaders on resident council follow up utilizing "Resident Council" policy by 10/27/23. (See attachment B) ED/designee will be monitoring call light response times. (See attachment 2) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee to educated department leaders on resident council follow up utilizing	

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	times, and not enough aides on the night shift. The facility follow up, dated 8/1/23, indicated staff education and updating staffing assignment to match census. The 8/30/23 minutes indicated residents were concerned about call lights being turned off prior to care and long call light wait times. The facility follow up record, dated 9/1/23, indicated the facility staff was educated on 8/25/23 and planned additional education on 9/13/23, as well as during daily rounds. The facility would review call light audits and reports. The 9/12/23 and 9/28/23 minutes indicated residents were concerned about staff use of earbuds and cell phones while on duty, call lights being turned off prior to care, and long call light wait times. The facility follow up record, dated 9/13/23, indicated the facility planned to address these issues with a mandatory all staff in-service on 9/13/23. During an interview and record review on 10/6/23 at 3:31 p.m., the Administrator indicated he was new to this facility and he had held a mandatory in-service on 9/13/23. He provided a copy of his outline for this in-service, which included the following main topics: customer care program, survey readiness, abuse/elopement, call light response time, shower sheets, accountability to be increased throughout facility, resident inventory sheets, personal cell phone usage and snacks to be offered to resident's on 2nd shift daily. He provided his contact information to all staff. He provided all the information verbally. A current facility policy, revised 2/20, titled, " Resident Council", provided by the Administrator on 10/6/23 at 3:05 p.m., indicated the following:		"Resident Council" policy by 10/27/23. (See attachment B) ED/Designee to review resident council meeting minutes, concerns, and department leader responses/resolutions following each meeting. Activities Director will maintain a binder of resident council minutes and ensure resolution of concerns. ED will be notified of any unresolved concerns. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The POC QAPI Tool Resident Council (See attachment 3) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed: Completion date:10/27/23	

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	"...Policy: The facility will promote and support the residents' right to participate and organize resident council... Procedure: ...6. Concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concerns to ensure through resolution of concerns...." 2. During the Resident Council meeting on 10/4/23 at 11:00 a.m., members indicated repeated concerns with missing clothing items. Resident 47 indicated she was missing shirts and she was certain her items were labeled. Resident 87 indicated she was missing several labeled shirts. The laundry room had a lost and found where the unlabelled clothing went, but if it was not claimed quickly, the facility donated it or gave it away to other residents. There was to be a special room for only lost and found items, but it had been eliminated due to it being overwhelming. Resident 59 indicated he had spent his own money replacing his shirts lost by the facility. His clothing was labeled and it could take months to see if the facility would reimburse a resident. The 7/25/23 minutes indicated the laundry lost items all the time. The facility follow up, dated 7/26/23, indicated staff were educated to make sure to sort laundry and place unlabelled items into a pile until some one asked for a certain item. The 9/12/23 minutes indicated missing items and wrong clothing placed into wardrobes. The facility follow up, dated 9/12/23, indicated education for laundry staff, labeling instructions, and inventory sheets to be updated.			

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	During an interview and record review on 10/6/23 at 3:38 p.m., the Laundry Manager indicated she had completed a laundry employee in-service. She took her staff to an empty room and set up a scenario to test their knowledge on the rules for laundry and return of resident belongings. During an interview on 10/10/23 at 9:14 a.m., Laundry Aide 16 indicated the lost and found was moved from the laundry room onto K Hall last week. She was not aware of this move beforehand. The laundry workers had complained about the labeling of resident clothing and how it should be done with the admission process. During an observation of the "lost and found" area inside of the K Hall storage room, accompanied by the DON, on 10/10/23 at 9:41 a.m., the DON indicated this was not how the lost and found should be kept and the previous housekeeping manager had made changes that had not worked. The room was a combined storage room with items from multiple departments such as boxes of nursing supplies, wheelchairs, trash cans, toilet risers, a broken toilet, and bed frames. The lost and found clothing was behind the miscellaneous items, in boxes on the floor, under the far left window. During an interview on 10/10/23 at 10:02 a.m., the DON provided a note which indicated the intent to have the resident clothing lost and found moved to an unused office next to the social services office. A current, revised 12/22, facility admission policy, provided by the Administrator on 10/2/23 at 10:00 a.m., indicated the following:" ...9. Personal Property a. Inventory: Loss or Theft. Resident or Resident Representative agree to furnish, maintain			

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	and label clothing and other items...Community is not responsible for items left in Resident's room except to the extent the Community shall exercise reasonable care for the protection of residents property from loss or theft...." 3.1-3(l)			
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;			

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	(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,			

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RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

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	codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to provide notice of transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman for 4 of 4 residents reviewed for hospitalization. (Residents 92, 22, 77, and 27) Findings include: 1. The clinical record for Resident 92 was reviewed on 10/3/23 at 3:02 p.m., Diagnoses included	F 0623	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Ombudsman notified of Resident 92, 22, 77, and 27 discharge. **How will you identify other residents having the potential to be affected by the same**	10/27/2023

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	chronic respiratory failure, uropathy, chronic pain and abnormal weight loss. The resident was transferred to the hospital on 8/8/23 and returned to the facility on 8/11/23. The clinical record lacked documentation of the Ombudsman notification for the transfer/discharge. 2. Resident 22's clinical record was reviewed on 10/3/23 at 3:58 p.m. Diagnoses included obstructive and reflux uropathy and personal history of urinary tract infections. The resident was transferred to the hospital on 8/29/23 and returned to the facility on 9/2/23. The clinical record lacked an Ombudsman notification for a transfer/discharge on the above mentioned date.3. Resident 27's clinical record was reviewed on 10/3/23 at 3:16 p.m. Diagnoses included vascular dementia, left sided hemiplegia, dysphasia, and secondary Parkinson's disease. The resident was transferred to the hospital on 8/2/23 and returned to the facility on 8/6/23. The clinical record lacked an Ombudsman notification for a transfer/discharge on the above mentioned date. 4. Resident 77's clinical record was reviewed on 10/6/23 at 9:15 a.m. Diagnoses included unspecified dementia with other behavioral disturbances, heart failure, and type 2 diabetes mellitus with chronic kidney disease. The resident was transferred to the hospital on 9/30/23 and returned to the facility on 10/6/23. The clinical record lacked an Ombudsman notification for a transfer/discharge on the above mentioned date. During an interview on 10/10/23 at 11:16 a.m., the SSD indicated he missed sending the August notifications to the Ombudsman at the beginning of September. A current facility policy, revised 4/18, titled, " Emergency Transfer Notifications," provided by		**deficient practice and what corrective action will be taken?** All residents who have hospital transfer/discharge have the potential to be affected by the alleged deficient practice. An audit was completed to ensure the Ombudsman had been notified of all residents discharges or transferred from 10/1/2023 to current. ED/Designee to educate Social Service Team on Ombudsman notification of residents with hospital transfers utilizing “Emergency Transfer Notifications” policy by 10/27/23. (See attachment C) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee to educate Social Service Team on ombudsman notification of residents with hospital transfers utilizing “Emergency Transfer Notifications” policy by 10/27/23. (See attachment C) Social Service Team to turn in a copy of Ombudsman notification of previous months hospital transfers/discharges to the ED on the first business day on the following month. Social Service Team to maintain a binder of monthly Ombudsman notification confirmations going forward.	

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	the SSD on 10/10/23 at 12:38 p.m., indicated the following: "...Procedure:...2. Designated facility staff will run the Census Activity Report for Hospital Leave from Matrix at the end of each month. 3. The Census Activity Report will be faxed or mailed to the state Ombudsman each month...." 3.1-12(a)(6)(A)(iv)		**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The POC QAPI Tool Ombudsman notification (See attachment 4) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were complete and accurate for 1 of 3 residents reviewed for oxygen therapy. (Resident 41) Finding includes: Resident 41's clinical record was reviewed on	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 41's Significant Change MDS was modified to reflect the Bipap and oxygen therapy.	10/27/2023

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	10/3/23 at 3:26 p.m. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, obstructive sleep apnea, and dependence on supplemental oxygen. A current order, dated 9/21/23, indicated the resident required oxygen at two liters per minute via nasal cannula. A current order, dated 5/9/23, indicated the resident required Bi-level Positive Airway Pressure (BiPAP) every shift. A significant change Minimum Data Set (MDS) assessment, dated 8/27/23, lacked indication of specialized treatments for BiPAP and oxygen therapy. An Interdisciplinary Team Note, dated 8/23/23, indicated the resident was dependent on supplemental oxygen. During an interview on 10/4/23 at 3:18 p.m., the resident indicated she had worn continuous oxygen for at least 2 years. She had worn continuous oxygen since she admitted to the facility. Her oxygen therapy was on via nasal cannula during the observation. During an interview on 10/10/23 at 10:58 a.m., MDS Assistant 5 indicated oxygen therapy and BiPAP had been omitted on the above mentioned significant change MDS assessment. During an interview on 10/10/23 at 12:26 p.m., the DON indicated the facility did not have a policy regarding complete and accurate MDS assessments, but followed the Resident Assessment Instrument (RAI) for completion of		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents receiving bipap and oxygen therapy have the potential to be affected by the alleged deficient practice. An audit was completed on all residents receiving bipap or oxygen to ensure MDS captured the specialized treatment per MDS by 10/27/23. Regional RAI specialist provided inservice on MDS coding, oxygen section O per RAI manual by 10/27/23. (See attachment D) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Regional RAI specialist provided inservice on MDS coding, oxygen section O per RAI manual by 10/27/23. (See attachment D) Regional RAI specialist to spot check MDS assessments submitted on resident receiving oxygen or bipap therapy weekly for accuracy. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The POC QAPI Tool oxygen/Bipap (See attachment 5)	

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	the MDS assessments. Review of the 2019 RAI manual, retrieved from https://downloads.cms.gov indicated: "...Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here...."		will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23	
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			

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	as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure proper management of a supra-pubic urinary catheter and infection prevention strategies were utilized during catheter care for 1 of 5 residents reviewed for catheters. (Resident 85) Finding includes: During an interview on 10/2/23 at 3:35 p.m., Resident 85's representative indicated the resident had problems with sediment and crystallization that clogged his supra-pubic catheter on a frequent basis. The staff had not been flushing his catheter until about one week ago, when he got a urinary tract infection. There were times it had not been flushed for two to three days. They were not completing suprapubic catheter care every shift. He had been receiving pain medication to help with the supra-pubic pain. During the observation, the resident's urinary catheter tubing contained amber urine with moderate sediment. Resident 85's clinical record was reviewed on	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 85 suprapubic catheter is being maintained without complications. QMA 6 was educated on catheter care by using suprapubic catheter care skills validation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with suprapubic catheters have the potential to be affected by the alleged deficient practice. DNS/Designee will conduct an in-service with all nursing staff on suprapubic catheter care by	10/27/2023

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	10/3/23 at 4:27 p.m. Diagnoses included chronic kidney disease stage three, history of urinary tract infection, obstructive uropathy and benign prostatic hyperplasia. A current order, dated 3/20/23, indicated to change the supra-pubic catheter and urinary drainage bag as needed for dislodgement, leakage, or occlusion. A current order, dated 1/31/23, indicated to use 60 milliliters of sterile water for irrigation of the supra-pubic catheter every 8 hours. An order, dated 9/21/23, indicated to send the resident to the Emergency Room for evaluation and treatment. An order for ciprofloxacin (antibiotic to treat urinary tract infection) 500 milligrams (mg) by mouth twice daily was discontinued on 9/30/23. An abnormal urinalysis was collected on 10/4/23 at 10:30 p.m. A Urine culture was required and confirmed a urinary tract infection on 10/8/23. An order for ceftriaxone (antibiotic injection for urinary tract infection) reconstituted solution indicated to inject 1 gram once daily. It was ordered on 10/4/23 and discontinued on 10/9/23. A quarterly Minimum Data Set (MDS) assessment, dated 9/14/23, indicated the resident had severe cognitive impairment. He required extensive assistance from staff for toileting and personal hygiene. The resident had an indwelling catheter. He was frequently incontinent of bowels. A care plan, dated 9/22/23, indicated the resident		10/27/23. (See attachment E) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will conduct an in-service with all nursing staff on suprapubic catheter care by 10/27/23. (See attachment E) Skills validation "Suprapubic Catheter Care" to be done with all nursing staff by 10/27/23. All new hires will complete skills validation "Suprapubic Catheter Care". DNS/Designee will review residents' medical records to ensure suprapubic catheters are flushed per order, changed as needed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The POC QAPI Tool Suprapubic Catheter (See attachment 6) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not	

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	had a urinary tract infection. Interventions included the following: administer antibiotic as ordered, document and notify the provider of any abnormal findings, and observe for continue or worsening signs and symptoms of a urinary tract infection such as suprapubic pain (9/22/23). During a supra-pubic catheter care observation on 10/4/23 at 4:18 p.m., QMA 6 placed washcloths directly on the resident's overbed table, against a package of cookies and other personal items, without a barrier. The insertion site was reddened approximately 1 inch surrounding the insertion site, with brown, dried residue around the insertion site. The QMA washed his hands and donned clean gloves. He reached into his pocket to get a bag to place on the bed for soiled linens. He dropped the roll of bags on the floor, picked it up, and with both gloved hands pulled a bag off of the roll. Hand hygiene was not performed and gloves were not changed. He placed the roll of bags back into this pocket and picked up the washcloths from the overbed table with the contaminated gloves. He entered the bathroom, turned on the sink faucet with his gloved hands, and wet the washcloths. He returned to the resident's bedside with the same gloves on and used the same washcloths to rinse the insertion site of the suprapubic catheter and tubing, and dried the areas using a dry rag. The resident jerked slightly with discomfort upon cleansing the insertion site. The catheter tubing had a significant amount of crystallization in the tube at the junction where the catheter and urinary drainage tube bag connect. The urine in the drainage tube was cloudy amber urine with sediment. The catheter bag was undated. QMA 6 indicated the resident had a fair amount of crystallization in the catheter tubing junction.		achieved, an action plan will be developed to ensure compliance. BY what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23	

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	During an interview on 10/4/23 at 4:46 p.m., QMA 6 indicated the reddened site, brown/crusty residue surrounding the insertion site, and crystallization needed to be reported to the nurse. QMA 6 indicated he should not have used the washcloths, as they were contaminated once placed directly against the overbed table contents to complete catheter care. He should not have used the contaminated gloves to continue catheter care after he picked up the bags off of the floor because of a risk for infection. During an interview on 10/6/23 at 11:52 a.m., the DON indicated the supra-pubic catheter would have indication to be changed if it had gunk in the tubing. Catheter flushing should have been completed as ordered. Contaminated rags placed on a surface without a barrier should not have been used to perform catheter site care. Contaminated gloves should not have been used during catheter site care as it was an infection prevention concern. A current facility policy, dated 2/2012, titled "Laundry/Linen," provided by the DON on 10/6/23 at 12:41 p.m., indicated the following: "...Policy: The laundry and nursing staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident-care areas... 2. Resident care areas: clean linen... a. Clean linen must be protected from soiling or contamination...." A current facility policy, dated 7/2012, titled "Suprapubic Catheter Care," provided by the DON on 10/6/23 at 2:45 p.m., indicated the following: "Procedure Steps: ...Established suprapubic catheter: 1. Apply clean gloves...6. Dressing is not necessary unless drainage is present... 9. Document procedure and pertinent			

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	information...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to manage respiratory equipment and oxygen therapy as ordered for 2 of 3 residents reviewed for oxygen therapy. (Resident 41 and Resident 9) Findings include: 1. During an interview on 10/2/23 at 4:00 p.m., Resident 41 removed her BiPAP mask. She was receiving oxygen via nasal cannula, which was set on 4.5 liters per minute. The resident indicated she required continuous oxygen at five liters per minute. Her nebulizer tubing and canister were on her night stand, next to her bed. The tubing and canister were undated. The resident's nasal cannula tubing and humidity bottle was undated. She indicated the staff used to change the nasal cannula oxygen tubing, humidification, and nebulizer tubing on a regular basis, but they had not been done that in quite some time. The facility no longer changed the oxygen tubing on a routine basis, but instead, changed it when the	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** MD notified of Resident 41 O2 discrepancy. Order clarified. Resident 41 was placed on 5L of O2 per MD order. O2 tubing changed and dated appropriately for Resident 41 and Resident 9. Resident 9 humidification canister replaced. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents receiving oxygen therapy have the potential to be affected by the alleged deficient	10/27/2023

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	residents complained because the tubing was hard. Resident 41's clinical record was reviewed on 10/3/23 at 3:26 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypercapnia, obstructive sleep apnea, and dependence on supplemental oxygen. A current order, dated 9/21/23, indicated the resident required oxygen at two liters per minute via nasal cannula. A current order, dated 5/9/23, indicated to change the nebulizer tubing and set weekly every Sunday. A current order, dated 5/9/23, indicated to change the oxygen tubing and humidity weekly every Sunday. A current order, dated 5/9/23, included albuterol sulfate (respiratory medication) solution for nebulization; 2.5 milligrams (mg)/3 milliliters (ml): administer 1 vial for inhalation via nebulizer every 4 hours. A significant change Minimum Data Set (MDS) assessment, dated 8/27/23, indicated the resident was cognitively intact. A current care plan, dated 6/9/22, indicated the resident was at risk for impaired gas exchange related to COPD, respiratory failure requiring supplemental oxygen, scheduled nebulizer treatments, and obstructive sleep apnea. Interventions included the following: administer oxygen as ordered (6/9/22) and BiPAP as ordered (6/9/22).		practice. DNS/Designee will conduct a full house audit of all oxygen and nebulizer tubing, humidification canisters by 10/27/23 to ensure they are being changed weekly. By what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23 DNS/Designee will review all oxygen orders for accuracy by 10/27/23. DNS/Designee will conduct an inservice with all licensed nurses on the weekly changing of oxygen/ nebulizer tubing and humidification canisters and MD orders by 10/27/23. (See attachment F) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will conduct an inservice with all licensed nurses on the weekly changing of oxygen/ nebulizer tubing and humidification canisters and following MD orders by 10/27/23. (See attachment F) DNS/Designee audit of all oxygen and nebulizer tubing, humidification canisters to ensure they are being changed utilizing weekly oxygen audit tool. All new oxygen orders to be	

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	During an observation on 10/3/23 at 3:41 p.m., the resident was resting in bed with her BiPAP in use. Her nasal cannula oxygen tubing and nebulizer tubing remained undated. During an interview on 10/4/23 at 3:18 p.m., the resident indicated she had worn continuous oxygen at 5 liters per minute for at least 2 years. Staff changed her oxygen humidity bottle on 10/3/23, but they did not change her nasal cannula oxygen tubing or nebulizer tubing because the tubing was not hard. During the interview, her oxygen was set at 4 liters per minute and the humidification was dated 10/3/23. The oxygen tubing and nebulizer tubing lacked dates. During an interview on 10/4/23 at 3:28 p.m., QMA 6 indicated Resident 41's oxygen therapy was set at 4 liters per minute via nasal cannula. He was unaware what the oxygen level setting should have been set on. The nasal cannula tubing and nebulizer tubing and set lacked any dates indicating when they had been changed. The supplies were not stored in a bag. Only the humidity bottle had been dated 10/3/23. During an interview on 10/4/23 at 3:36 p.m., LPN 7 indicated the resident's oxygen via nasal cannula should have been set at 5 liters per minute. Current oxygen orders in the resident's clinical record indicated it should be set at 2 liters per minute. The resident had COPD and had been on continuous oxygen therapy at 5 liters per minute for a very long time. She could not recall a time when the resident wore 2 liters per minute of oxygen via nasal cannula. She thought perhaps the order was changed when she went out to the emergency room. During an interview on 10/6/23 at 11:42 a.m., the		reviewed in daily clinical meeting. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** POC QAPI Tool Respiratory Equipment (See attachment 7) will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	155106	A. BUILDING 00 B. WING	10/10/2023

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	DON indicated Resident 41's oxygen therapy order should have been clarified when she returned to the facility because the order was incorrectly entered as 2 liters per minute. Oxygen therapy should have been administered as ordered. 2. During an observation on 10/2/23 at 10:45 a.m., Resident 9 was not in his room. A nasal cannula and tubing lacked a date and was visibly soiled, with distinct pink/orange residue, where the cannula went into each nare and between each nare. The humidification canister attached to his oxygen concentrator was dated 9/21/23. Resident 9's clinical record was reviewed on 10/3/23 at 4:20 p.m. Diagnoses included shortness of breath and end stage renal disease. A current order, dated 1/28/21, indicated to change oxygen tubing and humidity weekly on Sunday. A current order, dated 12/6/22, included oxygen therapy at 2 liter per minute via nasal cannula, as needed, for shortness of breath. Review of the quarterly MDS assessment, dated 8/14/23, indicated the resident was cognitively intact. A current care plan, dated 5/20/21, indicated the resident was at risk for impaired gas exchange related to supplemental oxygen as needed for shortness of breath. Interventions included oxygen therapy at 2 liters per minute via nasal cannula as needed every shift. During an observation on 10/4/23 at 9:42 a.m., Resident 9's nasal cannula remained visibly soiled			

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	with a pink/orange residue noted on the tubing that fits in and between the nares. The tubing remained undated and humidity remained dated 9/21/23. During an interview on 10/4/23 at 11:58 a.m., the resident indicated the facility had not been changing his oxygen tubing regularly. Sometimes it was one to two months before they changed his oxygen tubing. He was wearing the soiled oxygen tubing on his face during the interview. During an interview at the time of observation on 10/4/23 at 3:41 p.m., QMA 6 indicated Resident 9's nasal cannula oxygen tubing was visibly soiled at the nares and should not be used when it was soiled. The nurse should have been notified for replacement. The resident's nasal cannula should have been replaced immediately for infection prevention. The oxygen tubing lacked a date when it was last changed and the humidification was last changed on 9/21/23. During an interview on 10/5/23 at 3:25 p.m., LPN 7 indicated oxygen tubing and humidification should have been changed and dated weekly according to the order. Any nasal cannula with a soiled appearance should have been changed out immediately. Though it was a night shift nursing task to change the oxygen tubing, it was a responsibility of all staff to recognize a soiled nasal cannula to prevent any infections. During an interview on 10/6/23 at 11:42 a.m., the DON indicated nasal cannula oxygen tubing, nebulizer tubing and oxygen humidity should have been changed by nursing staff and dated weekly as ordered. Visibly soiled oxygen tubing should have been changed immediately as needed.			

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	During an interview on 10/6/23 at 12:20 p.m., LPN 8 indicated nasal cannula oxygen tubing, nebulizer tubing, and oxygen humidification were required to be changed and dated weekly according to the resident's orders. During an interview on 10/6/23 at 12:35 p.m., the DON indicated the facility lacked an oxygen or respiratory equipment policy. Staff were required to follow the physician orders regarding the change of oxygen tubing. 3.1-47(a)(6)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning			

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	and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure the nursing staff were competent to demonstrate skills and techniques necessary to provide care for a resident with Huntington's disease for 1 of 30 residents reviewed during the survey. (Resident 38) Findings include: During an observation on 10/6/23 at 11:05 a.m., Resident 38 was seated at a table in the lounge area, in her wheelchair. A staff member was seated at the table and was assisting the resident to eat some chicken. The resident was observed with uncontrolled, quick movements with her arms and legs, and leaning movements with her upper body and head. The clinical record review for Resident 38 was completed on 10/4/23 at 11:43 a.m. Diagnoses included Huntington's disease, dementia, major depressive disorder, chronic pain syndrome, anxiety disorder, and psychotic disorder with delusions. A health care plan, dated 9/15/2023, indicated Resident 38 should be "care in pairs" for safety related to her involuntary movements due to her diagnoses of Huntington's disease. A goal	F 0726	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff have received education on Huntington's Disease to better assist them in caring for Resident 38. (See attachment G) **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a diagnosis of Huntington's have the potential to be affected by the alleged deficient practice. No other residents residing in the facility have a diagnosis of Huntington's. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff to receive education on Huntington's disease to better	10/27/2023

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	included Resident 38 would not injure herself or others because of her involuntary movements. A quarterly Minimum Data Set (MDS) assessment, dated 8/9/23, indicated the resident had moderate cognitive impairment and was able to understand and make herself understood. She had no hallucinations, delusions, rejection of care or behaviors during the assessment period. She required extensive assistant of two staff for bed mobility, transferring, and toileting, and extensive assistant of one staff for dressing and eating. A nursing progress note, dated 10/4/23, indicated a CNA had reported resident was having behaviors during care by asking to get up, and then refusing to let the CNA get her up in the wheelchair, "when asked why resident was not wanting to get up and she stated she did not like this CNA." A nursing progress note, dated 9/29/23, indicated the resident continued "with uncontrolled, aggregated limb and body movements and/or behaviors. Resident requires care in pairs as she is hurting staff with her arms flaying and hitting staff as well as kicking." A nursing progress note, dated 9/28/23, indicated a CNA had reported to the nurse that the resident had scratched and hit staff during morning care. A nursing progress note, dated 9/14/23, indicated the resident had hit and scratched a CNA while receiving care. The resident had yelled and screamed at staff. The resident had also stood from her wheelchair at the nurses station demanding attention, despite numerous staff members giving redirection and asking her to sit down.		assist them in caring for Resident 38 by 10/27/23. (See attachment G) Huntington's education has been added to annual in-service calendar. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** POC QAPI Tool Huntington's (See attachment 8) will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. By what date the systemic changes for each deficiency will be completed: Completion date: 10/27/23	

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	An Interdisciplinary Team (IDT) Behavior Review Note, dated 9/15/23, reviewing the 9/14/23 nursing progress note, indicated the root cause of the behaviors as Huntington's disease, pain, and toileting. The staff indicated during IDT interview that the resident had not intentionally hurt them. The behavior was most likely due to the resident's involuntary movements related to Huntington's disease. During an interview on 10/6/23 at 11:07 a.m., the ADON indicated during an incident on 9/24/23, staff became frustrated during care and felt the resident was intentionally trying to hit and kick them during care. One of the CNAs indicated she was done providing care and was not going to continue to be abused by the resident. The ADON, assisted by another nurse, completed the resident's care. The resident did strike her on the forehead with her left arm when completing mouth care, but not intentionally. The resident apologized. She had not known the resident to hit or kick purposefully when receiving care. During an interview on 10/5/23 at 9:21 a.m., LPN 7 indicated she had not received education specific to the care for a resident with Huntington's disease. She felt it would be beneficial, as the resident's behaviors could be challenging to manage. During an interview on 10/5/23 at 9:29 a.m., CNA 9 indicated she had not received education or direction on caring for a resident with Huntington's disease. She had assisted other staff to care for Resident 38 before, but had not provided care on her own. She did not realize the resident's uncontrolled movements were due to Huntington's disease. She felt it would be			

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	beneficial to receive education regarding Huntington's disease and how best to work with her. During an interview on 10/5/23 at 09:32 a.m., CNA 13 indicated she had assisted Resident 38 to eat, and had no instruction regarding assisting a resident with Huntington's disease. She happened to be around with a physical therapist when the resident had been evaluated while eating and the therapist had shown her some tips when assisting Resident 38 to eat. During a telephone interview on 10/10/23 at 11:30 a.m., CNA 14 indicated she had not received any education for care for a resident with Huntington's disease. The staff did get extensive education regarding working with residents with dementia. She was unsure what the difference would be in caring for a resident affected Huntington's disease. During an interview on 10/5/23 at 11:21 a.m., the DON and Administrator indicated there had been no specific education in regard to caring for a resident with Huntington's disease, but the staff was trained to ask questions if needed. They both indicated the disease specific education would be beneficial in caring for Resident 38. The DON indicated there was no facility policy regarding staff education for specific disease processes. Review of Mayo Clinic education content titled "Huntington's disease," dated 5/17/22 and retrieved from www.mayoclinic.org/diseases-conditions/huntingtons-disease/symptoms-causes, indicated the following: "...Huntington's disease is a rare, inherited			

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	disease...Huntington's disease usually causes movement, cognitive and psychiatric disorders with a wide spectrum of signs and symptoms...The movement disorders associated with Huntington's disease can include both involuntary movement problems and impairments in voluntary movements, such as: Involuntary jerking or writhing movements (chorea) Muscle problems, such as rigidity or muscle contracture (dystonia) Slow or unusual eye movements Impaired gait, posture and balance Difficulty with speech or swallowing Impairments in voluntary movements - rather than involuntary movements - may have a greater impact on a person's ability to work, perform daily activities, communicate and remain independent... Cognitive impairments often associated with Huntington's disease include: Difficulty organizing, prioritizing or focusing on tasks Lack of flexibility or the tendency to get stuck on a thought, behavior or action (perseveration) Lack of impulse control that can result in outbursts, acting without thinking... Lack of awareness of one's own behaviors and abilities...." 3.1-14(k)(5)			