STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERVIEW VILLAGE	586 EASTERN BLVD CLARKSVILLE, IN 47129

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00402917. Complaint IN00402917 - No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12, 13, 14, and 17, 2023. Facility number: 000082 Provider number: 155165 AIM number: 100289640 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 4 Medicaid: 64 Other 16 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 19, 2023.	F 0000	Please accept this plan of correction as the facility's credible allegation of compliance FOR ANNUAL RE- CERTIFICATION and LICENSURE SURVEY dated 4/17/23. **Please note facility respectfully requests paper compliance review for this survey.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Tina Martin | Executive Director | 05/01/2023

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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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review, and interview, the facility failed to ensure appropriate notification to the physician for elevated blood sugar values, administration of insulin and performance of blood glucose monitoring for 2 of 3 residents reviewed for notification of change. (Residents 4 and 70) Findings include: 1. The clinical record for Resident 4 was reviewed on 4/14/23 at 9:31 a.m. The diagnosis included, but was not limited to type 2 diabetes mellitus. The care plan, dated 1/29/16 and last revised on 3/26/23, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to the use of glucose lowering medication and the diagnosis of diabetes mellitus. The interventions, dated 1/29/16, indicated to document abnormal findings and notify the MD (medical doctor), and monitor blood sugars as ordered. The physician's order, dated 2/26/21, indicated to conduct an accu (accurate) check (blood glucose monitoring test) as needed for signs or symptoms of hyperglycemia or hypoglycemia. Notify the MD if the blood sugar was less than 70 mg/dL (milligrams per deciliter) or greater than 400 mg/dL as needed. The Quarterly MDS (Minimum Data Set) assessment, dated 12/27/21, indicated the resident was moderately cognitively impaired. The physician's order, dated 1/27/22, indicated to	F 0580	**y respectfully requests paper compliance review for this survey.** **F-580 (D)- Notification of Changes** *Based on observation, record review, and interview, the facility failed to ensure appropriate notification to the physician for elevated blood sugar values, administration of insulin and performance of blood glucose monitoring for 2 of 3 residents reviewed for notification of change. (Residents 4 and 70)* 1.) Resident # 4 and # 70 experienced no ill effects from the alleged deficient practice. Residents 4 and 70 blood sugar levels are obtained per physician order, including physician notification if blood sugar is above or below set parameters, insulin administration per physican's order, and documentation in the medical record of findings and administration. 2.) All residents who have diagnosis of diabetes mellitus have the potential to be affected. All residents requiring Glucose monitoring will have chart audit completed to ensure physician call parameters are in place, insulin is administered per	05/12/2023

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	conduct an accu check four times daily. Notify the MD if the accu check was below 70 mg/dL or greater than 400 mg/dL. The physician's order, dated 1/27/22, indicated to administer 10 units of lispro subcutaneously three times daily. The May 2022 Diabetic Administration History report indicated the following: - On 5/3/22 the resident's blood sugar reading was not obtained at 8:00 p.m. There was no documentation to indicate why the blood sugar was not obtained. - On 5/15/22 at 7:28 p.m., the resident's blood sugar reading indicated 422 mg/dL. The documentation indicated the physician was not notified. - On 5/27/22 the blood sugar was not obtained at 8:00 p.m. The 45 units of Lantus was not documented as administered. There was no documentation to indicate why the medication was not administered. The physician's order, dated 5/23/22, indicated to administer 45 units of Lantus subcutaneously at bedtime. The June 2022 Diabetic Administration History report indicated on 6/10/22 the resident's blood sugar reading was not obtained at 6:30 a.m. and the 10 units of lispro was not documented as administered. The clinical record lacked documentation of why the blood sugar was not obtained and the medication was not given. The August 2022 Diabetic Administration History		physician's order, and blood sugar levels are obtained per physician order. 3.) All Nurses will be in-serviced on Blood Glucose Monitoring Policy and educated on how to pull EMAR compliance report at the end of each shift to ensure completion of blood glucose monitoring has been completed. DNS/designee will complete daily audit of residents blood sugars to ensure they are obtained per physician order, including physician notification if blood sugar is above or below set parameters, insulin administration per physician's order, and documentation in the medical record of findings and administration. 4.) DNS/designee will complete daily audit of residents blood sugars to ensure they are obtained per physician order, including physician notification if blood sugar is above or below set parameters, insulin administration per physician's order, and documentation in the medical record of findings and administration. DNS/Designee will complete Diabetic Monitoring QAPI too weekly times 4 weeks, then monthly times 6 weeks, then quarterly as an ongoing practice. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved an action	

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	report indicated on 7/11/22 the resident's blood sugar reading was not obtained at 8:00 p.m. and the 45 units of Lantus was not documented as administered. The clinical record lacked documentation of why the blood sugar was not obtained and the medication was not given. The October 2022 Diabetic Administration History report indicated the following: - On 10/6/22 the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the medication was not administered. - On 10/26/22 the resident's blood sugar reading was not obtained at 6:30 a.m. The 10 units of lispro was not documented as administered. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. - On 10/27/22 the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the medication was not administered. The nurse's note, dated 11/21/22 at 2:26 p.m., indicated an order to increase the resident's Lantus to 48 units subcutaneously at bedtime. The November 2022 Diabetic Administration History report indicated the following: - On 11/28/22 the resident's blood sugar reading was not obtained at 6:30 a.m. The 10 units of lispro was not documented as administered. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered.		plan will be developed to ensure compliance 5.) Date of Completion 5/12/23.	

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	- On 11/30/22 the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the medication was not administered. The physician's order, dated 12/15/22, indicated to administer 48 units of Lantus subcutaneously at bedtime. Notify the MD if the blood sugar was less than 60 mg/dL or greater than 400 mg/dL. The January 2023 Diabetic Administration History report indicated the following: On 1/26/23 the blood sugar reading was not obtained at 8:00 p.m. The 48 units of Lantus was not documented as administered at 8:00 p.m. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. On 1/30/23 the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the medication was not administered. The February 2023 Diabetic Administration History report indicated the following: - On 2/8/23 the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the medication was not administered. - On 2/20/23 the blood sugar was not obtained at 6:30 a.m. The 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. - On 2/27/23 indicated the 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the			

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	medication was not administered. - On 2/28/23 indicated the blood sugar was not obtained at 4:00 p.m. The 10 units of lispro was not administered at 4:00 p.m. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. - On 2/28/23 indicated the blood sugar was not obtained at 4:00 p.m. The 10 units of lispro was not documented as administered at 4:00 p.m. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. The April 2023 Diabetic Administration History report indicated the following: - On 4/1/23 at 10:48 a.m., the blood sugar reading indicated "HIGH." There was not documentation of physician notification. - On 4/9/23 the blood sugar was not obtained at 6:30 a.m. The 10 units of lispro was not documented as administered at 6:30 a.m. There was no documentation to indicate why the blood sugar was not obtained or the medication was not administered. During an interview on 4/17/23 at 8:52 a.m., LPN (Licensed Practical Nurse) 3 indicated the resident was good about letting them check her blood sugar and administer her insulin. The parameters when obtaining a blood sugar were to contact the MD if her blood sugar was below 70 mg/dL or above 400 mg/dL. During an interview on 4/17/23 at 10:11 a.m., RN 1 indicated if the MAR (Medication Administration Record) was left blank, that could have meant they forgot to chart. 2. The clinical record for Resident 70 was reviewed			

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	on 4/11/23 at 10:49 a.m. The diagnosis included, but was not limited to type 2 diabetes mellitus. The care plan, initiated on 7/25/22 and last revised 2/26/23, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions included, but were not limited to document abnormal findings and notify the physician, medications as ordered, and monitor blood sugars as ordered. The physician's order, dated 3/20/23, indicated to administer insulin glargine (Lantus) 100 unit/ml 10 units subcutaneous daily at bedtime. Special instructions indicated to notify the physician if the resident's blood sugar was less than 60 mg/dL or greater than 400 mg/dL. The physician's order, dated 3/21/23 at 8:00 p.m., indicated to administer insulin lispro 100 unit/ml per sliding scale and to notify the physician of blood sugar levels of less than 60 mg/dL or greater than 400 mg/dL. The February 2023 MAR indicated for administration of the resident's 8:00 p.m. dose of sliding scale insulin lispro on 2/8/23, the resident's blood sugar was 498 mg/dL. The supplemental documentation on the MAR for physician notification indicated the physician was not notified. The April 2023 MAR for the resident's Lantus 10 units at bedtime order lacked documentation of administration on April 8 and 9, 2023. The April 2023 MAR for the resident's sliding scale insulin lispro indicated the following:			

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	- On 4/6/23 the 6:30 a.m. dose was not documented as administered. There was no documentation to indicate why the medication was not administered. - On 4/8/23 the 8:00 p.m. dose was not documented as administered. There was no documentation to indicate why the medication was not administered. - On 4/9/23 the 8:00 p.m. dose was not documented as administered. There was no documentation to indicate why the medication was not administered. - On 4/10/23 the 6:30 a.m. dose was not documented as administered. There was no documentation to indicate why the medication was not administered. - On 4/12/23 for the 4:00 p.m. dose, the resident's blood sugar was 462 mg/dL. The documentation indicated the physician was not notified. - On 4/13/23 for the 8:00 p.m. dose the resident's blood sugar was 420 mg/dL. The documentation indicated the physician was not notified. During an interview on 4/17/23 at 9:00 a.m., RN 6 indicated the resident received insulin at least four times daily. He used a sliding scale. They checked blood sugars when they did that. He got Lantus at night and lispro three times daily. He had parameters on his blood sugars. Staff were to call the NP (Nurse Practitioner) if the resident's blood sugar was over 400 mg/dL. They would document that on the MAR and they could also do a progress note. He had been known to refuse. He could not locate documentation of a reason for the holes in the resident's MAR. There were no comments on the documentation. The holes in the MAR without comments would indicate that the administration was missed. If the resident refused, he would expect to see the physician was notified.			

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	The "N" on the MAR would indicate the physician was not notified of the blood sugar level. When it was outside the parameters the MAR should indicate yes, the physician was notified. The Blood Glucose Monitoring policy, last revised 2/2015, provided on 4/14/23 at 11:11 a.m. by the Director of Nursing, included but was not limited to, " ... Procedure ... Residents who have a physician's order specifying the blood glucose parameters requiring physician's notification ... The physician will be notified when the resident's blood glucose is outside the physician stated parameters ... Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or in the medication administration record ..." 3.1-5(a)(2)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and	F 0686	**F-686 (D) Treatment/Svcs to**	05/12/2023

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	interview, the facility failed to ensure accurate skin assessments for residents with pressure injuries were conducted for 2 of 3 resident's reviewed for pressure ulcers. (Residents 74 and 37) 1. The clinical record for Resident 74 was reviewed on 4/12/23 at 10:00 a.m. The diagnoses included, but were not limited to, acute osteomyelitis right ankle, foot, and heel, peripheral autonomic neuropathy, muscle weakness, abnormalities of gait and mobility, folate deficiency anemia, vitamin B12 deficiency anemia, and vitamin D deficiency. The Admission Observation, dated 11/6/22 at 5:21 p.m., indicated the resident had no alterations in skin. The nurse's note, dated 11/6/22 at 6:00 p.m., indicated the resident admitted to the facility at 1:50 p.m. The only skin impairments documented were a surgical incision to the right hip, multiple healed scratches, bruises to all four extremities, and redness to the right heel. The Braden Scale for Predicting Pressure Sore Risk, dated 11/6/22, indicated the resident had no sensory impairment, was rarely moist, walked occasionally, was slightly limited in mobility, had excellent nutrition, had no apparent problem with friction and shear, and was scored as 21 points which equated to the resident not being at risk for pressure ulcers and indicated there were no interventions necessary at the time. The care plan, initiated on 11/7/22 and last revised on 4/3/23, indicated the resident was admitted with an unstageable to the right heel and a left heel calloused area that was re-identified as an unstageable pressure ulcer identified on 1/30/23.		**Prevent/Heal Pressure Ulcer** *Based on observation, record review, and interview, the facility failed to ensure accurate skin assessments for residents with pressure injuries were conducted for 2 of 3 resident's reviewed for pressure ulcers. (Residents 74 and 37)* 1.) Resident # 37 has been discharged from the facility. Resident # 74 has documented weekly skin assessments that are timely and accurate. 2.) All residents with pressure ulcers or at risk for pressure ulcers have the potential to be affected by the alleged deficient practice. · 100% audit was completed by DNS/designee of all weekly skin assessment to determine accuracy and timeliness. · A full house skin sweep was completed to identify any discrepancies in documented skin conditions compared to most recent weekly skin assessment. · All nursing staff will be in-serviced by DNS/designee regarding timeliness and accuracy of skin assessments, preventative interventions for residents with pressure ulcers or at risk for pressure ulcers. 3.) All nurses will have in-service provided on facility's weekly skin assessment policy and educated on proper documentation of skin impairment including admission	

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	The interventions included, but were not limited to, assess for pain, assess wound weekly documenting measurements and description. The care plan, initiated on 11/7/22 and last revised on 3/1/23, indicated the resident was at risk for skin breakdown due to needing assistance with transfers and bed mobility. The interventions included, but were not limited to, assess and document skin condition weekly and as needed, notify MD (Medical Doctor) of abnormal findings. The IDT (Interdisciplinary Team) note, dated 11/7/22 at 2:25 p.m., indicated the resident had an unstageable ulcer to his right heel. The resident reported he developed the wound at the hospital. The wound observation, dated 11/7/22 at 1:03 p.m., indicated the wound to the resident's right heel measured 8 cm (centimeters) in length by 8 cm in width. The wound was 100% (percent) slough and/or eschar. The Admission MDS (Minimum Data Set) Assessment, dated 11/12/22 indicated the resident was cognitively intact, required extensive assistance of 2 staff with bed mobility and transfers, and had one unstageable pressure ulcer which was present on admission. The Weekly skin assessment, dated 11/12/22, indicated the resident's bilateral feet were warm and dry with intact skin, and he had reddened or discolored areas. The assessment indicated the resident did not have any areas of skin integrity alteration. The skin assessment indicated if the resident had an open area to assess if they had pain at the site. The documentation indicated, "NA" (not applicable).		assessments. DNS/Designee will complete daily audits of weekly skin assessments will be completed to ensure accuracy and timeliness. 4.) DNS/Designee will complete Wound Management QAPI tool weekly times 4 weeks, then monthly times 6 months and will be completed quarterly as ongoing practice. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance 5.) Date of Completion 5/12/23.	

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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
	The Weekly skin assessment, dated 11/18/22, indicated the resident's bilateral feet were warm and dry with intact skin, and he had reddened or discolored areas. The assessment indicated the resident did not have any current areas of skin integrity alteration. The skin assessment indicated if the resident had an open area to assess if they had pain at the site. The documentation indicated, "NA". The IDT note, dated 11/22/22 at 4:03 p.m., indicated the resident had a new wound/skin injury which was a callus to the left heel. The area resulted from the resident using his foot to reposition himself in the bed and his foot frequently slipped created a callus to his left heel. The new intervention would be to continue to float the resident's heels, remind him to use his bed rails to help him reposition, and treatment with betadine. The Weekly Skin assessment, dated 11/26/22, indicated the resident's bilateral feet were warm and dry with intact skin, and he had no reddened or discolored areas. Under the "discolorations/rashes" section, the assessment indicated the resident had an "unstageable r [right] heel, callous to left heel". The skin assessment indicated if the resident had an open area to assess if they had pain at the site. The documentation indicated, "NA". The Weekly Skin assessment, dated 12/3/22, indicated the resident had no current areas of skin impairment. The resident's bilateral feet were warm and dry with intact skin, and he had reddened or discolored areas. The nurse's note, dated 12/9/22 at 4:39 a.m., indicated the resident had a small open area on his			

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	155165	A. BUILDING 00 B. WING	04/17/2023

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	coccyx with pain. He also had excoriation in the same area. Barrier cream and a dry dressing were applied. All parties were notified. The Weekly Skin assessment, dated 12/10/22, indicated the resident's bilateral feet were warm and dry with intact skin, and he had reddened or discolored areas. The clinical record lacked documentation of any new skin events or wound measurements of this area. The nurse's note, dated 12/10/22 at 4:45 a.m., indicated the resident continued with an open area to his coccyx, the unstageable to his right heel, and a thick callus to the right heel. The Weekly Wound assessment of the right heel, dated 12/23/22 at 2:11 p.m., indicated the wound measured 2 cm (centimeters) in length by 3 cm in width, with no depth and no exudate. The wound was 100% necrotic tissue. The resident was non-compliant with shoe selection and was instructed again to get diabetic shoes or backless shoes. The resident had the shoes ordered but was unsure of the arrival date. He was instructed that slipper socks were acceptable until they arrived. The IDT note, dated 12/23/22 at 2:51 p.m., indicated the resident's redness to his sacrum was healed and the treatment was discontinued. The weekly skin assessment, dated 12/23/22, indicated the resident's bilateral feet were warm and dry with intact skin, and he had reddened or discolored areas. The wound assessment of the right heel, dated			

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	12/30/22 at 9:21 p.m., indicated the wound measured 4.5 cm in length, 3.5 cm in width, with no depth, light bloody exudate, and 100% necrotic tissue. The weekly skin assessment, dated 1/13/23, indicated indicated the resident's bilateral feet were warm and dry with intact skin, and he had no reddened or discolored areas. The skin assessment indicated if the resident had an open area to assess if they had pain at the site. The documentation indicated, "NA". The weekly skin assessment, dated 1/20/23, indicated the resident's bilateral feet were warm and dry with intact skin, and he had no reddened or discolored areas. The wound assessment of the left heel, dated 1/30/23 at 4:20 p.m., indicated the wound measured 3 cm in length, 2 cm in width, and was reclassified as an unstageable pressure ulcer due to 100% necrotic tissue. During an interview on 4/10/23 at 1:20 p.m., Resident 74 indicated he had pressure ulcers to his bilateral heels. The right heel he had admitted with, the left heel had developed in the facility. He had used a heel lift pillow since admission, he could turn and reposition himself, and they used pillows to elevate his heels, his foot would slip during the night. The facility was ordering L'nard splints for him. The wounds were improving and he saw wound care. During an interview on 4/14/23 at 9:34 a.m., RN 1 indicated the resident had admitted with a pressure injury to the right foot. The left foot had started as a callous because he was pushing it into the bed to reposition himself. He was initially			

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	very reluctant to care. During an observation of wound care for Resident 74, on 4/14/23 at 10:46 a.m., RN 1 removed the resident's dressings to his bilateral heels. .The left heel had an open area which was quarter sized. There was a brown eschar cap to the center of the wound which was surrounded by pink granulation tissue. The right heel was fully granulating with minimal serous drainage and no necrotic tissue. During an interview on 4/14/23 at 12:08 p.m., the DON (Director of Nursing) indicated when a resident arrived to the facility the nurse should go in and look at all of their skin. They would then put what they find in the notes or the assessment. They should document weekly skin assessments and those should reflect if they have a wound, and document any pain to the wound and what preventative measures were in place. During an interview on 4/17/23 at 12:03 p.m., RN 6 indicated he did not recall admitting the resident. He could not recall if the resident had a pressure ulcer or not. For new admissions, he did his best to go from head to toe. He did physically look at their skin from head to toe. He would document any impairments in the progress notes. They didn't put it on the admission observations. It was just something he missed. He indicated he would mark, the admission assessment as "no" for impairments even if they had impairments because it would throw off the system, so he would document it in the progress notes. On the admission progress note if it was unstageable it would say the unstageable was present with the estimated size. The wound nurse would follow up on the nursing note. He did do weekly skin assessments. If a resident had an open area he would indicate it on the weekly skin assessments.			

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	He would document any pain and he would document the resident had bilateral heel unstageable ulcers. During an interview on 4/17/23 at 12:12 p.m., RN 1 indicated nurses did the initial skin assessment. It's supposed to be documented under the initial observation, but sometimes they put it in a note. If they marked it as no they needed to put a note in. He would have like to have seen more on his note or observation. The impairments should be on assessment the skin assessment. He would never have told someone to mark it as no. On the weekly skin impairments they should mark old impairments. During an interview on 4/17/23 at 12:22 p.m., the DON indicated they had not ever informed nursing staff to not accurately complete the admission observation and it should reflect open areas. She wanted nurses to document that an area was there, and she would not expect them to stage it but she would like measurements. She felt the nurses lacked confidence documenting it and indicated they might be afraid to mess it up. 2. The clinical record for Resident 37 was reviewed on 4/12/23 at 10:12 a.m. The diagnoses included, but were not limited to, sepsis, urinary tract infection, type 2 diabetes mellitus with hypoglycemia without coma, dementia, and reduced mobility. The Admission MDS assessment, dated 2/8/23, indicated the resident was severely cognitively impaired. The physician orders, dated 4/11/23, indicated encourage the resident to turn and reposition q (every) 2 hours and gently cleanse the open area on the coccyx, pat dry and place an Opti foam			

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	dressing over the open area of the coccyx. The care plan, dated 4/11/23, indicated Resident 37 had impaired skin integrity due to risks that included slightly impaired sensory perception with the risk for friction or sheering, occasional moist skin, needs assistance with significant position changes, and chair fast status. Interventions included but were not limited to assess the wound weekly and document measurements and description. The wound care note, dated 4/11/23 at 1:09 p.m., indicated, the resident had a wound to the left second toe, which measured 0.4 cm in length by 0.2 cm in width. The resident also had a stage 2 pressure ulcer to the coccyx measuring 0.4 cm in length and width. The IDT note, dated 4/11/23 at 12:54 p.m., indicated the resident had 2 new areas the skin. One was a small skin tear to the left second toe, and stage 2 pressure area to the coccyx. The Weekly Skin assessment, dated 4/11/23 at 6:47 p.m., indicated the resident had no open areas of skin impairment. During an interview on 4/14/23 at 9:00 a.m., RN 1 indicated prevention included turn and reposition every 2 hours and as needed, float heels, weekly skin assessments, low air loss mattress, treatment as ordered by the physician, a cushion in her wheelchair, and monitor for worsening or signs and symptoms of infection. During an interview on 4/14/23 at 11:37 a.m., LPN (Licensed Practical Nurse) 2 indicated the residents had a weekly skin assessment. She would do a head-to-toe assessment for any skin			

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	impairments. Whatever impairment was observed she would document it in the observation section of the clinical record. If the nurse was doing the weekly skin assessment and looking at her resident, and there was a pressure wound, she would document in the weekly skin assessment section that the resident had a wound. During an interview on 4/14/23 at 12:20 p.m., the DON indicated when a skin impairment was observed, such as a pressure wound the nurse, would open a new skin event, inform the IDT team, wound management, family and the doctor. The skin impairment should have been added to the resident's weekly assessment when the nurse did the assessment. The skin impairment would be documented on the weekly skin assessment until the wound was healed. The Skin Management Program policy, dated 3/2010 and last revised on 5/2022, provided on 4/14/23 at 11:11 a.m., by the Executive Director, included, but was not limited to, "... 1. All residents will be assessed at admission using a skin risk (Braden) assessment to determine risk for pressure ulcer/injury with initiation of a plan of care. 2. The admission skin assessment will include but not limited to: Head-to-toe skin assessment... Skin alterations present on admission, skin discoloration and any evidence of scarring on pressure points... 6. Any skin alteration noted by direct care givers during daily care and or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin alterations by the direst caregivers on the shift reported ... Facility skin sweeps (head-to-toe assessments) are conducted monthly to assess all residents'			

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	current skin condition and to ensure appropriate preventative measures are in place... 3. All alterations in skin integrity will be documented on the admission observation in the medical record on the admission observation (new admitted and readmitted residents). 4. All newly identified areas after admission will be documented on the New Skin Event..." 3.1-40(a)(1)			
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 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 and interview, the facility failed to ensure employees provided meal service in a safe and sanitary manner for handling of food while serving meals in the Cottage Unit Dining	F 0812	**F-812 (D) Food Procurement, Store/Prepare/Serve-Sanitary** *Based on observation and interview, the facility failed to*	05/12/2023

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	Room for 1 of 4 staff observed. (CNA 4) Findings include: During the lunch meal service in the Cottage Unit Dining Room on 4/10/23 at 11:20 a.m., CNA (Certified Nurse Aide) 4 was delivering a meal to Resident 36. She picked up the top bun for the fish sandwich with her bare hands and added tartar sauce. She placed the bun on top of the fish with her bare hand, mashing down on the bun with her palm. During the lunch meal service in the Cottage Unit Dining Room on 4/10/23 at 11:30 a.m., CNA 4 delivered a meal to Resident 53. She picked up the top bun of the fish sandwich with her bare hand, laying it in the plate. She applied the tartar sauce to the fish and placed the bun on top of the fish, using her bare hand. During an interview on 4/13/23 at 1:26 p.m., CNA 4 indicated she would perform hand washing prior to the provision of meal trays. She would also apply hand sanitizer between resident's trays. She should not touch the food with her hands and would use utensils for the bread products. During an interview on 4/13/23 at 1:32 p.m., the DON indicated the staff should not touch the food with their hands. The General Food Preparation and Handling policy, revised on October 2022, was provided by the DON on 4/13/23 at 2:10 p.m. The policy included, but was not limited to, " ... 3). Bare hands should never touch raw or ready to eat food directly. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid bare hand		*ensure employees provided meal service in a safe and sanitary manner for handling of food while serving meals in the Cottage Unit Dining Room for 1 of 4 staff observed. (CNA 4)* 1.) Resident #36 has experienced no ill effects from the alleged deficient practice. Food has been served in a sanitary manner. 2.) All residents have the potential to be affected. A meal service audit was completed by IDT to ensure food is handled in a safe and sanitary manner. 3.) In-service education will be provided to all staff involved in meal service in regard to facility policy on General Food Preparation and Handling. ED/designee will complete daily rounds of meal services to ensure food is handled in a safe and sanitary manner. 4.) DNS/Designee will complete QAPI Tool on Meal Observation weekly times 4 weeks, then monthly times 6 months and Quarterly as an ongoing practice. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5.) Date of Completion 5/12/23.	

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	contact of foods..." 3.1-21(i)(3)			