STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	06/09/2023

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00406551 and IN00406829. Complaint IN00406551 - No deficiencies related to the allegations are cited. Complaint IN00406829 - Federal/State deficiencies related to the allegations are cited at F921. Survey dates: June 5, 6, 7, 8, and 9, 2023 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 1 Medicaid: 80 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/15/23.	F 0000		
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			

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

Philip Marc Birn | Administrator | 07/09/2023

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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to a	F 0550	**F550—Resident's Rights** **1. What corrective action(s) will be accomplished for those**	08/01/2023

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	resident lying exposed in her room with no privacy curtains or doors closed for 1 of 2 residents reviewed for dignity. (Resident 70) Finding includes: On 6/5/23 at 11:04 a.m., Resident 70 was observed lying in bed with a hospital gown open exposing her upper and lower body. The curtains in the room were not pulled closed and the room door was open. There were two other residents also residing in the same room. On 6/6/23 at 1:41 p.m., the resident was observed lying in bed with a hospital gown open exposing her upper body. The curtains in the room were not pulled closed and the room door was open. On 6/7/23 at 9:54 a.m., the resident was observed lying in bed with a hospital gown open exposing her upper and lower body. The curtains in the room were not pulled closed and the room door was open. Resident 70's record was reviewed on 6/7/23 at 12:58 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke and non-traumatic intracerebral hemorrhage (bleeding into brain tissue). The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/23, indicated the resident was severely cognitively impaired. The resident required extensive assistance for bed mobility and was totally dependent on staff for transfers, eating, and toileting. There was no care plan related to behaviors for the resident.		**residents found to have been affected by the deficient practice?** · Resident 70 did not have a negative outcome related to the alleged deficient practice. 2. **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.** · An audit of residents will be completed to ensure that their dignity is maintained at all times. · Care cards will be updated to include the type of care required by each resident. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · Nursing staff will be re-educated on resident's rights related to maintaining the resident's dignity and how to maintain their privacy. · Leaders will complete " angel round" daily on residents-each will inquire about their dignity, ensuring each resident's dignity is maintained. 4. **How the corrective action(s) will be monitored to ensure the deficient practice**	

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	Interview with the Director of Nursing on 6/8/23 at 2:50 p.m., indicated the curtains should have been pulled for privacy. 3.1-3(t)		**will not recur, i.e., what quality assurance program will be put in place?** · Unit Mangers/Designee will do rounds to ensure that all residents privacy and dignity is maintained. · Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results or these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had an assessment to self-administer their own medications for 1 random resident reviewed for self-administration of medication. (Resident 75) Finding includes:	F 0554	**F554-<u>Resident Self-Administration Medications</u>** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	08/01/2023

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	On 6/5/23 at 10:09 a.m., Symbicort and Ventolin inhalers were observed in Resident 75's room. One inhaler was on the over-bed table and the other was on top of his dresser. Interview with the resident at that time, indicated both inhalers were prescribed to him, he received the Symbicort twice a day and the Ventolin as needed. On 6/8/23 at 11:39 a.m., the Ventolin inhaler was observed on top of the resident's dresser. The resident indicated at that time, the Symbicort was in his dresser drawer. He also indicated he had used the Ventolin inhaler a couple of times in the past week. The record for Resident 75 was reviewed on 6/7/23 at 2:27 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was cognitively intact. Physician's Orders, dated 3/6/23, indicated the resident was to receive Symbicort Aerosol 80-4.5 micrograms (mcg), inhale 2 puffs orally twice a day and Ventolin HFA Inhalation Aerosol Solution 108 (90 base) mcg, inhale 1 puff every 6 hours as needed (prn) for wheezing. There was no Physician's Order to self-administer the medications and there was no self-administration of medication assessment available for review. The May and June 2023 Medication Administration Records, indicated the Ventolin inhaler had not been signed out as being		· Resident 75 surrendered the medication to the Nurse. · Resident 75 did not have a negative outcome related to the alleged deficient practice 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Audit of all residents completed to inquire if they wish to self-administer medication. · Residents requesting self-administration will be assessed for the ability to self-administer medication, assessment will be completed in PCC and care plan will be updated as appropriate. · MD orders will be obtained for self-administration if appropriate. · Residents found to have medications in his/her possession that do not wish to self-administrate or do not meet the self-administration assessment measures will be asked to surrender the items to be secured in the medication carts. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · **Re-education** will be provided to staff members to	

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	administered. Interview with the 200 Unit manager on 6/8/23 at 11:55 a.m., indicated a self-administration of medication assessment had not been completed and no documentation had been completed of the Ventolin being used. She indicated she would re-educate the staff regarding medication administration. The facility policy titled, Self-Administration of Medications and Treatments, provided by the Director of Nursing on 6/9/23 at 9:00 a.m., indicated if a resident desired to participate in self-administration, the Interdisciplinary Team would assess the competence of the resident to participate by completing a self-administration of medication assessment in the medical record. 3.1-11(a)		include: **a. Immediately** reporting observation of medications visualized in resident's possession. **b. Charge nurse** to immediately to respond to reports of medication in resident's possession to assure orders & care plan for self-administration. **c. Charge nurse** to request surrender of medication to secure until a self-administration assessment is completed followed by MD orders and care plan if appropriate. **d.** If it is determined a resident is able to self-administer medication, the resident must also understand and demonstrate securing items for the safety of other residents. 4. **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 in place?** · UM/Designee will complete audits to ensure that all residents that wish to self-administer medication has all appropriate assessments, care plans and orders in place. · UM/Designee will complete audits to ensure that only residents with appropriate self-administer medication assessments, care plans, and orders have medication in their	

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			rooms. · Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly x 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to getting out of bed for 1 of 2 residents reviewed for ADL's. (Resident 48) Finding includes: On 6/5/23 at 10:30 a.m. and 1:30 p.m., Resident 48 was observed in his room in bed. The resident was wearing a hospital gown at the time.	F 0677	**F677 ADL Care Provided for Dependent Residents** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 48 did not have a negative outcome related to the alleged deficient practice. 2. **How will you identify other residents having the**	08/01/2023

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	On 6/6/23 at 10:32 a.m., 1:27 p.m., 2:30 p.m., and 3:25 p.m., the resident was again observed in his room in bed wearing a hospital gown. On 6/7/23 at 9:51 a.m., 11:45 a.m., and 1:30 p.m., the resident was observed in his room in bed wearing a hospital gown. On 6/8/23 at 9:00 a.m., 10:30 a.m., and 2:00 p.m., the resident was observed in his room in bed wearing a hospital gown. The record for Resident 48 was reviewed on 6/6/23 at 1:33 p.m. Diagnoses included, but were not limited to, stroke, seizures, and dementia with behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 5/16/23, indicated the resident was cognitively impaired for daily decision making and required extensive assistance with bed mobility. He was totally dependent on staff for transfers. A Care Plan, reviewed on 5/19/23, indicated the resident had an ADL self-care performance deficit due to history of a stroke with residual effects on mobility and function due to hemiplegia (muscle paralysis) and range of motion limitations. Interventions included, but were not limited to, the resident required total assistance by 2 staff with use of a full body mechanical lift for transfers. Interview with the Director of Nursing on 6/9/23 at 10:00 a.m., indicated the resident had no orders for bed rest and he should have been assisted out of bed. 3.1-38(a)(2)(B)		**potential to be affected by the same deficient practice and what corrective action will be taken?** · An audit of residents dependent residents will be completed to ensure that they receive assistance with ADLs related to getting out of bed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · Nursing staff will be re-educated on ADLs for dependent residents including getting them out of bed. · Care Cards will be updated to ensure that dependent residents receive ADL assistance to get out of bed as tolerated/care planned. 4. **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 in place?** · Unit Manager/Designee /MOD will do rounds to ensure residents are up out of bed as tolerated. · UM/Designee will complete audits to ensure dependent residents are out of bed as tolerated and care planned. · Audits will be completed	

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			daily x5, weekly x 4 weeks, bi-monthly x 2 months, monthly for 6 months then quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed in by the QAPI committee until sustained compliance is maintained for 2 consecutive quarters. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 3 of 4 residents reviewed for activities. (Residents 48, 21, and 70)	F 0679	**F679 – Activities meet interest/ needs of each resident** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the**	08/01/2023

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	Findings include: 1. On 6/5/23 at 10:30 a.m. and 1:30 p.m., Resident 48 was observed in his room in bed. The resident was wearing a hospital gown at the time. There was 1 television located in the corner of the resident's room which was turned on. On 6/6/23 at 10:32 a.m., 1:27 p.m., 2:30 p.m., and 3:25 p.m., the resident was again observed in his room in bed wearing a hospital gown. The television was also turned on. On 6/7/23 at 9:51 a.m., 11:45 a.m., and 1:30 p.m., the resident was observed in his room in bed wearing a hospital gown. The television was also turned on. On 6/8/23 at 9:00 a.m., 10:30 a.m., and 2:00 p.m., the resident was observed in his room in bed wearing a hospital gown. The television was also turned on. The record for Resident 48 was reviewed on 6/6/23 at 1:33 p.m. Diagnoses included, but were not limited to, stroke, seizures, and dementia with behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 5/16/23, indicated the resident was cognitively impaired for daily decision making. He was also totally dependent on staff for transfers. The resident's activity preference was listening to music. A current Care Plan, which was reviewed on 5/19/23, indicated the resident had signs of some cognitive loss and he required assistance from staff to complete his daily task. Continue to		**deficient practice?** · Residents 48, 21 and 70 have been provided with activities to meet their interests and needs and did not have a negative outcome related to the alleged deficient practice. **2. 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 cognitively impaired and dependent residents in the facility have the potential to be affected by alleged deficient practice. · Audit completed of all cognitively impaired and dependent residents to ensure that each resident has a current care plan and interventions to invite and assist the resident to scheduled activities. · Audit completed of all cognitively and dependent residents to ensure that each resident has individualized group and 1:1 activity plans as appropriate. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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	provide with invites for participation based on the resident's level of participation. Interventions included, but were not limited to, invite the resident to scheduled activities. The Annual Activity assessment, dated 5/17/23, indicated the resident received one to one sensory stimulation with staff 3 times a week. The One-to-One visit log for May and June 2023, indicated the following: 5/20 - Book reading 5/21 - Patient care. He was getting patient care. I will check back later. 5/22 - Snacks. I went to get resident some snacks and he ate them. 5/27 - Asleep. Resident was asleep I will check back later. 5/28 - Music. I played some music for him and he enjoyed it. 5/29 - Book reading. Read to him. 6/3 - Asleep. I will check back later. 6/4 - Book reading. Read to him. 6/5 - Snacks. I gave him some snacks and he ate them. Interview with the Activity Director on 6/9/23 at 9:39 a.m., indicated the resident loved music, he could engage in conversation but he did pick and choose whom he would speak to, and he was receiving one to one visits three times a week. At 12:35 p.m., the Activity Director indicated the resident had a radio in his room that should have been turned on and if the resident was sleeping when staff stopped by for a one to one visit, he should have been reapproached later. 2. On 6/6/23 at 1:35 p.m., Resident 21 was observed laying in bed staring out of the doorway. There were no ongoing activities occurring such as music or a		**practice does not recur?** * All activity staff in-service will be conducted by the activity director/designee to be in compliance with standards of practice for following scheduled activities for all cognitively impaired and dependent residents of all interests to support the physical, mental and psychosocial well-being of the residents · All activity staff will be educated on the development and execution of an activity plan / care plan for cognitively impaired and dependent residents. **4. 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?** · Activity director/designee will complete Activity audit to monitor residents' activity status and participation based on their plan of care. Audit will be completed daily x 5, weekly x 4 weeks, bi monthly for 2 months, monthly for 6 and then quarterly to encompass all residents until continued compliance is maintained for 2 quarters.	

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	television. On 6/7/23 at 9:52 a.m., the resident was observed laying in bed with the covers pulled up over her head. There were no ongoing activities occurring at the time in her room. On 6/7/23 at 11:13 a.m., the resident was observed laying in bed looking out into the hallway with no ongoing activities occurring at the time in her room. On 6/8/23 at 12:18 p.m., the resident was observed sitting in a wheelchair staring at the wall. There were no ongoing activities occurring at the time in her room. Resident 21's record was reviewed on 6/7/23 at 10:08 a.m. Diagnoses included, but were not limited to, stroke, dementia, and bipolar type schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was severely cognitively impaired. A Care Plan, dated 4/18/19, indicated the resident preferred to be in bed the majority of the time and was at risk for skin breakdown, inactivity, and social depression. Interventions included, but were not limited to, give the resident the choice to get out of bed, provide one-to-one activities, and provide environmental stimuli such as television or radio. A Care Plan, dated 1/3/19, indicated the resident had little or no activity involvement related to no interest. Interventions included, but were not limited to, the resident would benefit from one-to-one activity visits three times a week.		· The results or these audits will be reviewed by the CQI committee overse If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance **5. By What date will the systematic changes be completed** **· Compliance date of August 1, 2023**	

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	The Individual Visits (One-to-One) Visits Response Form for May and June 2023, indicated the resident received one-to-one visits with the Activity Department on 5/14/23, 5/15/23, 5/20/23, 5/28/23, 5/29/23, and 6/4/23. Interview with the Activity Director on 6/9/23 at 9:39 a.m., indicated the resident should have received visits from Activities at least three times weekly. Interview with the Director of Nursing on 6/9/23 at 11:58 a.m., indicated she had no further information to provide. 3. On 6/5/23 at 11:04 a.m. and 2:21 p.m., Resident 70 was observed laying in bed looking around the room. There was no ongoing activity such as a television or music playing in the room. On 6/6/23 at 1:41 p.m., the resident was observed laying in bed looking around the room. There was no ongoing activity such as a television or music playing in the room. On 6/7/23 at 9:54 a.m., the resident was observed laying in bed looking around the room. There was no ongoing activity such as a television or music playing in the room. Resident 70's record was reviewed on 6/7/23 at 12:58 p.m. Diagnoses included, but were not limited to non-traumatic intracerebral hemorrhage (bleeding into brain tissue), aphasia (lack of ability to express speech), and hemiplegia (one-sided weakness) following a stroke. The Quarterly Minimum Data Set (MDS)			

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	assessment, dated 5/12/23, indicated the resident was severely cognitively impaired. A Care Plan, dated 8/11/22, indicated the resident had little or no activity involvement due to limited physical abilities. Interventions included, but were not limited to, invite/encourage the resident's family members to attend activities with the resident in order to support participation, the resident needed a variety of activity types and locations to maintain interests, and needed assistance/escort to activity functions. Interview with the Activity Director on 6/9/23 at 9:46 a.m., indicated the resident had not been on the list for one-to-one activities. Interview with the Director of Nursing on 6/9/23 at 11:58 a.m., indicated she had no further information to provide. 3.1-33(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure floor mats were in place for a resident who was a fall risk for 1 of 1 residents reviewed for accidents. (Resident 48)	F 0689	**F689 Free of Accidents Hazards/Supervision/Devices** **1. What corrective action(s) will be accomplished for those residents found to have been**	08/01/2023

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	Finding includes: On 6/6/23 at 10:32 a.m. and 1:27 p.m., Resident 48 was observed in his room in bed. The bed was in the low position. A floor mat was observed on the floor next to the left side of his bed. The floor mat on the right side of the resident's bed was pushed next to his roommate's bed. The floor tile was visible on the right side of the resident's bed. The record for Resident 48 was reviewed on 6/6/23 at 1:33 p.m. Diagnoses included, but were not limited to, stroke, seizures, and dementia with behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 5/16/23, indicated the resident was cognitively impaired for daily decision making and required extensive assistance with bed mobility. He was totally dependent for transfers. The resident had one fall since his last assessment with no injury. A current Care Plan, which was reviewed on 5/19/23, indicated the resident was at risk for falls related to his impaired ability to stand, transfer, history of falls, incontinence, medication profile, seizures, poor safety awareness, made attempts to get out of the bed and chair, behaviors of kicking his foot board, and restlessness. He also leaned out of the side of his bed. Interventions included, but were not limited to, fall mats times two when in bed. A Fall Risk assessment, dated 5/15/23, indicated the resident was at risk for falls. The June 2023 Physician's Order Summary (POS), indicated the resident was to have floor mats		**affected by the deficient practice?** · Resident 48 was not negatively impacted by the alleged deficient practice. 2. **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 orders for floor mats while in bed have the potential to be affected by the alleged deficient practice.** · An Audit of residents with care plan/ orders for floor mats will be conducted to ensure that floor mats are properly place. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · Staff will be re-educated on the proper positioning of resident's floor mats when resident is in bed. · **Care** cards will be audited to that floor mats are noted. · Angel Rounds will be updated to include information regarding floor mats while in bed. 4. **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 in place?** · Unit Managers/Designee/MOD will do	

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	times 2 every shift for fall prevention. Interview with the Director of Nursing on 6/9/23 at 10:00 a.m., indicated the resident's floor mat should have been positioned closer to his bed. 3.1-45(a)(2)		rounds to ensure that floor mats are properly placed · Audits will be completed daily x7 days x 4 weeks, weekly x 4 weeks, bi-monthly x4 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of the audits will be reviewed by the QAPI Committee until sustained compliance is maintained for 2 consecutive quarters. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a dialysis access site was assessed for 1 of 1 residents reviewed for dialysis. (Resident 49) Finding includes: The record for Resident 49 was reviewed on 6/7/23	F 0698	**F698 Dialysis** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 49 did not have a negative outcome related to the	08/01/2023

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	at 9:13 a.m. Diagnoses included, but were not limited to, dementia and dependence on renal dialysis. The Significant Change Minimum Data Set (MDS) assessment, dated 3/29/23, indicated the resident was severely impaired for daily decision making and he was receiving dialysis while a resident at the facility. A Care Plan, dated 12/10/20 and reviewed on 4/19/23, indicated the resident had a right subclavian permacath (dialysis access site). Interventions included, but were not limited to, monitor dressing to right subclavian permacath every shift and monitor/document/report as needed (prn) signs and symptoms of infection at the site: drainage, inflammation, swelling, redness, and warmth. A Physician's Order, dated 4/18/23, indicated the resident was to attended dialysis 5 times a week, Monday through Friday. A Physician's Order, dated 6/2/23, indicated the permacath site was to be checked daily and upon return from dialysis. There was no documentation related to the permacath site being checked daily on the April and May 2023 Medication Administration Records (MAR's). Interview with the 200 Unit Manager on 6/8/23 at 10:30 a.m., indicated the original order for monitoring the permacath site was dated 10/5/22. She also indicated there was no documentation on the April and May 2023 MAR's related to monitoring the permacath site. When residents go out to the hospital, their orders were discontinued		alleged deficient practice. · The order is in place to check the resident's Perma Cath daily and upon return from dialysis. 2. **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 in the facility that are receiving dialysis have the potential to be affected by the alleged deficient practice.** · An audit of all residents receiving dialysis will be completed to ensure that orders are in place to monitor dialysis access site pre and post dialysis. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · **Licensed Nursing staff will be re-educated on the pre and post dialysis UDA assessment, (which includes assessment of dialysis access site) to be completed before the resident leaves for dialysis and upon their return from dialysis.** 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	and needed to be resumed upon return. The resident had returned from the hospital on 4/14/23. The facility policy titled, "Hemodialysis" was provided by the Director of Nursing on 6/9/23 at 8:45 a.m. The policy indicated, residents with an external dialysis catheter would be assessed every shift to ensure the catheter dressing was intact and not soiled. 3.1-37(a)		**assurance program will be put in place?** · DON/Designee will complete the dialysis audit tool to ensure that all residents have necessary dialysis assessments in place. · Audits will be completed daily x 5, weekly x 4 weeks, bi -monthly for 2 months, monthly for 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023 -	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited			

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	to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure signs and symptoms of anxiety were monitored, anti-anxiety medications were available, and interventions were implemented based on an individualized interdisciplinary approach to care with resident involvement for 1 of 1 residents reviewed for mood/ behavior. (Resident 81) Finding includes: Interview with Resident 81 on 6/5/23 at 10:49 a.m., indicated he was on Ativan (an anti-anxiety medication) for 14 days. He indicated the medication took the edge off and he slept better when he was receiving it. He had asked to get back on the medication but no one had done anything about it. The record for Resident 81 was reviewed on 6/7/23 at 10:28 a.m. Diagnoses included, but were not limited to, diabetes and anxiety disorder. The resident was admitted to the facility on 3/22/23. The Admission Minimum Data Set (MDS) assessment, dated 3/29/23, indicated the resident was cognitively intact. A Care Plan, dated 3/28/23, indicated the resident used anti-anxiety medication related to anxiety. Interventions included, but were not limited to, administer anti-anxiety medications as ordered by the Physician and monitor for side effects and effectiveness every shift. Monitor/record occurrence of the target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication,	F 0740	**F740 Behavioral Health Services** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · **Resident 81 continues to be seen by the Psychiatrist and Psychologist** · **Orders for monitoring for signs and symptoms of Anxiety are in place.** · **Continues to receive medications per doctor's orders.** 2. **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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · **Licensed Nursing staff will be re-educated on signs and symptoms of Anxiety.** · **Audits will be done to ensure that all residents with diagnosed anxiety have orders for monitoring in place.** · **Any abnormal findings /**	08/01/2023

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	violence/aggression towards staff/others. etc., and document per facility protocol. A Physician's Order, dated 3/22/23, indicated the resident was to receive Ativan 0.5 milligrams (mg) every 24 hours as needed (prn). A Physician's Order, dated 3/24/23, indicated the resident may be seen and treated by the Psychiatrist. A Physician's Order, dated 3/27/23, indicated the resident was to receive Ativan 0.5 mg, one tablet every 24 hours prn for anxiety for 14 days. The hospital discharge instructions, dated 3/22/23, indicated the resident was to receive the Ativan 0.5 mg every 8 hours prn for anxiety. The order was changed to once daily per the Physician. Nurses' Notes, dated 3/22/23 at 3:17 p.m., indicated the resident's Physician was notified of his arrival and all orders were reviewed and noted. Nurses' Notes, dated 3/22/23 at 3:30 p.m., indicated a late entry was noted. Documentation indicated upon verifying the discharge medication orders, the Ativan was to be started daily. Nurses' Notes, dated 3/24/23 at 7:58 a.m., indicated the pharmacy was contacted about the Ativan order. The facility was informed the resident would need a prescription for the medication. Psychiatric progress notes, dated 3/27/23, indicated the resident had an anxiety disorder. He also had a history of anxiety and depression with past use of psychotropic medications prior to his referral. He appeared anxious at the time of his		**behaviors will be documented and reported to MD/Psyche services.** 4. **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 in place?** · Unit Managers/Designee will audit 24 reports daily for documentation related to anxiety. · DON/ADON will complete audits daily x 5 days, weekly x4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI Committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023	

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	visit. A Physician's progress note, dated 3/27/23 at 4:16 p.m., indicated the resident was very anxious and depressed at times. He would be prescribed prn Ativan. An Administration Note, dated 3/28/23 at 12:30 a.m., indicated the resident was to receive Ativan 0.5 mg every 24 hours prn for anxiety for 14 days. He received the medication due to complaints of being anxious and restless. A Psychiatric progress note, dated 4/4/23, indicated the resident reported waking up one night and feeling paralyzed which triggered anxiety. He reported he was currently having a lot of difficulty sleeping and he reported trying Trazodone (an antidepressant and sedative) in the past which was ineffective. He brought up concerns about his current Ativan order expiring which was causing more anxiety. The resident reported using Xanax (an anti-anxiety medication) while at home since approximately 2009. Zoloft (an antidepressant) 25 mg was to be added daily and Melatonin (a sleep aide) 5 mg at bedtime. Interview with the resident on 6/7/23 at 1:20 p.m., indicated he had anxiety about not sleeping, about his roommate, and he took Xanax while at home since 2009. He was currently not receiving anything for anxiety, just Zoloft for depression. He had asked the nurses and Nurse Practitioner (NP) several times to start his Ativan back up again, but "nothing ever happens." He also indicated the Zoloft and Melatonin did not help. Interview with the 200 Unit Manager on 6/7/23 at 1:25 p.m., indicated the resident said he had anxiety, but she didn't see any signs of it. When			

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	asked about the care plan to monitor for signs of anxiety, she indicated that was for while he was on the prn Ativan and the MDS staff should have removed that from the care plan. The April 2023 Medication Administration Record (MAR) indicated side effects of the Ativan had been monitored but there was no monitoring related to signs of anxiety. On 6/7/23 at 2:00 p.m., the Director of Nursing was informed the resident had not received his scheduled Ativan from 3/22-3/28/23 and there was no monitoring for signs and symptoms of anxiety per the care plan. 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were labeled properly for 1 of 2 medication carts observed. (Cart 1 on the 500 Unit) Finding includes: On 6/8/23 at 2:18 p.m., Medication Cart 1 on the 500 Unit was observed with RN 1. There was a bottle of Omega XL (extended release) (a medication for joint pain), Hemp pain relief cream maximum strength, Vitamin D3 5,000 IU (international unit), Breztri Aerosphere (an inhaler) 160 mcg/9 mcg/4.8 mcg (micrograms) and Antacid extra strength observed at the bottom of the medication cart. The bottles were only labeled with the type of medication and not any information regarding the residents or specific orders. Interview with RN 1 at that time, indicated she did not normally work on that cart and she had no knowledge of the medications. The medications were removed from the cart. Interview with the Director of Nursing (DON) on 6/8/23 at 2:43 p.m., indicated the nursing staff should have discarded any medication that was not completely labeled in the cart. The facility policy titled "Medication Storage and Medication Labeling" received as current from the DON on 6/9/23 at 8:45 a.m., indicated: ".... Medication Labeling: 1. Labeling of medications and biologicals dispensed by the pharmacy is	F 0761	**F761 Label/Store Drugs and Biologicals** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents experienced negative outcomes related to this alleged deficient practice. 2. **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 medications have the potential to be affected by this alleged deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?** · Nursing staff will be re-educated on the proper storage and labeling of all medications. 4. **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**	08/01/2023

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	consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; g. appropriate instructions and precautions ...." 3.1-25(k)		**in place?** · ADON/Nursing Managers will audit medication carts using the Medication Cart/Storage tool to ensure that all medications are stored and labeled correctly. · Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI Committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 5. **By what date will the systemic changes for each deficiency be completed?** · August 1, 2023 -	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's			

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	reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, record review, and interview, the facility failed to ensure the menu was followed as written and resident preferences were honored for 1 of 5 residents reviewed for food. (Resident 75) Finding includes: Interview with Resident 75 on 6/5/23 at 10:20 a.m., indicated he did not get the food that was listed on his tray ticket. Additional interview with the resident on 6/8/23 at 9:19 a.m., indicated he was not aware of any food choices and he just got what he was served. On 6/8/23 at 12:44 p.m., the resident received his lunch tray. He was served in his room. The resident received Salisbury steak and mashed potatoes. Interview with the resident at that time, indicated he didn't want that meal. His tray ticket indicated he was to receive chicken tenders and macaroni and cheese. Interview with the Dietary Food Manager on 6/8/23 at 12:48 p.m., indicated they ran out of chicken tenders but they had "chicken parts"	F 0803	**F803 – Menus Meet Resident Needs/ Prep** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Cooks will make sure to have all ingredients and food items prepared and ready to follow the recipe for all meals. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Cooks before they start to prepare food will make sure they have all ingredients and food items for all meals and all diets. **3. What measures will be**	08/01/2023

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	which consisted of legs and thighs. She indicated she would go and talk to the resident. The resident indicated to her that he only wanted macaroni and cheese. The record for Resident 75 was reviewed on 6/7/23 at 2:27 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was cognitively intact. 3.1-20(a)		**put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An all Cooks and staff that prepare food in-service will be conducted by Food Service Director/designee to be in compliance with standards of practice for following the menus. Cooks will have a return demonstration and competency of menus, spread sheet and recipes. Food quality test trays for palability, needs and temp testing to measure quality. Routine of asking residents of food trays. **4. 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?** · A Validation Checklist – Kitchen observation" will be completed by Food Services Manager/ designee, audit will be completed. Audits will be completed daily x 5 , weekly then x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters. Any concerns will be addressed by Food Service director and	

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			follow up will be overseen by the ED and Food services director. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in repair practices will result in re-training and progressive disciplinary action up to and including termination of responsible employee(s). **5. By What date will the systematic changes be completed** **· Compliance date of August 1, 2023**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure recipes were followed for a mechanical soft diet. This had the potential to affect the 9 residents who received a mechanical soft diet from the kitchen. (The Main Kitchen)	F 0804	**F804 Nutritive Value/ Appear, Palatable, Prefer Temp** **1. What corrective action(s) will be accomplished for those residents found to**	08/01/2023

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	Finding includes: On 6/8/23 at 10:02 a.m., Cook 1 was observed preparing the mechanical soft food for 9 residents for lunch. Cook 1 found the recipe for ground chicken tenders with broth, washed his hands, and donned gloves. He removed 10 servings of chicken breast tenders (20 chicken breast tenders) and placed them into the food processor. He proceeded to add two cups of water and blended to the appropriate consistency for a mechanical soft diet. Interview with Cook 1 on 6/8/23 at 10:08 a.m., indicated they had run out of chicken broth so he only had water to add to the chicken breast tenders to make the correct consistency. The recipe for Ground Chicken Tenders with Broth, received from the Dietary Food Manager on 6/8/23 at 2:35 p.m., indicated 10 servings required 1 and 1/4 cups of chicken broth and 20 chicken breast tenders. The instructions to prepare the dish indicated, "place prepared chicken tenders in food processor and grind to appropriate consistency. Reheat to minimum temperature of 165 degrees Fahrenheit for 15 seconds, and hold for service at 135 degrees Fahrenheit. Serve 2 ounces ground protein portion with #12 scoop, plus 1 ounce hot broth to keep moist." Interview with the Dietary Food Manager on 6/8/23 at 10:37 a.m., indicated Cook 1 should have followed the recipe for the ground chicken tenders with broth, however they were out of the chicken broth. 3.1-21(a)(1)		**have been affected by the deficient practice?** · Cooks will make sure to have all ingredients prepared and ready to follow the recipe for all meals. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Cooks before they start to prepare food will make sure they have all ingredients for all meals and all diets. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An all Cooks and staff that prepare food in-service will be conducted by Food Service Director/designee to be in compliance with standards of practice for following recipes. Cooks will have return demonstration and competency of menus, spread sheets and recipes. There will be food quality trays to meet palatability needs and taste and color and temp testing to measure quality.	

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			4. 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? · A Validation Checklist – Kitchen observation" will be completed by Food Services Manager/ designee, audit will be completed. Audits will be completed daily x 5 , weekly then x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters. Any concerns will be addressed by Food Service director and follow up will be overseen by the ED and Food services director. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in repair practices will result in re-training and progressive disciplinary action up to and including termination of responsible employee(s). **5. By What date will the systematic changes be completed** · **Compliance date of August 1, 2023**	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment, cooking items stored incorrectly, and improper hand hygiene during food preparation for 1 of 1 kitchens observed. This had the potential to affect the 79 residents who received food from the kitchen. (The Main Kitchen) Findings include: 1. During the Brief Kitchen Sanitation Tour on 6/5/23 at 9:00 a.m. with the Dietary Food Manager,	F 0812	**F812 Food Procurement, Store/Prepare/ Serve- Sanitary** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The knives that were stored on the bottom shelf under the prep sink were removed. · The oven that buildup of	08/01/2023

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	the following was observed: a. There were knives stored on the bottom shelf under prep sink uncontained. b. The oven had built up food debris and was dirty. c. The stove top grates had an accumulation of food debris. d. There were 3 pots stored upright underneath the prep sink. Interview with the Dietary Food Manager on 6/5/23 at 9:32 a.m., indicated the above areas were in need of cleaning and she would in-service staff on proper storage of kitchen utensils. 2. During an observation of food preparation on 6/8/23 at 10:02 a.m., Cook 1 was observed preparing a puree diet. He had prepared a pureed macaroni and cheese dish and was observed cleaning up the work station with the sanitizer solution and a towel. He put the sanitizer solution away and donned a pair of gloves and then began gathering items to prepare a pureed mixed vegetable dish. Cook 1 did not wash his hands after using the sanitizer solution with his bare hands. 3. On 6/8/23 at 10:25 a.m., Cook 1 was observed preparing a ground chicken tender dish for a mechanical soft diet. Cook 1 washed his hands with soap and water, touched his glasses on his face with his hands, and put on clean gloves. He continued to gather the container of chicken and utensils from the steam table to begin making the ground chicken tenders. Cook 1 did not wash his hands after he touched his glasses and face		food debris has been cleaned and the oven has been cleaned. · The stove grates no longer have an accumulation of food debris. · The pots stored underneath the prep sink will be stored properly · All cooks have been in serviced on proper sanitization of area and about proper hand hygiene technique during food preparation. **2. 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. · Knives will not be stored on the bottom shelf under prep sink uncontained, the oven and stove grates will be kept clean at all times, pots will not be stores underneath the prep sink, food services staff will use proper hand hygiene technique during food preparation. **3. What measures will be put into place or what systemic**	

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	before donning gloves. Interview with the Dietary Food Manager on 6/8/23 at 10:37 a.m., indicated Cook 1 should have performed proper hand hygiene after using sanitizing solution and after touching his glasses. 3.1-21(i)(3)		**changes you will make to ensure that the deficient practice does not recur?** · An all dietary/Food service staff in-service will be conducted by Food Service Director/designee to be in compliance with standards of practice for safe food handling in order to prevent foodborne. **4. 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?** · A Validation Checklist – Kitchen observation" will be completed by Food Services Manager/ designee, audit will be completed. Audits will be completed daily x 5 , weekly then x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters. Any concerns will be addressed by Food Service director and follow up will be overseen by the ED and Food services director. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in repair practices will result in re-training and	

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			progressive disciplinary action up to and including termination of responsible employee(s). **5. By What date will the systematic changes be completed** **· Compliance date of August 1, 2023**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not completing respiratory assessments and not testing a symptomatic resident timely for COVID-19 for 2 of 3 residents reviewed for COVID-19. (Residents 39 and 12) Findings include: 1. The record for Resident 39 was reviewed on 6/7/23 at 10:00 a.m. The resident was diagnosed with COVID-19 on 5/31/23. A Physician's Order, dated 5/31/23, indicated the resident was to have a respiratory assessment completed every shift for 9 days. The only respiratory assessment completed on 5/31/23 was at 8:27 a.m. No respiratory assessments were completed for the evening shift on 6/3, 6/5, and 6/6/23. A Care Plan, dated 6/5/23, indicated the resident tested positive for COVID-19 on 5/31/23. Interventions included, but were not limited to, assess respiratory status and vital signs every shift and notify the Physician of abnormal findings. Interview with the Director of Nursing on 6/9/23 at 9:00 a.m., indicated the respiratory assessment	F 0880	**F880 Infection Prevention & Control** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · **Respiratory assessments have been completed for all residents who were positive for COVID** · **Residents 39 and 12 received the diagnosis of COVID and were both monitored and treated per MD orders** · **Residents 39 and 12 are currently COVID free.** 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Any residents with signs and symptoms of a respiratory infection has the potential to be affected by the alleged deficient practice. · Currently, there are no COVID positive residents in the facility. **3. What measures will be put into place or what systemic**	08/01/2023

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	form should have been completed every shift. 2. The record for Resident 12 was reviewed on 6/9/23 at 8:41 a.m. Diagnoses included, but were not limited to, COVID-19. Nurses' Notes, dated 5/26/23 at 10:11 a.m., indicated the resident complained of coughing at times. The Physician was notified and orders were received for Robitussin DM (a cough syrup) 2 tablespoons every 4 hours as needed (prn) for cough. Nurses' Notes, dated 5/27/23 at 9:34 a.m., indicated the resident was complaining of generalized pain. Norco (a narcotic pain medication) was given as ordered. No coughing was noted that morning. Will continue with the plan of care. Nurses' Notes, dated 5/29/23 at 7:33 p.m., indicated the facility was currently in outbreak testing. A point of care (POC) test was performed and the resident was positive for COVID-19. The resident was made aware as well as her Physician. Interview with the Infection Preventionist (IP) on 6/9/23 at 10:50 a.m., indicated the outbreak began on 5/29/23. She indicated they couldn't identify the first person or how the outbreak started. Several residents were noted with respiratory issues on the 500 hall. All of the 500 hall residents were tested on 5/29 and 13 were positive for COVID-19. The IP indicated routine testing was no longer being done but symptomatic residents should be tested immediately. She indicated Resident 12 was not tested prior to 5/29 because nursing did not let her know the resident had symptoms and they did not test her like they should have. 3.1-18(b)		**changes will be made to ensure that the deficient practice will not recur?** · **Staff to be re-educated on the signs and symptoms of COVID, need to notify IP and the need to test upon initial development of s/sx.** · **IP is to be notified of the resident and their symptoms, IP will swab the resident and if negative results, will swab the resident again in 48 hours** · **If positive, all COVID precautions and interventions will be put into place.** 4. **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 in place?** · IP/ Designee will audit to ensure that all residents with s/sx of covid are tested per policy. · Audits will be completed daily x 5, weekly x 4 weeks, bi -monthly for 2 months, monthly for 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI Committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. **By what date will the**	

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			systemic changes for each deficiency be completed? · August 1, 2023 -	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment as well as the kitchen area was clean and in good repair related to dirty pipes and debris along the floor/baseboards, dirty ceiling vents, floor tiles dirty and broken, marred walls, doors, and closets, gouges in walls, dirty ceiling tiles, missing transition pieces and trim, chipped caulk, and chipped paint in 1 of 1 kitchen areas and on 2 of 4 units. (The Main Kitchen, 200, and 400 Units) Findings include: 1. During the Brief Kitchen Sanitation Tour on 6/5/23 at 9:00 a.m. with the Dietary Food Manager, the following was observed: a. There was debris on the floor and the pipes were dirty under the 3-compartment sink. b. There was debris noted on the floor under the steam table and behind the oven, stove, and drink station along the baseboards. Interview with the Dietary Food Manager on 6/5/23 at 9:32 a.m., indicated the above areas were in need of cleaning.	F 0921	**F921 Safe/Functional/Sanitary/Comfortable Environment** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Debris on the floor and the pipes under the 3-compartment sink were cleaned during the survey after it was pointed out. * The debris noted on the floor under the steam table and behind the oven and the stove and drink station along the baseboard have been cleaned.* Ceiling vent in the bathroom in room 203 has been cleaned and the black stains on the tile under the floor register has been cleaned.* Ceiling vent in the bathroom of room 209 has been cleaned. The ceiling tiles in the bathroom have been replaced.* The broken tiles at the bathroom entrance in room 401 has been replaced and the bathroom door where the	08/01/2023

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	2. During the Environmental Tour with the Housekeeping Supervisor on 6/9/23 at 11:26 a.m., the following was observed: Unit 200 a. The ceiling vent in the bathroom in Room 203 had an accumulation of dust and dirt. There were black stains on the tile under the floor register. There was one resident in the room and who used the bathroom. b. The ceiling vent in the bathroom of Room 209 had an accumulation of dust and dirt. The ceiling tiles in the bathroom were stained. There were four residents who shared the bathroom. Unit 400 a. There were broken tiles at the bathroom entrance in Room 401 and the bathroom door had chipped paint. There were six residents who shared the bathroom. b. There was a large gouge in the wall in Room 404 near bed one. The closet doors were dirty and marred. There were two residents who resided in the room. c. The floor tile was chipped in Room 406. The transition piece to the restroom was missing as well as the trim around the restroom door. The caulking around the sink was chipped. The paint on the toilet seat lid was chipped. There were two residents who resided in the room and five residents who shared the bathroom. d. There were missing pieces of tile flooring in Room 407 next to the beds and behind the head of the bed. There were two residents residing in the		chipped paint has been scraped and repainted,* The large gouge on the wall in room 404 near bed 1 has been filled in and repainted.* The floor tile that was chipped in room 406 has been replaced and the transition piece to the rest room that was missing has been replaced and the trip around the restroom door has been replaced, The caulking around the sink has been recalked. The toilet seat has been replaced.* The missing pieces of tile flooring in room 407 next to the beds and behind the head of the bed has been fixed, **2. 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.· All resident rooms in the facility have been assessed and plans for repair have been started.**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?·** An all staff in-service will be conducted by ED/designee for all maintenance issues to be reported to the Maintenance/Housekeeping Director for repairs via the maintenance/housekeeping	

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	room. The Housekeeping Supervisor indicated at the time of observations that the noted concerns were in need of cleaning and/or repair. This Federal tag relates to Complaint IN00406829. 3.1-19(f)		request form log.· Maintenance/Housekeeping will perform facility rounds monthly to identify problems or needed repairs via the form.**4. 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?**· A "Maintenance Rounds Audit Tool" will be completed by Maintenance director/ designee, audit will be completed. Audits will be completed daily x 5 , weekly x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters.From the results of the checklist, problems or needed repairs will be assigned to the responsible employee for correction. Follow up will be overseen by the ED and Maintenance director. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in repair practices will result in re-training and progressive disciplinary action up to and including termination of responsible employee(s).**5. By What date will the systematic changes be completed· Compliance**	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (p) Initial orientation of all staff must be conducted and documented and shall include the following: (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure each new employee had a criminal history check that was completed by the Indiana State Police and their Physical Exam was signed by a Physician and/or a Nurse Practitioner (NP) for 5 of 5 new employees who had been hired within the last 120 days. The facility also failed to	F 9999	**date of August 1, 2023** **F99999 Personnel** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were affected by the deficient practice. · Facility has set up with the Indiana State Police to do a criminal history check and did do all employees before survey was finished. · Facility has set up with Facility Nurse Practitioner to do the employee physical examinations. · Facility will ensure that prior to working in the facility that all in services related to resident rights, and abuse and dementia training have been completed and that annual in service training for resident rights and abuse and dementia training are completed. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	08/01/2023

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	ensure the 5 new hires had completed inservices related to resident rights and abuse and 2 of 5 employees hired prior to the last 120 days had received annual inservice training related to resident rights and abuse. (Housekeeper 1, RN 2, Dietary Employee 1, CNA 1, LPN 1, CNA 2, and LPN 2) Findings include: The Employee files were reviewed on 6/6/23 at 3:00 p.m. a. Housekeeper 1, RN 2, Dietary Employee 1, CNA 1, and LPN 1 had been hired within the last 120 days. Their criminal history checks had not been run through the Indiana State Police. Their physical exams were signed as being completed by the Director of Nursing (DON) rather than a Physician or NP. Interview with the Human Resources Director on 6/6/23 at 3:30 p.m., indicated she was unaware the DON could not sign the physical exam form. Interview with the Administrator and Human Resources Director on 6/7/23 at 10:30 a.m., indicated they were unaware their current background check company did not fulfill the Indiana State Police requirements and they would get that set up immediately for future hires. b. Housekeeper 1, RN 2, and Dietary Employee 1, who had been hired within the last 120 days, had not received resident rights and abuse inservices at the time of hire. CNA 1 and LPN 1, who had also been hired in the last 120 days, had not received a resident rights inservice at the time of hire.		**taken?** · All residents have the potential to be affected by the alleged deficient practice. · · Facility will ensure that prior to working in the facility that all in services related to resident rights, and abuse and dementia training have been completed and that annual in service training for resident rights and abuse and dementia training are completed. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Human Resources staff will receive an in-service will be conducted by Administrator/designee to be in compliance with standards Personnel and Personnel trainings and inserivces. **4. 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?** A spread sheet of all current employees and when new employees are hires will be made	

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	c. CNA 2 and LPN 2 had not received their annual resident rights and abuse inservice for the year 2022. Interview with the Human Resources Director on 6/6/23 at 3:30 p.m., indicated she was responsible for making sure all of the annual and initial inservices were completed yearly and at the time of hire.		to monitor and ensure that the deficient practice does not occur. Audits will be completed, weekly then x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters. Any concerns will be addressed by Human Resources director and follow up will be overseen by the ED. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. Deficiency in repair practices will result in re-training and progressive disciplinary action up to and including termination of responsible employee(s). **5. By What date will the systematic changes be completed** **· Compliance date of August 1, 2023**	