STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 7th, 8th, 9th, 10th, and 12th, 2021. Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 1 Medicaid: 55 Other: 2 Total: 58 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 17, 2021	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of 11-30-2021 The facility respectfully requests a desk review for this Plan of Correction.	
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure bathroom accommodations were honored for 4 of 4 residents	F 0558	**What corrective action will be accomplished for those residents found to have been**	11/30/2021

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

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	reviewed. (Resident 14, Resident 12, Resident 55 and Resident 46) Findings include: An observation of the bathroom between rooms 103 and 104 on 11-9-2021 at 9:25 a.m., indicated the toilet seat remained broken and not attached on one side to the toilet, the light did not work, and the light cover was on the counter. Resident 12, Resident 14, Resident 46, and Resident 55 shared this bathroom. The record review for Resident 55 began on 11-12-2021 at 11:33 a.m. Diagnoses included but were not limited to, diabetes and chronic obstructive pulmonary disease. A significant change MDS (Minimum Data Set) assessment dated 10-21-2021, indicated the BIMS (Brief Interview for Mental Status) score was 15/15, which indicated the resident was cognitively intact. The resident needed limited assist of one person for transfers, toilet use, and supervision with set up help for locomotion on and off the unit. The resident used a wheelchair. During an interview with Resident 55 on 11-7-2021 at 2:37 p.m., the resident indicated the bathroom light did not work, the light cover was on the counter, and the toilet wobbled. The resident indicated she almost slipped off the toilet and used the bathroom on her own. Resident 55 indicated she had asked Maintenance to fix the wobbly toilet. During an observation on 11-8-2021 at 2:15 p.m., Resident 55 was observed to ask the Maintenance Supervisor about fixing the broken toilet seat. The Maintenance Supervisor indicated to Resident 55, he would get to it this day.		**affected by the deficient practice;** Repairs were made to the toilet seat, light fixture and light cover for resident's #12, 14, 46, and 55. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** Resident's that reside in the facility have the potential to be affected. All resident bathrooms were audited to ensure all applicable repairs have been completed on 11/30/21 by the Executive Director/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on properly completing maintenance work order forms by the Executive Director/Designee on 11/30/21. Resident room/bathroom rounds will be made daily five times per week to ensure no necessary repairs are needed. Maintenance request forms will be filled out and	

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	An observation of the bathroom shared by Resident 46 and Resident 12 on 11-7-2021 at 2:42 p.m., indicated the light did not work, the light cover was on the counter, the toilet seat was not secured to the toilet on one side and slipped back and forth easily. The floor tiles did not fit the floor, there were missing tiles and gaps between the tiles. The bathroom had dried spills on the floor. An observation of Resident 46 on 11-8-2021 at 9:15 a.m., indicated she was walking independently in the hall. An observation of Resident 12 on 11-8-2021 at 1:20 p.m., indicated the resident was walking in the hall independently. The record review for Resident 14 began 11-10-2021 at 3:59 p.m. Diagnosis included but was not limited to, Multiple Sclerosis. A quarterly MDS assessment dated 11-5-2021, indicated the resident had a BIMS of 15/15. The resident needed supervision with set up help only for transfers, walking in room, and toilet use. An interview with Resident 14 on 11-8-2021 at 1:01 p.m., indicated the toilet seat was loose and not attached on one side causing it to shift back and forth and the light did not work. The light cover was observed on the counter. Resident 14 was observed in a wheelchair. She indicated she used the bathroom on her own. An interview with Housekeeping/Laundry 1 on 11-10-2021 at 11:40 a.m., indicated she had just cleaned rooms 103 and 104 including the bathroom. She indicated the light was working.		reviewed by the Executive Director/Designee to ensure compliance. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool Reasonable Accommodation will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	On 11-10-2021 at 11:42 a.m., the bathroom in rooms 103 and 104 was observed. The light worked but the light cover was observed on the bathroom counter. The toilet seat was observed and was not secured to the toilet on one side. The toilet seat was observed to shift back and forth. At this time, Resident 46 was observed to open the bathroom door to use the bathroom. In an interview on 11-10-2021 at 12:29 p.m., the Maintenance Supervisor indicated he repaired the light in the bathroom for rooms 103 and 104 and secured the light cover over the light. He indicated he had the bolts to fix the toilet seat, but had not fixed the toilet seat yet. He indicated if a maintenance request was not completed or if no one reported what items needed to be fixed, he would not know about the repairs needed. An interview with CNA 4 (Certified Nurse Aide) on 11-12-2021 at 10:37 a.m., indicated she worked routinely on the West hall and the 4 residents in rooms 103 and 104 (Resident 14, Resident 12, Resident 55 and Resident 46) used the shared bathroom and were able to use the bathroom independently. She indicated the residetns had told the Maintenance Suprvisor about the needed repairs in the bthroom, so she did not fill out a work order. 3.1-3(v)(1)			
F 0578 SS=E Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure the Physician's Order for Scope of Treatment Form (POST Form, a Physician's order	F 0578	**What corrective action will be accomplished for those residents found to have been**	11/30/2021

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	for treatment for medical care at end of life) was completed for 6 of 6 residents reviewed with Advanced Directives (Resident 7, Resident 13, Resident 1, Resident 41, Resident 48, and Resident 49) Findings include: 1. A record review for Resident 7 began on 11/8/2021 at 11:00 a.m. Diagnoses included but were not limited to, delusional disorders, dementia, epilepsy, atrial fibrillation, and hypertension. The Advance Directive section on Resident 7's face page listed DNR (Do Not Resuscitate) Review of Resident 7's physician orders printed on 11-9-2021 at 2:31 p.m., was provided by the DON on 11-9-2021 at 2:59 p.m. There was an order dated 12-21-2020 for DNR. Review of Resident 7's Indiana POST form listed Resident 7's name, date of birth, medical record number and was dated as prepared 12-18-2020. Resident 7's POST indicated Do Not Attempt Resuscitation/DNR. The Physician's signature, printed name, physician's office telephone number and physician's license number were typed on the form, but the physician signature was not dated. 2. A record review for Resident 13 began on 11-8-2021 at 2:09 p.m. Diagnoses included but were not limited to, major depressive disorder, Alzheimer's disease, dementia, benign neoplasm of cerebral meninges, and hypertension. The Advance Directive section on Resident 13's face page listed DNR. Review of Resident 13's physician orders dated 8-6-2021 indicated the resident wished to be DNR.		**affected by the deficient practice;** POST forms and/or advanced directives were reviewed, completed and signed by the physician for residents #7, 13, 1, 41, 48, and 49 according to their wishes (or responsible parites) on 11/15/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** Resident's that reside in the facility have the potential to be affected. All residents were audited to ensure POST forms and/or advanced directives were completed on 11/30/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing and social service staff were educated on advanced directives and POST forms by the DNS/Designee on 11/30/21. All newly admitted residents will have the POST form/advanced	

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	Review of Resident 13's Indiana POST form listed Resident 13's name, date of birth medical record number and had a date prepared of 8-5-2021. Resident 13's POST did not indicate to attempt CPR nor Not Attempt Resuscitation/DNR. The physician's signature, physician's office telephone number, physician's license number and the name of the professional preparing the form was blank, but was dated 8-5-2021. The box for the printed name of the physician was a copy of the Physician's last name. 3. A record review for Resident 1 began on 11-8-2021 at 4:05 p.m. Diagnoses included but were not limited to, paranoid schizophrenia, type 2 diabetes mellitus, hypertension chronic kidney disease, anxiety disorder and major depressive disorder. The Advance Directive section on Resident 1's face page listed CPR Review of Resident 1's physician orders dated 4-1-2021 was to initiate CPR (Cardiopulmonary Resuscitation). Review of Resident 1's Indiana POST form, prepared on 4-1-2021 indicated to attempt Resuscitation/CPR. The physician's signature, date, physician's office telephone number, physician's license number and the name of the professional preparing the form was left blank. The box for the printed name of the physician was a copy of the Physician's last name. 4. A record review for Resident 41 began on 11-9-2021 at 10:23 a.m. Diagnosis included and were not limited to chronic obstructive pulmonary disease, type 2 diabetes mellitus, arteriosclerotic heart disease, peripheral vascular disease, paraplegia, major depressive disorder and anxiety		directives reviewed the next business day following admissions by Social Services/Designee. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool Advanced Directive will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	disorder. The Advanced Directive section on Resident 41's face page listed DNR. Review of Resident 41's physician orders, dated 7-7-2021 indicated the resident wanted to be DNR. Review of Resident 41's Indiana POST form listed Resident 41' s name, date of birth, medical record number and had a date prepared of 7-6-2021. Resident 41's POST indicated do not attempt resuscitation/DNR. The physician's signature, physician's office telephone number, physician's license number and the name of the professional preparing the form was blank, but was dated 7-6-2021. The box for the printed name of the physician was a copy of the Physician's last name. 5. A record review for Resident 48 began on 11-9-2021 10:30 a.m. Diagnoses included but not limited to chronic obstructive pulmonary disease, atrial fibrillation hypertension, schizoaffective disorder, major depression disorder and anxiety disorder. The Advanced Directive section on Resident 48's face page listed CPR. Review of Resident 48's physician orders, dated 3-3-2021 was for CPR. Review of Resident 48's Indiana POST form listed Resident 48's name, date of birth, medical record number and was dated 8-11-2021. Resident 48's POST indicated to Attempt Resuscitation/CPR. The physician's signature, physician's office telephone number, physician's license number and the name of the professional preparing the form was blank, but was dated 8-11-21. The box for the printed name of the physician was a copy of the Physician's last name. 6. A record review for Resident 49 began on			

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	11-9-2021 at 1:41 p.m. Diagnoses include but were not limited to, atrial fibrillation, hypertension, chronic kidney disease, delusional disorder, and anxiety disorder. The Advanced Directive section on Resident 49's face page listed DNR. Review of Resident 49's physician orders dated 10-8-2021 was for DNR. Review of Resident 49's Indiana POST form listed Resident 48' s name, date of birth, medical record number and was dated 10-8-2021. Resident 49's POST indicatedn Do Not Attempt Resuscitation/DNR. The physician's signature, physician's office telephone number, physician's license number and the name of the professional preparing the from was blank, but was dated 10-8-21. The box for the printed name of the physician was a copy of the Physician's last name. An interview with the DON on 11-9-2021 at 2:05 p.m., indicated the POST Forms should be completed with all information, signed and dated by the physician. Review of the current Indiana Physician Orders for Scope of Treatment (POST) State Form 55317 Indiana State Department of Health-IC 16-36-6, indicated "...Signature Page: This form consist of two (2) pages. Both pages must be present. the following page includes signatures required for the POST form to be effective...." Review of a current facility policy provided by the DON on 11-9-2021, titled, Advanced Directives, dated October 2019, indicated, "...It is the policy of Majestic Care to provide information to resident/responsible party regarding his/her rights to formulate advanced directives including the right to refuse or accept medical care. The facility			

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	will not discriminate against any individual based on whether or not they have implemented and advanced directive. I a resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive, in accordance with state law. Policies regarding the implementation and use of DO Not Resuscitate and POST forms have a separate policy. Review of a current facility policy provided by the DON on on 11-9-2021, Do Not Resuscitate Order, with revised date of April 2017, indicated, "...Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident with there is a Do Not Resuscitation Order in effect...2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record. a. Use only State-Approved DNR forms b. If no State forms is required, use facility-approved form...3. In addition to the advance directive and DNR order form, state-specified forms may be used to specify whether to administer CPR in case of a medical emergency. State specific forms include:...Physician Orders for Scope of Treatment (POST)...." 3.1-4(f)(5)(7)			
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			

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safe smoking practices for 2 of 23 residents who smoke at the facility. (Resident 161, and a random resident) Findings include: 1. The record review for Resident 161 began on 11-9-2021 at 1:59 p.m. Diagnoses included but were not limited to, schizoaffective disorder bipolar type, delusional disorder, unspecified psychosis, major depressive disorder, chronic obstructive pulmonary disease, and diabetes type 2. A quarterly MDS (Minimum Data Set) assessment completed on 9-27-2021, indicated Resident 161 had a BIMS (Brief Interview for Mental Status) score of 15/15, which indicated the resident was cognitively intact. The resident had physical and verbal behavior symptoms directed towards others, which had occurred 1 to 3 days prior to the assessment. Resident 161 only required supervision with set up help for transfers, walk in room/corridor, and locomotion on/off unit. The safe smoking review for Resident 161 dated 11-3-2021 indicated the resident would be a supervised when smoking. The resident was marked as smoking safely and included the following: "does not allow ashes or lit material to fall while smoking, inhaling or holding smoking, remains alert and aware while smoking; does not forget he/she is smoking or falls asleep holding	F 0689	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #161 was assessed with no negative outcome Resident #161's room was searched for smoking related materials All resident's that choose to smoke will be supervised at all times by facility staff during designated smoke times. "Random" residents was not identified on the 2567 therefore no corrective action could be identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All residents that choose to smoke have the potential to be affected. Activity Director was educated on the supervised smoking policy by	11/30/2021

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	item. Does not endanger self or others while smoking; does not burn furniture, clothing, skin, self or others. Turns oxygen off prior to lighting cigarette; smokes only in designated area." During an observation on 11-8-2021 at 1:25 p.m., 5 staff were walking down the East hall to Resident 161's room. When staff opened the door, Resident 161 was observed with a lit cigarette in her mouth and a smoke odor came out of the room. The staff was overhead to tell the resident she could not smoke in her room as it was a fire hazard. The staff then closed the door and the resident was overheard yelling at the staff. The 5 staff exited the room with the resident yelling. An interview at this time with Nurse 5, indicated Resident 116 must have stashed a cigarette during one of the smoking breaks. Staff was observed to have removed the resident's lighter, ashtray, and the cigarette. 2. An observation of the residents participating in smoke time on 11-8-2021 at 3:14 p.m., indicated 17 residents were outside smoking. The Activity person was observed inside still passing out cigarettes to residents while some of the residents had began smoking. One of the residents was observed lighting other residents' cigarettes. Once the Activity person passed out all the cigarettes, she went outside. Prior to the Activity person going outside for supervised smoking, no staff were observed outside supervising residents. An interview with the Activity Director on 11-9-2021 at 10:10 a.m., indicated she was inside the facility passing out cigarettes to the residents while there were 15 residents outside smoking. She indicated she was usually the only person supervising the residents, but today an activity		the Executive Director/Designee on 11/23/21. All staff were educated on ensuring residents that choose to smoke do not retain any smoking materials following the designated smoking times and on the supervised smoking policy on 11/31/21 by the Executive Director/Designee. All resident that choose to smoke will have a safe smoking assessment quarterly and as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** An audit was completed for all resident that chose to smoke to ensure safe smoking assessments were completed and accurate on 11/30/21. All residents that choose to smoke were re-educated on the smoking policy on 11/30/21 by the Executive Director/Designee. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;**	

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	assistant from another facility came to help. The Activity Director indicated she would light cigarettes for the residents. She indicated a couple of residents had been assessed as safe enough to light their own cigarettes, but she discouraged the residents to light other residents' cigarettes. An undated current policy, Smoking Safely, was provided by the Administrator on 11-8-2021 at 4:40 p.m. The policy indicated, "...The purpose of this procedure is to establish uniform guidelines related to smoking, smoking safety...1. The Facility will have a designated smoking area for residents in accordance with Federal, State and other entities having jurisdiction laws...5. Smoking items (cigarettes, lighters) will be kept secured in a designated area with limited staff access...6. All residents will be screened as part of the admission evaluation for smoking practices...14. Visual supervision...15. lighting cigarette for the resident...." 3.1-45(a)(2)		Executive Director/Designee will monitor designated smoke times at random times to include weekends to ensure all residents are supervised appropriately during designated smoke times. Any unsafe smoking practices will be brought to the Executive Director immediately. QAPI tool Safe Smoking will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a			

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	resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure interventions for behaviors were attempted prior to administering prn (as needed) antipsychotic	F 0758	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;**	11/30/2021

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	medications for 1 of 6 residents reviewed for unnecessary medications. (Resident 161) Findings include: The record review for Resident 161 began on 11-9-2021 at 1:59 p.m. Diagnoses included but were not limited to, schizoaffective disorder bipolar type, delusional disorder, unspecified psychosis, major depressive disorder, chronic obstructive pulmonary disease, and diabetes type 2. A quarterly MDS (Minimum Data Set) assessment dated 9-27-2021, indicated Resident 161's BIMS (Brief Interview for Mental Status) score was 15/15, which indicated the resident was cognitively intact. The resident had physical and verbal behaviors symptoms directed towards others, which had occurred 1 to 3 days prior to the assessment. Resident 161 only required supervision with set up help for transfers, walk in room/corridor, and locomotion on/off unit. A review of the physician orders dated 11-8-21 indicated an order for Haldol Solution 5 mg/ml (milligrams/milliliter) inject 10 mg intramuscular every 8 hours as needed for agitation. There was not an end date to this order. A review of the progress notes for Resident 161 indicated: On 11-5-2021 at 1:22 p.m., the resident had refused all medications. She had been verbally defensive when addressed with medications and care. Resident expressed how unhappy she was living at the facility and blamed othersfor her redience at the facility. An observation of Resident 161 on 11-8-2021 at		Resident #161 was assessed for negative outcomes, none noted. Resident#161's physician was notified of administration of PRN Haldol on 11/10/21. Resident #161's PRN Haldol was discontinued on 11/12/21 upon order for resident to have behavioral health stay and will be re-evaluated upon return to the facility. Resident #161's care plans will be reviewed and updated as needed upon return to the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All residents that reside in the facility with PRN (as needed) psychotropic medication order have the potential to be affected. All resident receiving PRN psychotropic drugs have been reviewed on 11/29/21 to ensure proper non-pharmacological interventions are in place prior to administration by DNS/Designee. **What measures will be put into**	

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	9:15 a.m., indicated the resident was seated on her walker by the nurse station. Another resident was observed to walk by Resident 161. Resident 161 was observed to yell at the resident to not come back, then she turned, looked at the surveyor and yelled for the surveyor to get out. Staff were observed at the nurse station. No interventions for behavior were implemented. On 11-8-2021 at 1:16 p.m., the resident had been noted yelling off and on at staff, lunging at staff and had verbal aggression. The resident shattered the Welcome Board in the Front Entrance. The resident then went into ED (Executive Director) office, throwing things and destroying the ED office. The resident then started throwing things at the ED. Finally, she calmed enough through staff effort to exit the ED office. An observation of Resident 161 on 11-8-2021 at 1:25 p.m. included; she was yelling as she was going down East hall to her room. Five staff members were observed to follow the resident down the hall. The nurse indicated she was going to administer a Haldol injection to the resident. When staff opened the door, Resident 161 was observed with a lit cigarette in her mouth and a smoke odor came out of the room. The staff told the resident she could not smoke in her room as it was a fire hazard. The staff then closed the door and the resident was overheard yelling at the staff. The 5 staff exited the room with the resident yelling. There were no interventions to prevent or calm the behavior at that time. Staff was observed to have removed the resident's lighter and ashtray with the cigarette. On 11-8-2021 at 1:45 p.m., 2 ml of 5 mg/ml prn Haldol was given in the left deltoid due to		**place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff have been educated on non-pharmacological interventions on 11/30/21 by DNS/Designee. MD/Psych Services will review all PRN Psychotropic order to ensure they remain necessary no less than monthly. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool Psychotropic Medications will be completed weekly X 4 weeks, bi-monthly X 2, and monthly X 4 months by Executive Director/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the montly meeting.	

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	psychosis related to schizophrenia. Documentation on 11-8-2021 at 6:34 p.m., indicated the Haldol was effective. On 11-9-2021 1:45 p.m., the resident had been very calm and pleasant. She welcomed staff this morning with a hug and an I love you. She was very apologetic about her behavior the prior day. A care plan, revised on 10-1-2021, for behaviors of physical and verbal aggression towards staff and others included the following interventions: Administer medications as ordered. Allow resident to vent feelings/needs. Approach resident in a calm and friendly manor. Document behaviors per behavior management program. Encourage family involvement. Explain to resident what you are going to do before initiating task. Give the resident as many choices as possible about care and activities. Maintain a safe environment for resident. Notify MD and psych services for increases in behavioral symptoms. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. Provide resident personal space. Provide resident with diversional activity listening to music. Psych services as ordered. Documentation was lacking on any interventions from the behavior care plan prior to administering the Haldol injection. Documentation was lacking on notification to Resident 161's responsible party/emergency contact on the behaviors or the administration of the Haldol. Documentation of the notification was lacking to the MD/NP/Psych			

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	regarding the behaviors or end date of the prn Haldol order. An interview with Social Services on 11-10-2021 at 12:23 p.m., indicated Resident 161 was only to be able to be re-directed by staff she liked. Social Services indicated the resident had not had behaviors as severe since she was at a recent psychiatric hospital stay. An interview with the DON (Director of Nursing) on 11-12-2021 at 9:53 a.m., indicated other behavior interventions should have been attempted prior to giving prn Haldol. 3.1-48(b)(2)			
F 0761 SS=E 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 listed in Schedule II of the Comprehensive			

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	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, interview and record review, the facility failed to ensure medications were labeled, stored per pharmacy guidelines and secured for 2 of 2 medications carts and 1 of 1 treatment carts observed. This affected 17 of 58 residents residing in the facility. (Resident 34, Resident 15, Resident 22, Resident 19, Resident 24, Resident 26, Resident 18, Resident 45, Resident 55, Resident 48, Resident 47, Resident 44, Resident 14, Resident 8, Resident 43, Resident 30 and Resident 57) Findings include: 1. An observation of a treatment cart outside the nurse station on 11-7-2021 at 11:10 a.m., indicated the treatment cart was unlocked. The treatment cart drawers were able to be opened and treatments were observed. At least 8 residents who were mobile, were observed near or walked by the unlocked treatment cart. Staff were observed in the area, but were far enough away and did not observe the treatment cart drawers being opened. An observation of a treatment cart on 11-7-2021 at 3:25 p.m., indicated it was outside the nurse station and was unlocked. There were several independently, mobile residents observed in the vicinity of the treatment cart. An observation of a treatment cart on 11-9-2021 at 9:19 a.m., indicated the treatment cart was unlocked, outside of the nurse station, and near	F 0761	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** All medication and treatment carts were immediately secured and items without a resident name or administration instructions were disposed of. Resident #34's discontinued insulin was disposed of according to policy on 11/10/21. Resident #16's undated insulin and Advair was disposed of and reordered according to policy on 11/10/21. Resident #22's Soothe Night Ointment was labeled with date opened on 11/10/21. Resident #19's Advair, and Symbicort inhalers were disposed of and reordered according to policy on 11/10/21. Resident #24's Advair was disposed of and reordered according to policy on 11/10/21.	11/30/2021

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	the medication storage room. Staff were observed sitting in the nurse's station with their backs to the treatment cart. At least 3 residents were observed in the area, two were independently walking and one resident was self-propelling their wheel chair. An observation of the East hall medication cart on 11-9-2021 at 1:10 p.m., indicated the medication cart was unlocked and unattended. There were 2 staff observed at the nurse station who were unable to see the side of the medication cart with the drawers. Continued observation of the East hall medication cart on 11-9-2021 at 1:20 p.m. indicated the medication cart was unlocked and unattended. Two staff remained seated at the nurse station, unable to see the front of the medication cart. Another staff member was observed down the hall with the Administrator. Three residents, independently mobile, were observed seated near the unlocked medication cart. On 11-10-2021 at 12:19 p.m., Social Services provided a list of 44 confused and independently mobile residents who resided in the facility. She indicated medication and treatment carets are to be locked when unattended.2. Observation of the East Hall medication cart with QMA 6 on 11-10-2021 from 11:06 a.m. to 11:40 a.m., found the top drawer contained multi-dose medications, insulin, inhalers and eye medications. The following multi-dose medications were lacking open dates written on the label: A vial of Humulin insulin (Insulin lsipro) for Resident 34 was opened but the Prescription (Rx) label was lacking an open date. The Rx label for the Humulin Insulin was dated 8-30-21. Resident		Resident #18's Albuterol was disposed of and reordered according to policy on 11/10/21. Resident #45's Advair was disposed of and reordered according to policy on 11/10/21. Resident #55's Trelegy Ellipta, Advair, Albuterol inhalers and insulin were disposed of and reordered according to policy on 11/10/21. Resident #48's Advair and Symbicort inhalers were disposed of and reordered according to policy on 11/10/21. Resident #44's Advair was disposed of and reordered according to policy on 11/10/21. Resident #14's Latanaprost eye drops and insulin were disposed of and reordered according to policy on 11/10/21 Resident #43's insulin was disposed of and reordered according to policy on 11/10/21. Resident #30's Rhopressa eye drops were disposed of and reordered according to policy on 11/10/21. Resident #57's insulin was disposed of and reordered according to policy on 11/10/21.	

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	34's Humulin insulin would expire 28 days after being opened per facility policy. A record review for Resident 34 began on 11/12/21 at 10:40 a.m. Diagnosis included but were not limited to type 2 diabetes mellitus with diabetic neuropathy. Review of Resident 34's current physician orders indicated Humulin insulin was not listed on the orders. Review of Resident 34's MAR (Medication Administration Record) for September 2021, October 2021 and November 2021, Humulin insulin was not administered. 3. A vial of Humalog insulin for Resident 15 was opened but the Rx label was lacking an open date. The Rx date for the Humalog insulin was 10-17-21, and read to inject 20 units (a dose measurement for insulin) 3 times a day. A vial of Humulin 70/30 insulin for Resident 15 was opened but the Rx label was lacking an open date. The Rx date for the Humulin 70/30 insulin was 10-31-21, and read to inject 85 units SQ (subcutaneous) 2 times a day. The Humalog and Humulin 70/30 insulin were not expired. An inhaler of Advair Diskus 250/50 (dose per puff) was removed from foil pouch and was lacking an open date on the Rx label. The dose counter on the inhaler read 28. The Advair Diskus contains 60 doses. The Rx date for the Advair Diskus was 9/17/21. The Advair Diskus would expire 28 days after being opened per facility policy. Interview with QMA 6 on 11-10-21 at 11:10 a.m.,		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All resident's that resident in the facility have the potential to be affected. All medication and treatment carts were audited on 11/30/21 by the DNS/Designee to ensure all medications are appropriately dated and labeled. All licensed nursed and QMA's were educated on 11/30/21 by the DNS/Designee on proper medication storage, dating and labeling. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All medication carts will be audited on a routine basis to ensure proper storage, dating and labeling. **How will the corrective action(s) will be monitored to ensure the deficient practice**	

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	indicated Resident 15 had just returned from the hospital last night. Resident 15 was hospitalized from 10-5-21 to 11-9-21. Review of Resident 15's current physician orders dated 11-10-2021 read Humalog (Insulin Lispro), inject 20 units before meal and also per sliding scale before meals. Humulin 70/30 Insulin, inject 50 units SQ 2 times a day before breakfast and dinner. Advair Diskus was not listed on current orders. Review of Resident 15's MAR for October 2021 indicated Wixeia Inhub Aerosol Powder (same as Advair Diskus) with a start date of 9-7-2021 and discontinued on 11-6-21. The Wixeia Inhub was administered 2 times a day from 10-15-21 to 10-31-21 for 34 doses after earliest expired date. Review of Resident 15's MAR for November 2021 indicated the Wixeia Inhub was administered 2 times a day from 11-1-21 to 11-5-21 for 10 doses after earliest expiration date. 4. Observation of Soothe Night Ointment tube for Resident 22 was opened but was not labeled with an open date. The Rx date was 7/6/2021 and the Rx instructed to instill 0.25 inch at bedtime. The multi-dose tube was not labeled with an opened date. 5. Observation of an Advair Diskus AER 250/50 Inhaler for Resident 19 indicated the medication was opened and removed from foil package. The inhaler and Rx label were lacking an open date The Rx date was 9/7/2021 and the Rx instructed 1 puff 2 times a day. The Advair Diskus would expire 28 days after being opened per facility policy. A record review for Resident 19 began on 11/12/21		**will not recur, ie., what quality assurance program will be put into place;** QAPI tool Medication Storage, dating and labeling will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by the Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	at 10:50 a.m. Diagnosis included but were not limited to chronic obstructive pulmonary disease (COPD). Review of Resident 19's current physician orders, printed on 11-12-21 at 10:26 a.m., listed Wixeia Inhub Aerosol Powder 250-50 1 puff inhale orally 2 times a day related to COPD with a start date of 9-7-2021. Review of Resident 19's MAR indicated for October 2021 the Wixeia Inhub was administered 54 doses. Resident 19's MAR for November 2021 was administered 17 doses. 6. Observation of a Flutic/Salme (Advair Diskus-Fluticasone/Salmeterol) for Resident 24 was opened and removed from foil package was lacking an open date on the Rx label. The Rx date was 9/15/2021 and Rx instructed to inhale 1 puff 2 times a day. The dose counter was 57. The Advair Diskus would expire 28 days after being opened per facility policy. A record review for Resident 24 began on 11-12-21 at 10:55 a.m. Diagnosis included but were not limited to, moderate persistent asthma. Review of Resident 24's current physician orders, printed on 11-12-2021 at 9:21 a.m., listed an order for Wixeia Inhub Aerosol Powder 250/50 1 puff inhaled orally 2 times a day with a start date of 6-25-2021. Review of Resident 24's MAR for October 2021 indicated 36 doses were administered after 10-13-21. Reviewed Resident 24's MAR for November 2021 indicated 19 doses were given from 11-1-21 to 11-10-21.			

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	Interview with QMA 6 on 11-10-21 at 10:40 a.m., indicated the insulin, inhalers and eye medications should be labeled with an open date on the Open Date label or the vial or inhaler. 7. An observation of the West Hall medication cart with QMA 7 on 11-20-21 a.m., at 11:00 a.m. to 12:15 p.m., found the top drawer contained multi-dose medications, which included insulin, eye drops, inhalers and nasal sprays. The following multi-dose medications were lacking open dates written on the label and indicated the following: A Combivent AER 20-100 (a respiratory medication) inhaler for Resident 26 was opened but was lacking an open date on the Rx label and the inhaler. The Rx date was 9-19-2021. The Combivent inhaler would expire 3 months after being assembled per manufacture instructions and would not be expired until 12-19-21. 8. An Albuterol AER HFA (a respiratory medication) inhaler for Resident 18 was opened but an open date was not written on the label nor the inhaler. The Rx date was 9/22/21 and the Rx instructed 1 puff every 4 hours as needed for shortness of breath. The Albuterol inhaler would expire 1 year after being being removed for foil pouch and would expire on 9-22-2022. 9. A Flutic/Salme AER 250/50 (Advair Diskus Inhaler) for Resident 45 was opened but an open date was not written on the label nor the inhaler. The Rx date was 9-17-2021 and the Rx instructed 1 puff 2 times a day. the Dose Counter read 48. The Flutic/Salme/Advair Diskus would expire 28 days after being opened per facility policy. A Combivent AER 10-100 Inhaler for Resident 45			

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	was opened but an open date was not written on the label nor the inhaler. The Rx date was 9-19-21 and the Rx instructed 1 puff every 6 hours as needed for COPD. The Combivent inhaler would expire 3 month after being assembled per manufacture instructions and would not expire until 12-19-21. A record review for Resident 45 began on 11-12-2021 at 12:00 p.m. Diagnosis included but were not limited to chronic obstructive pulmonary disease (COPD). Review of Resident 45's current physician orders printed on 11-12-2021 at 9:24 a.m., listed orders for: Combivent Resplmat Aerosol 20-100, 1 puff inhale orally every 6 hours as needed for COPD with a start date of 9-17-2021 and Wixeia Inhub/Flutic Salme 250/50 1 puff inhale orally 2 times a day related to COPD with a start date of 9-17-2021. Review of Resident 45's MAR for October 2021 indicated Wixeia Inhub Aerosol Powder 250/50 Inhaler indicated 32 doses were given from 10-16-2021 to 10-31-2021. Resident 45's MAR for November 2021 indicated Wixeia Inhub Aerosol Powder Inhaler was administered 19 doses from 11-1-2021 to 11-10-2021. 10. A Trelegy Ellipta AER (a respiratory medication) Inhaler for Resident 55 was opened and was lacking an open date written on the label nor the inhaler. The Rx date was 10-8-2021 and the Rx instructions were 1 puff daily for COPD. The Trelegy Ellipta inhaler would expire 6 weeks after the foil package was opened. The Trelegy Ellipta inhaler would expire on 11-19-2021. A Flutic/Salme AER 250/50 Inhaler for Resident 55 was opened but was lacking an open date written			

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	on the label nor the inhaler. The Rx date was 9-28-21 and Rx instruction 1 puff 2 times a day. The Flutic/Salme/Advair Diskus would expire 1 month after being opened per manufacture instructions. Would expire on 10-28-2021. Albuterol AER HFA inhaler for Resident 55 was opened but was lacking an open date written on the label nor the inhaler. The Rx date was 10-5-2021 and the Rx instruction 2 puffs every 4 hours as needed for shortness of breath. The Albuterol inhaler would expire 1 year after being being removed for foil pouch per manufacture instructions and would expire on 10-5-2022. A vial of Semglee Soln (Lantus insulin) 100 U (unit, and insulin dose measurement)/ml (milliliter, a measurement) for Resident 55 was opened, but was lacking an open date on the lable nor the vial. The Rx date was 10-1-2021 and Rx instructed to inject 15 units SQ once daily for diabetes mellitus. The Semglee insulin expires 28 days after being opened. A record review for Resident 55 began on 11-12-2021 at 12:05 p.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease (COPD) and type 2 diabetes mellitus with diabetic neuropathy. Review of Resident 55's current physician orders printed on 11-12-2021 at 9:30 a.m., did not list Semglee Insulin but listed Lantus (Insulin Glargine) inject 15 units SQ one time a day and had a start date of 10-8-2021. Review of Resident 55's MAR for October 2021 indicated Semglee Insulin had a start date on 10-01-2021 and a discontinued date of 10/5/2021 and was documented as administered once a day			

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	from 10-1-21 to 10-5-2021. Resident 55's expired Semglee Insulin was discontinued and remained in the medication cart. 11. A Wixela Inhub AER 250/50 inhaler for Resident 48 was opened and removed from foil package. An open date was not written on the label nor the inhaler. The Rx date was 8/11/2021 and Rx instructed 1 puff inhaled orally 2 times a day. Wixela Inhaler expires 1 month after removed from foil package per manufacture's instructions and would expire on 9/11/2021. A record review for Resident 48 begun on 11-12-2021 at 12:10 p.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease. Review of Resident 48's current physician orders printed on 11-12-21 at 9:38 a.m., listed Wixeia Inhub 250/50 Aerosol Powder inhaler to be administered 1 puff inhaled orally 2 times a day and had a start date of 8/12/2021. Review of Resident 48's MAR for September 2021 indicated Wixela Inhub inhaler was administered 40 doses after expired on 9-11-2021. Review of Resident 48's MAR for October 2021 Wixela Inhub inhaler was administered 62 doses. Review of Resident 48's MAR for November 2021 Wixela Inhub inhaler was administered 19 doses from 11-1-2021 to 11-10-2021. 12. Observed a Symbicort AER 80-4.5 mcg (a measurement) inhaler for Resident 47 was opened but was lacking an open date written on the label nor the inhaler. The Rx date was 8-8-2021 and the Rx instruction was to inhale 2 puffs 2 times a day. The Symbicort inhaler expires in 3 months after opening per manufacture's instructions. The			

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	Symbicort inhaler would expire on 11-8-2021. Observed a Budesonide and Formoterol Dihydrate Aerosol (Symbicort) inhaler 80-4.5 mcg for Resident was opened but was lacking an open date written on the label nor the inhaler. The Rx date was 9/29/2021 and the Rx instruction was to inhale 2 puffs 2 times a day. The Symbicort inhaler expires in 3 months after opening per manufacture's instructions. The Symbicort inhaler would expire on 12-29-2021. An interview with QMA 7 on 11-10-2021 at 11:20 a.m., indicated they did not know which inhaler was used and indicated the inhalers should be labeled with an open date. 13. A Flutic/Salme AER 250/50 inhaler for Resident 44 was opened but was lacking an open date written on the label nor the inhaler. The Rx date was 10-5-2021 and the Rx instruction 1 puff 2 times a day for COPD. The dose counter was 53. The Flutic/Salme/Advair Diskus would expire 1 month after being opened per manufacture instructions. Would expire on 11-5-2021. A record review for Resident 44 began on 11-12-21 at 12: 15 p.m. Diagnoses included but were not limited to, chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of Resident 44's current physician orders printed on 11-12-2021 at 9:57 a.m., listed an order for Wixela Inhub Aerosol Powder Inhaler with a start dated on 10-5-2021. The order instructed 1 puff orally 2 times a day for COPD. Review of Resident 44's MAR for November 2021 indicated Wixeia Inhub Inhaler was administered 9			

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	doses after 10-5-2021. An opened vial of Semglee Insulin Glargine was loose in the medication cart top drawer. The vial was not labeled with a script from the pharmacy, no a resident name nor instructions for administration were on the Semglee Insulin vial. An interview with QMA 7 on 11-10-2021 at 11:25 a.m., indicated she does not give insulin and did not know who the insulin belonged too. 14. A Latanoprost Sol 0.005% (eye drop dose) for Resident 14, was opened but was lacking an open date written on the label nor the bottle. The Rx date was 10-19-2021 and the Rx instruction to instill 1 drop in both eyes at bedtime. The Latanoprost Eye Drops expired in 6 weeks after being opened per manufacture's instructions. The Latanoprost Eye Drops would expire on 11/30/2021. 15. A vial of Semglee (Insulin Glargine) for Resident 8 was opened but was lacking an open date written on the bottle. The Rx date was 9/13/2021 and the Rx instructed to inject 12 units SQ at bedtime. The Semglee insulin expires 28 days after being opened. The Semglee insulin would expire on 10-11-2021. A record review for Resident 8 began on 11-12-2021 at 12:25 p.m. Diagnoses included but were not limited to type 2 diabetes mellitus. Review of Resident 8's current physician orders printed on 11-12-2021 at 10:00 a.m., listed an order for Insulin Glargine and order to inject 12 units SQ at bedtime. Review of Resident 8's MAR for October 2021,			

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	indicated Insulin Glargine was administered 20 doses from 10-12-2021 to 10-31-2021. Review of Resident 8's MAR for November 2021 indicated Insulin Glargine was administered 10 doses from 11-1-2021 to 11-10-2021. 16. Observation of a vial of Humalog Insulin for Resident 43 was opened but was lacking an open date written on the label nor the vial. The Rx date was 10/29/2021 and Rx instructed to inject 10 units SQ before meals and bedtime. The Humalog Insulin would expire 28 days after opening. The Humalog Insulin would expire on 11-24-2021. 17. Observation of a bottle of Rhopressa Sol 0.02% Eye drop for Resident 30 was opened but was lacking an open date written on the label nor the bottle. The Rx date was 9/2/2021 and the Rx instructed to instill 1 drop in both eyes at bedtime. The Rhopressa Eye Drop could be kept for 6 weeks after opening per manufacture's instructions and would be expired on 10-14-2021. A record review for Resident 30 began on 11-12-2021 at 12:30 p.m. Diagnoses included but were not limited to, glaucoma. A review of Resident 30's current physician orders printed on 11-12-2021 at at 10:10 p.m., listed an order for Rhopressa Solution 0.002%, instill 1 drop in both eyes at bedtime for glaucoma, with a start date of 4/22/2021. A review of Resident 30's MAR for October 2021 indicated the Rhopressa Eye drops were administered 17 doses from 10-15-2021 to 10-31-2021. Review of Resident 30's MAR for November 2021 indicated the Rhopressa Eye drops were administered 9 doses from 11-1-2021 to 11-9-2021.			

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	18. A vial of Semglee Sol (Insulin Glargine) for Resident 57 was opened but was lacking an open date written on the label or the vial. The Rx date was 9/28/2021 and Rx instructed to inject 20 units SQ at bedtime. The Semglee insulin expires 28 days after being opened. The Semglee insulin would expire on 10-26-2021. A Combivent AER 20-100 (ipratropium/albuterol) inhaler was opened but was not labeled with open date. The Combivent inhaler was also lacking an Rx label and was not in a box nor a plastic bag with Rx label. Resident 57's name was written on the inhaler with a marker. The Combivent inhaler expires 3 months after the inhaler was assembled per manufacture's instruction. A ProAir Respi (albuterol sulfate inhaler powder) was opened without an Rx label nor a box or bag with an Rx label for the ProAir Respi inhaler. Resident 57's name was written on the inhaler with a marker. The dose counter was 198 of 200 doses. A ProAir Respi inhaler expires 12 month after removed from the foil package per manufacture's instructions. A record review for Resident 57 began on 11-12-2021 at 12:35 p.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease (COPD) and type 2 diabetes mellitus. A review of Resident 57's current physician orders printed on 11-12-2021 at 10:19 a.m., listed the following orders: Albuterol Sulfate Aerosol Powder, inhale 1 puff orally every 6 hours as needed for shortness of breath. Insulin Glargine Solution, inject 30 units SQ at bedtime. Combivent AER was not listed on current orders.			

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	A review of Resident 57's MAR for October 2021 indicated the Insulin Glargine had a start date on 9-28-2021 and discontinued on 11-2-2021. The Insulin Glargine was administered for 5 doses after the expiration date. The Combivent Respimat 20-100 inhaler with a start date of 5/27/2021 and discontinued dated of 11-2-2021. The Combivent Respimat 20-100 inhaler was administered 4 times a day from October 1, 2021 to October 31, 2021. The Albuterol Sulfate Aerosol Powder inhaler 1 puff orally every 6 hours as needed for shortness of breath or wheezing had a start date of 1-23-2021 and was not administered in October 2021. A review of Resident 57's MAR for November 2021 indicated: Insulin Glargine 20 units was administered at bedtime on 11-1-2021; Insulin Glargine 25 units was administered at bedtime every night from 11-2-2021 to 11-5-2021; Insulin Glargine 30 units was administered at bedtime every night from 11-6-2021 to 11-9-2021. The Combivent Respimat inhaler was administered 4 times on 11-1-2021 and 2 times on 11-2-21 and was discontinued on 11-2-2021. The Albuterol Sulfate inhaler was not administered in November 2021. An interview with the Director of Nursing (DON) on 11/10/2021 at 11:33 a.m., indicated insulin, inhalers and eye medications should be labeled with open dates. She indicated she would not be able to determine the open dates for the non-dated multi-dose medications. She indicated the Nurse or QMA should check for expiration dates before administering the medication. She indicated the pharmacy had not been in to check the medication carts since she began working at the facility. The DON indicated the medication and treatment carts should be locked when not using.			

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	Review of a current facility policy provided by the DON on 11-10-2021 at 11:50 a.m., titled, Medication and Biological Storage Requirements, with an effective date of 2-1-2018, indicated, "...In accordance with state and Federal laws, and manufacturer or supplier recommendations, the facility must store al medications and biologicals in compartments or storage rooms under proper temperature controls, and permit only authorized personnel to have access to the keys...Access to medication(s) may be controlled by keys, security codes or cards, or other technology such as biometrics (i.e. fingerprints, retina scan)...21) Disposal of medication(s) should be completed for medication(s) that are without secure closure, outdate, contaminated and/or deteriorated. a. Disposal needs to be timely b. Removal medication(s) immediately from stock...*Note: Some medications have shortened expiration dates. Pleas refer to the expiration dating policy for information on these medications...." Review of a current facility policy provided by the DON on 11-10-2021 at 11:50 a.m., titled, Labeling of Medication, with an effective date of 2-1-2018, indicated, "...To ensure that the facility, in coordination with the licensed pharmacist, provide for accurate labeling to facilitate safe administration of medications and considerations of precautions in accordance with the currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 1) Medication labeling must be typed or printed and clearly indicated...a. Resident full name c. prescription number, d. Brand name, generic name or both, e. Strength of drug, f. Prescribed dose of drug/medication, g. Route of administration, h. Time of administration, j. Date dispensed, k. Expiration date (i.e. time-dated			

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	drugs) l. Prescriber/Physician name...3) Multi-dose medications vials/devices a. Should be labeled with date opened/accessed...Pharmacy recommends using a marker directly on vial/device if there is not adequate room for a "Date Open" sticker...Once opened/accessed the vial/device should be dated and discarded within 28 days unless the manufacturer specified a different (shorter or longer) date for vial/device after opened/accessed...After medication(s) with difficult labeling are used, they must always be returned immediately to the labeled box, baggy or vial...." 3.1-25(j) 3.1-25(k)(1)(2)(3)(4)(5)(6)(7) 3.1-25(m) 3.1-25(o)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review the facility failed to ensure the kitchen was maintained clean and sanitary. This affected 58 of 58 residents who ate their meals from the kitchen. Findings include: 1. During an observation in the dining room on 11-7-2021 at 11:35 a.m., several residents were seated in the dining room. The tables had been cleaned, but there was food (yellow scrambled eggs) on the floor in several areas. The residents indicated lunch had not been served. An observation on 11-10-2021 at 11:39 a.m., indicated there were scrambled eggs and pieces of cereal on the dining room floor from breakfast, which had not been cleaned. 2. During an observation of the kitchen on 11-7-2021 at 11:37 a.m., the dietary staff were plating the noon meal. There were ants observed on the floor to the left of the stove between the stove and the steamer. Food was observed on the floor (yellow scrambled eggs) There were ants on the food and crawling back to the wall behind the steamer. The Kitchen Manager indicated the kitchen was treated for ants recently, but she did not know the ants were currently in the kitchen. The wall behind the steamer was splattered with brown splatters. The area to the right of the stove on the wall was splattered with brown spatters and the side of the stove had whitish splashes. The light switch to the right of the stove had smears and brown splatters on it. The microwave	F 0812	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The floor in the dining room and kitchen was immediately cleaned on 11/7/21. Pest control was notified regarding ants in the kitchen and an additional visit was requested on 11/29/21. The wall behind the steamer was cleaned on 11/30/21. The stove was cleaned on 11/30/21. The microwave was cleaned on 11/28//21. The walk-in refrigerator was cleaned on 11/30/21. All undated items were immediately discarded. The vent in the dishwasher room was cleaned on 11/30/21. **How other residents having the potential to be affected by the same deficient practice will be**	11/30/2021

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	was not clean on the inside and had yellow splatters on the inside walls and dried food debris on the glass tray. Continued observation in the kitchen of the walk in refrigerator indicated the floor had dark brown areas on it and the inside covering of the door had yellowish splatters on it. There were 2 gallon size bags of cooked sausage patties without a label on them. The Kitchen Manager indicated they were from this morning and should have been labeled. The vent in the dishwasher room on the wall was observed with brownish debris on the vent slats. During an observation of the kitchen on 11-10-2021 at 9:35 a.m., the walk in refrigerator floor was not clean and had brownish areas on the floor. The interior door was observed to have a large circular yellow splatter on the lower part of the door. The oven and stove area was observed and the wall behind and to the left and right of the oven had dried brown splatters on it. The floor along the baseboard behind the stove/oven had food debris, and trash. The light switch to the right of the oven was observed to have brownish smears on it. The screen to the window behind where the microwave and cooking pots were stored, was not secured in the frame. There was a feathery whitish web type material at the bottom between the screen and window. There was debris and small dead insects observed on the window sill. The cooking pots were observed to be stored right below this area. There were 2 circular vents on the ceiling in the main kitchen, one on each end and one above the steam table. There was a brownish color debris on the circular vent slats of each of the two vents and there was a brownish feathery type debris observed on the ceiling outside of these 2 circular vents. The floor area in the dish washing room between		**identified and what corrective action will be taken;** All resident that reside in the facility have the potential to be affected. All dietary staff have been educated on the cleaning schedule and the process for signing off on the completed tasks daily on 11/25/21 by the Dietary Manager/Designee. All dietary staff have been educated on proper dating, labeling and disposal of items on 11/25/21 by the Dietary Manager/Designee. All staff have been educated on dating and labeling items prior to putting items in the pantry on 11/25/21 by the Executive Director/Designee. All housekeeping staff have been educated on dining room cleaning scheduleds on 11/30/21 by the Housekeeping Supervisor/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A cleaning schedule was implemented on 11/29/21 by the	

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	the 3 compartment sink and the end of the dishwasher counter had an approximate 8 x 12 inch metal cover with grooves around it with blackish debris, crumbs and dirt. The top of the metal piece had grooves in it which had brownish debris, crumbs and dirt. The 3 compartment sink had a named lab dispensers for the soap and the sanitizer. There were brownish gold areas on the sink and some darker rust color material on the sinks. Inside the sanitizer sink was a pink film covering the surface of the sink. An interview with the Kitchen Manager on 11-10-2021 at 9:45 a.m., indicated when she came to the facility, there was not any cleaning/scrubbing devices to clean the kitchen. She indicated she had tried to get the items she needed to clean the kitchen. She indicated she had scrubbed the 3 compartment sink, but had not been able to remove any of the stains and the pink film just smeared on the surface of the sink. The Kitchen Manager was interviewed about the ceilings and the cleaning schedule for the ceiling. She indicated the kitchen staff did not clean the ceiling and they only did the walls and the floors. On 11-10-2021 at 10:16 a.m., the Kitchen Manager provided the cleaning schedule for October 2021. She indicated it was one used at another facility and she was trying to incorporate it at this facility. She indicated she was cooking most of the time and a lot of the tasks were not completed. The Cleaning Schedule for October 2021 had the following areas designated to be cleaned and none of the days of October had any of the cleaning checked off to indicate the task had been completed. The task areas included but were not		Dietary Manager/Designee. The Cleaning schedule sign off will be reviewed daily to ensure tasks are completed. Any areas of concern will be addressed with corrective action. The nourishment pantries were added to the housekeeping cleaning schedule on 11/8/21. Housekeeping staffing will be reviewed daily to ensure adequate staffing is met to ensure a clean and homelike environment. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool Environment will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by the Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. Dietary Sanitation review will be completed daily until threshold is met and then will be conducted weekly X 4 weeks and then monthly ongoing.	

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	limited to: Three compartment sink Steam table Microwave interior and exterior Deep clean refrigerators inside and outside Sweep and mop serving line area Deep clean interior and exterior of plate warmer Wall and baseboard behind cooking equipment Sweep and Mop Dish room area Wall and baseboard behind 3-compartment sink Sweep and mop dry storage room Soiled dish table including legs and garbage disposal Interior and exterior of oven Wall behind oven Clean Hand washing sink, soap and paper towel dispenser in prep area Deep Clean all freezers inside and outside Sweep and mop cooking and in prep area Deep Clean Pot and Pan storage rack under table Clean the Diet Kitchen Refrigerator and Freezer Clean 3 tier cart 100 hall Clean 3 tier cart 200 hall Clean 3 tier cart 300 hall Monthly task--clean all light covers All ceiling vents Walk-in cooler fans Walk-in freezer fans Power scrub kitchen floor Instructions on the task sheet were to make sure to initial each task upon completion. None of these tasks were initialed on the October 2021 cleaning task form. On 11-10-2021 10:21 a.m., the Kitchen Manager provided a blank undated weekly sanitation audit she was going to use for cleaning tasks. The Kitchen Manager was interviewed about the November cleaning schedule and the cleaning			

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	schedules prior to October. She indicated she had not started the November cleaning schedule and there were no cleaning schedules prior to October. 3. During an observation of the facility pantry on 11-10-2021 at 1:55 p.m., the floor was sticky and there was a reddish color substance on the floor. The walls were splattered with brown debris. There was a blue sticky substance on the bottom of the freezer unit. An uncovered, unlabeled cup was observed 1/3 full with a frozen brown substance inside the freezer. A sealed plastic bag with 3 round brown items inside was labeled with a name and no date. There was an opened 128 ounce container (about 3/4 full) of fruit of the earth aloe vera wild berry juice, which did not have a label with a name or date on the container. There was an opened 128 ounce container of diet half and half ice tea/lemonade which was not labeled with a name/opened date. An opened 16 ounce container of coffee creamer was not labeled with an opened date. To the right of the refrigerator was a cabinet with a whole loaf of butter topped wheat bread with a best by date of 11-5-2021. There were 3 to 4 slices which was observed with a greenish feathery substance on it. An opened loaf of butter topped wheat bread with 7 slices left was observed with a white color feathery substance on the side of the bread and on the crust of several pieces of the bread. A staff member then was observed to have brought in an opened container of liquid Lemon Flavored thickener and placed it into the refrigerator. She indicated she had just gotten from the kitchen and it was not labeled. An interview with the Kitchen Manager on 11-10-2021 at 2:05 p.m., indicated they had just checked and cleaned the pantry refrigerator yesterday. She indicated the blue liquid in the			

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	freezer was not there and she did not know where the cup with the brown frozen liquid came from. The Kitchen Manager was interviewed about the lemon thickener not having an opened date on it and she indicated it was not opened. The Kitchen Manager was informed the staff had given some of the lemon thickener to a resident. The cap to the lemon thickener was opened and the seal had been punctured. An observation on the top of the container indicated a use by date of 7-21-2021. The Kitchen Manager was made aware of the 2 loaves of bread. She indicated she was unaware of the use by dates and the growth of the greenish and white feathery substances on the bread. She was observed to remove the bread from the pantry. The Kitchen Manager indicated housekeeping was supposed to keep the floor clean and she indicated it was still sticky. An interview with the Director of Environmental Services on 11-10-2021 at 12:09 p.m., indicated the dining room floor was to be cleaned by housekeeping two times a day, after breakfast and after lunch. He indicated he only had enough staff to clean the dining room floor twice a day. The Director of Environmental Services indicated he only had 1 laundry staff in the building this past Saturday and Sunday and the laundry person would have been responsible for housekeeping and laundry duties on Saturday and Sunday. He indicated they just started documentation on 11-9-2021 of the areas which were cleaned. An interview with Housekeeping/Laundry 1 on 11-11-2021 at 10:31 a.m., indicated if she was assigned to laundry on the weekend, it was impossible to clean the facility including the dining room and do the laundry tasks during her shift.			

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	A copy of the housekeeping cleaning check off list was provided by the Director of Environmental Services on 11-10-2021 at 12:30 p.m. The nourishment room was not on the check off list as an area to be cleaned. A current policy, "Equipment" dated October 2019, was provided by the Kitchen Manager on 11-12-2021 at 10:55 a.m. The policy indicated "...the Dining Services Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials...ensures all staff members are properly trained in the cleaning and maintenance of all equipment...ensures all food contact equipment is cleaned and sanitized after every use...ensures that all non-food contact equipment is clean...." 3.1-21(i)(3)			
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,			

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	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; §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.			

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	§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 of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to to properly prevent and COVID-19 for 1 of 2 quarantined residents reviewed for infection control (Resident 160). Findings include: The record review for Resident 160 began on 11-10-2021 at 2:55 p.m. Resident 160 was admitted to the facility on 11-5-2021. Diagnoses included but were not limited to dementia with behavioral disturbance, mood disorder, depression, diabetes and tremors. A review of the physician orders for Resident 160 indicated an order for contact isolation for 14 days was dated 11-5-2021 with an end date of 11-19-2021. The DON provided a copy of Resident 160's Pfizer Covid-19 vaccine information on 11-10-2021 at 2:55 p.m. The resident had one dose of the Pfizer vaccine on 9-21-2021. Documentation was lacking for the second dose. A care plan for Resident 160 dated 11-5-2021	F 0880	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #160 no longer requires TBP related to being a new admission. Resident #160 will be reminded by staff to wear a mask that covers his nose and mouth while moving about the facility. Resident #160 is scheduled to received his 2nd Covid-19 vaccination on 12/10/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All residents that reside in the	11/30/2021

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	indicated the resident was at risk for infection related to the inability to comprehend and/or is resistant to the concept of social distancing and/or adhering to infection control practices (face covering, hand washing, covering coughs/sneezes, isolation to room). Interventions included but were not limited to, encourage resident to stay at a distance of six feet from other residents and remind the resident of the importance of wearing face covering when out of room or going to appointments. During a review of the progress notes for Resident 160, an entry by the DON (Director of Nursing) on 11-8-2021 at 3:02 p.m., indicated the resident had a diagnosis of dementia and cognitive impairment. The resident was reminded by the DON to stay in his room at this time as he was in isolation due to being a new admission with only one vaccine at this time. The notes indicated the resident continued to come out of his room due to the inability to remember instructions. An observation of Resident 160 on 11-7-2021 at 11:18 a.m., indicated he was in his high backed wheelchair with his facemask below his chin. The resident was wandering and wanted to find his room. An interview with a staff member indicated the resident's room was 108 and the bed was by the door. An observation of room 108 indicated there was a yellow zone sign, a contact precaution sign, and a droplet precaution sign posted on the wall to the left of the door. A container with PPE (personal protective equipment) was also outside the door. CNA 8 was interviewed on 11-7-2021 at 11:25 a.m. CNA 8 indicated Resident 160 was not in TBP (Transmission Based Precautions), the PPE were		facility have the potential to be affected. C.N.A. #8 was educated on proper transmission based precautions on 11/30/21. All staff were educated on "yellow zone" transmission based precautions and reminding residents to wear a mask over their nose and mouth when moving about the facility on 11/30/21 by the DNS/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All residents that admit to the facility not fully vaccinated against Covid-19 will be placed in 14 day quarantine (yellow zone) with proper transmission-based precautions in place per policy. All residents will be reminded per staff to wear a mask that covers their nose and mouth when moving about the facility. A RCA was completed by the Infection Preventionist on 11/29/21 with input from the facility Medical Director and DNS. The facility LTC infection control assessment was reviewed and	

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	just there. CNA 8 was observed to enter the room, placed the resident's red blanket on the bed and made the bed. The CNA did not use hand hygiene or don a gown or gloves. She was observed with a facemask and faceshield. The CNA was then observed to exit the room and was not observed to use hand hygiene. CNA 8 indicated she would check with the nurse to see if the resident was in the yellow zone. An interview with CNA 8 on 11-7-2021 at 11:30 a.m., indicated Resident 160 was recently admitted and in quarantine in the yellow zone. The resident was observed in the hallway outside the room with his facemask under his chin. CNA 8 was not observed to remind the resident to cover his mouth and nose with his facemask. An observation of Resident 160 on 11-7-2021 at 12:10 p.m., indicated he was wandering the halls in his wheelchair with his mask down below his chin. No staff were observed to remind the resident to pull the facemask over his mouth and nose. An observation of Resident 160 on 11-8-2021 at 11:42 a.m., indicated the resident was in his wheelchair wandering the hallway and did not have a facemask donned. No staff were observed to remind the resident to pull the facemask over his mouth and nose. An observation of Resident 160 on 11-9-2021 at 9:33 a.m., indicated the resident was in his wheelchair by the nurse station without a facemask. Staff were observed at the nurse station and no staff were observed to remind the resident to put on a facemask. An observation of Resident 160 on 11-10-2021 at 1:06 p.m., indicated the resident was sitting in his		updated as necessary. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool infection control will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by the Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. The DNS/Designee will complete daily visual rounds through-out the facility to ensure proper infection control practices are followed. This will occur for a minimum of 6 weeks until compliance is maintained.	

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	wheelchair near the nurse station without a facemask. Four other residents were sitting in the area. No staff were observed to remind the resident to put on a facemask. An observation of Resident 160 on 11-12-2021 at 9:53 a.m., indicated the resident was in his wheelchair without a facemask donned. The resident was observed sitting right outside the DON's office and when staff assisted the resident, the staff was not observed to remind the resident to put on a facemask. An interview with the DON on 11-12-2021 at 10:33 a.m., indicated there was a concern with Resident 160 not remaining in quarantine and wandering in the hallways without a facemask. The DON indicated he had 1 of the Covid 19 doses and they care planned him for not being compliant with quarantine. A current copy of the Yellow Zone Transmission Based Precautions sign was provided by the DON on 11-10-2021 at 2:55 p.m. The sign indicated PPE required was a N95 mask or approved KN95 mask, universal eyewear, faceshield or goggles, single gown, and gloves (hand hygiene donning/doffing). A current copy of the Contact Precautions sign was provided by the DON on 11-10-2021 at 2:55 p.m. The sign indicated everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry and discard gloves before room exit; put on gown before room entry and discard gown before room exit. A current copy of the Droplet precautions sign indicated everyone must: clean their hands, including before entering and when leaving the			

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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
	room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. 3.1(b)(1)			
F 0908 SS=F Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record, the facility failed to ensure the kitchen equipment was in working order. 58 of 58 residents residing in the facility ate their meals from the kitchen. Findings include: The kitchen was observed on 11-7-2021 at 11:37 a.m. The Kitchen Manager, a cook and a dietary aid were observed to be preparing the noon meal trays. The Kitchen Manager indicated the oven was not working as the temperature of the oven could not be controlled and was overcooking the food. She indicated the temperature of the oven would be set at 350 degrees Fahrenheit and then while baking, the temperature would fluctuate up to 500 degrees Fahrenheit. She indicated there were baffles for the oven on order and were to be delivered by 11-10-2021. The Kitchen Manager indicated the steam table only had 3 of 5 wells working and a new steam table was to be delivered on 11-8-2021. The kitchen Manager indicated the corporation	F 0908	F908 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Menus were adjusted to provide the proper nutrition. A new steamtable was quick shipped and received 11/08 and parts were obtained to have the steam table drain correctly on 11/09. The oven was serviced on 10/11, 10/18, 11/04, 11/22, and 11/23. Calls were made to the Vulcan Company regarding the oven and cooking process on 11/23, 11/24, and 11/30. 11/19 a new baffle was installed. Recommendations from Vulcan were received, and action taken. A new oven was ordered on 11/30. The steamer is now working correctly since part of the menu is cooked in the smaller oven. **How other residents having the**	11/30/2021

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	155359	A. BUILDING 00 B. WING	11/12/2021

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	removed the prep sink which was on the same wall as the stove because it kept backing up. An interview with the Kitchen Manager on 11-9-2021 at 9:10 a.m., indicated the new steam table came on 11-8-2021, but needed to have a drain installed. The Kitchen Manager indicated the Maintenance Supervisor had to get the parts and was to install the drain. The Kitchen Manager indicated now the steamer was not working correctly to get the food up to temperature and they were still waiting on the oven parts. The Kitchen Manager indicated she was waiting on instructions on what they were going to do for lunch since all she had was a working stove. The cook indicated since the prep sink was removed, she did not have a place to rinse meat, drain pasta or clean the potatoes. An interview with the Kitchen Manager on 11-9-2021 at 1:30 p.m., she indicated for lunch, they served cold meat sandwiches. An interview with the Kitchen Manager on 11-10-2021 at 9:50 a.m., indicated the steam table was in use and working. She indicated the steamer was worked on yesterday and was still not heating the way it should. She indicated she called for the company to come out again to fix the steamer. The oven was not working as they were waiting on parts. On 11-10-2021 at 11:29 a.m., the Kitchen Manager was observed to begin to plate the food for lunch. The Kitchen Manager was observed to pick up a plate from the plate warmer. An observation of the plate warmer indicated the red light was not on. The Kitchen Manager indicated the stackable plate warmer did not work.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. Menus were adjusted to provide the proper nutrition. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Work orders will be done on any equipment that is not working properly. Maintenance will repair or contact a service technician. If the equipment cannot be fixed to work properly, replacement equipment will be obtained timely. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Administrator/Designee will complete visual rounds through-out the facility to ensure proper working equipment. These rounds will occur daily for 1 week, weekly for 3 weeks and monthly for 5 months until compliance is maintained. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	An interview with the Maintenance Supervisor on 11-10-2021 at 12:29 p.m., indicated he had placed phone calls to a named repair company about the steamer and the oven. He indicated he did not have any paperwork on repairs. He indicated he was not aware the plate warmer was not working. He indicated he would see if he could get documentation on the repairs for the steamer and oven. Two invoices were provided by the Maintenance Supervisor for the oven on 11-10-2021 at 2:01 p.m. One invoice dated 6-3-2019 indicated the oven was not cooking evenly and the thermostats for the ovens needed to be replaced. The second invoice dated 7-11-2019 indicated the oven was not at temperature. The oven knobs were calibrated. The notes indicated the ovens should run a higher temperature now at the same settings. A current estimate dated 10-12-2021 was provided for the ovens. The estimate included 2 new thermostats and a burner baffle. A current policy, Equipment, dated October 2019, was provided by the Kitchen Manager on 11-12-2021 at 10:55 a.m. The policy indicated, "...It is the center policy that all foodservice equipment is clean, sanitary, and in proper working order...The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed...The Dining Services Director will notify the Administrator when repairs are complete...Copies of service repairs and preventative maintenance reports will be submitted monthly...." 3.1-19(bb)			

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F 0921 SS=F 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, interview and record review, the facility failed to ensure a clean and sanitary environment the 58 residents who resided in the facility. Findings include: During an observation of the facility on 11-7-2021 at 11:00 a.m., there were splatters on the wall to the left of the electronic screening device at the receptionist area of the facility. The electronic screening device had crumbs and debris on the screen. The floors leading to the nurse station had dried and wet reddish and brownish spills observed. In the West hall, dried brownish spills were observed on the floor. A yellow mop bucket with a mop and dirty water was observed across from room 108. South hall was observed with dried brownish splatters and a spot of liquid on the floor outside the ice machine room. During an observation of the East hall sitting area on 11-8-2021 at 8:53 a.m., the sliding glass door in the sitting room had a white film which prevented anyone from being able to see outside. The floor was sticky, crumbs were on the floor and brown debris was throuhgout the floor. On 11-8-2021 at 9:01 a.m., the West hall lounge floor was observed to have food crumbs, dried spills and a cigarette butt on the floor. The door which was labeled, not an exit, was glass and padlocked. The glass was covered with a white film which could be wiped off. the film prevented	F 0921	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The west hall central bathing room was deep cleaned on 11/29/21. The south hall central bathing room was deep cleaned on 11/29/21. The screening device in the front lobby was immediately cleaned on 11/12/21. West hall was immediately mopped on 11/7/21. South hall was immediately mopped on 11/7/21. East hall sitting area floor and door was immediately cleaned on 11/8/21. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All residents that reside in the	11/30/2021

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	anyone from seeing through the glass door. The bottom ledge of the door had brown debris on it and the corners of the entrance were dirty with brown debris in them. On 11-10-2021 at 8:39 a.m., the COVID-19 screening device was observed to have dried splatters on the screen. An interview with the Director of Environmental Services on 11-10-2021 at 12:09 p.m., indicated he did not have documentation for the specific rooms/lounges/showers/hallways which were cleaned in October or November. He indicated they just started documentation yesterday of the rooms/lounges/showers/hallways which were cleaned. He indicated we were just trying to get done what we could get done. He indicated for spills on the floor, if it was body fluids, the CNA (Certified Nurse Aide) would clean the spill and housekeeping would sanitize the area. For regular spills, he indicated it would be whomever got to the spill first would clean it.During the initial tour of the facility on 11-7-21 at 11:34 a.m., a random resident indicated the shower had "black mold" in it. The resident then pointed to the shower room door, and said the mold was in there. The central bathing room was located on the west hall. A Certified Nursing Assistant 13 (CNA) was walking into the central bathing room. The CNA 13 explained she had to help another resident out and she would be leaving the room. During the observation, on 11-7-21 at 11:35 a.m. on the inside of the shower, in the left and right corners and along the back close to the ground there appeared to visible a black substance. More observation of the black substance was visible on the left side of the shower along and in between the tile. On the same side on the tile was a orange discoloration.		facility have the potential to be affected. Housekeeping services will be staffed 7 days per week effective 11/30/21. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff were educated on proper cleaning of the bathing facilities on 11/30/21. All housekeeping staff were educated on proper cleaning of the bathing facilities on 11/30/21 by the Housekeeping Supervisor/Designee. Housekeeping staffing will be reviewed daily to ensure adequate staffing. All staff have been educated on 11/30/21 by the Executive Director/Designee on immediately cleaning spills. The receptionist was educated on 11/29/21 by the DNS/Designee on cleaning the screening device after each usage to ensure no debris are present.	

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	Further observation of the shower room, past the shower down on the right side, there was a toilet located. Behind the toilet on the floor was black flecks and an orange discoloration. During an observation on 11-7-21 at 2:00 p.m., with the Director of Nursing (DON), in the west side central shower room, black substance all inside of the shower, the trash visible on the floor, the black flecks on the floor on the back side of the toilet, and the inside of the toilet that had yellow coloration inside were noted. During an observation on 11-7-21 at 2:03 p.m., with the DON, in the South Central Bathing room, inside of the room there was a clean linen cart with used towels on top of cart next to the shower. Inside of the shower on the edges there was a black substance along the side of the wall. The shower head had an orange discoloration that came down the wall to the shower handle. By the sink there was a small trash can observed, the small trash can was over filled with brown paper napkins and used briefs. The DON indicated, the staff knew better than this. During an observation 11-7-21 at 2:06 p.m., with the DON in the east side central bathing room, inside the shower, the drain had some plastic inside of the it. The DON indicated the shower rooms were used by all residents in the facility and then removed the plastic trash with bare hand from the drain. Near the toilet there was a wheelchair, and shower chair pushed against the toilet. The toilet was missing the toilet seat. During an interview on 11-7-21 at 2:00 p.m., the DON indicated they have contract housekeeping. They do not have housekeeping on the weekends.		**How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place;** QAPI tool Environment will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by the Executive Director/Designee if 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthy meeting.	

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	During an interview on 11-9-21 at 1:34 p.m. on 11-9-21 the EVS manager, indicated they do work on the weekends but they spilt the staff to do housekeeping and laundry. The nursing and EVS are the ones that will clean the shower rooms. Nursing is to clean after every use, EVS will leave the chemicals for them and they are to spray the shower after every use. During an interview on 11-10-21 at 4:34 p.m., the DON, indicated they do not have a policy/procedure for cleaning the shower rooms. 3.1-19(f)			
F 0924 SS=E Bldg. 00	483.90(i)(3) Corridors have Firmly Secured Handrails §483.90(i)(3) Equip corridors with firmly secured handrails on each side. Based on observation, interview, and record review, the facility failed to ensure the handrails were in good repair for 56 of 58 residents who were mobile in the facility. Findings include: During an observation of the facility on 11-7-2021 at 12:13 p.m., the curved part of the hand rail outside of the soiled utility room in South hall was cracked, broken and jagged. On 11-7-2021 at 2:27 p.m., the curved portion of the hand rail in the South hall right before ice machine was observed to be broken and jagged. Observations of the hand rails in the facility on 11-8-2021 at 8:50 a.m. indicated the following:	F 0924	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Handrail parts were ordered on 11/30 and will be repaired upon delivery. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that are mobile have the potential to be affected. Handrail parts have been ordered and will be repaired upon deliver. **What measures will be put into place and what systemic**	11/30/2021

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	The curved part of the hand rail in the East hall by the third door on the left was observed to be missing. The end of the plastic hand rail was rough. To the left of the Environmental Supervisor door, a curved piece of the handrail was observed to be broken with jagged edges. The curved piece of the handrails at the entrance to the East hall sitting area, were cracked and had jagged edges. In the West hall, the curved hand rail piece to the right of the nourishment room was loose. The curved hand rail piece to the right of room 102, was loose, cracked and jagged. The curved hand rail piece to the left of room 104 was cracked and jagged. The curved hand rail piece to the left of room 108 was cracked and jagged. An interview with the Maintenance Director on 11-10-2021 at 12:29 p.m., indicated he was aware of the broken corners on the handrails and had reported it to his supervisor. He was observed to contact his supervisor at 12:40 p.m. and the supervisor indicated he did not have access to his paperwork on the hand rails. An interview with the DON (Director of Nursing) on 11-12-2021 at 10:32 a.m., indicated 56 of the 58 residents were able to move about the facility independently or with a mobility device. 3.1-19(f)(3)		**changes will be made to ensure that the deficient practice does not recur;** Maintenance request forms will be filled out and reviewed by the Executive Director/Designee to ensure compliance. All staff were educated on properly completing maintenance work order forms by the Executive Director/Designee on 11/30. Majestic Rounds will be made daily by the IDT Team five times per week to ensure no necessary repairs are needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool Environment will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure the kitchen was free from pests 58 of 58 residents residing in the facility ate their meals from the kitchen. Findings include: During an observation of the kitchen on 11-7-2021 at 11:35 a.m., food was observed on the floor in the area to the left of the stove between the stove and the steamer. Ants were observed on the food on the floor and were observed crawling back to the wall behind the steamer. The kitchen manager indicated they were sprayed for ants recently and she did not know the ants were in the kitchen. An interview with the Kitchen Manager on 11-10-2021 at 11:28 a.m., indicated all 58 residents eat from the facility kitchen. An interview with the Maintenance Supervisor on 11-10-2021 at 12:29 p.m., indicated he was asked about the pest control documentation for the treatment of pests in the kitchen. He indicated he would have to get the invoices. On 11-10-2021 at 2:01 p.m., the Maintenance Supervisor provided an invoice from a named pest control company for the general pest control program for October 2021. A note on the invoice indicated the pest control service came back to the facility on 11-8-2021, but there was not an invoice available. The invoice did not describe what type of treatments were done in the kitchen	F 0925	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The floor was cleaned of all food and ants. Pest control was notified on 11/29 to have the kitchen inspected and treated to eliminate ants. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. Pest control will treat the kitchen to eliminate ants. Staff will complete a maintenance work order for any ants that are seen and make sure the kitchen is free of ants. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance request forms will be filled out and reviewed by the Executive Director/Designee to ensure compliance. All staff were educated on properly completing maintenance work	11/30/2021

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	for ants. A current policy, "Pest Control" dated October 2019, was provided by the Kitchen Manager on 11-12-2021 at 10:53 a.m. The policy indicated, "...It is the center policy that there is a program established for the control of insects and rodents for the Dining Services Department...The Dining Services Director coordinates with the Director of Maintenance to arrange pest control services on a monthly basis or as needed...All food preparation, service, and storage areas will be monitored regularly for any signs of pest/vermin...." 3.1-19(f)(4)		order forms by the Executive Director/Designee on 11/30. Majestic Rounds will be made daily by the IDT Team five times per week to ensure no necessary repairs are needed. Maintenance request forms will be filled out and reviewed by the Executive Director/Designee to ensure compliance. All staff were educated on properly completing maintenance work order forms by the Executive Director/Designee on 11/30. **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;** QAPI tool Environment will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. Dietary Sanitation review will be completed daily until threshold is met and then will be conducted weekly X 4 weeks and then monthly ongoing.	
F 9999 Bldg. 00				

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	410 IAC 16.2-3.1-14 Personnel Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1; IC 16-28-13-3 Sec.14. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. This state rule was not met as evidenced by: Based on interview, and record review, the facility failed to ensure the requirements of employee files were completed for 5 of 5 employee files reviewed. Findings include: 1. During a record review on 11-10-21 at 11:03 a.m., indicated Registered Nurse 9 (RN) did not have an employee file. The hire date was on 6-22-2021. 2. During a record review on 11-10-21 at 11:05 a.m., indicated RN 10 did not have any of the following completed in the employee file: 2nd step Tuberculosis (TB)/risk assessment ,specific orientation, job description, and resident rights completed. The hire date was on 9-20-2021. 3. During a record review on 11-10-21 at 11:10 a.m., indicated Personal Care Attendant 11 (PCA) did not have any of the following completed in the employee file: personal references, physical exam, TB testing/risk assessment, job description, general orientation, specific orientation, resident rights and abuse training. The hire date was on 10-14-2021 4. During a record review on 11-10-21 at 11:15 a.m., indicated Director of Nursing (DON) did not have	F 9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Registered nurse 9 (RN) file was completed on 11/30 to be in substantial compliance until the original file can be located. RN 10 received their 2nd step Mantoux, specific orientation, job description and resident rights completed on 11/30. Personal Care Attendant 11's was corrected on 11/30 to include personal references, physical exam, TB testing/risk assessment, job description, general orientation, specific orientation resident rights and abuse training. The Director of Nursings' file was corrected on 11/30. Certified Nursing Assistant 12's was corrected on 11/30 to include personal references, TB/risk assessment, and dementia training. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected. **What measures will be put into place and what systemic**	11/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

(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
	any of the following completed in the employee file: job description, specific orientation, and the 2nd TB testing/ risk assessment. The hire date was on 5-19-2021. 5. During a record review on 11-10-21 at 11:25 a.m., indicated Certified Nursing Assistant 12 (CNA) did not have any of the following completed in the employee file: personal references, TB/risk assessment, and Dementia training. The hire date was on 2-14-2020. During an interview with the Business Office Manager (BOM) on 11-10-21 at 11:03 a.m., indicated there was no employee file for Registered Nurse 9 (RN), was not sure what happen to it. What ever we have in the record is what we have. During an interview with the DON on 11-10-21 at 12:58 p.m., indicated there is no policy for employee files, they just a checklist.		**changes will be made to ensure that the deficient practice does not recur;** All employee files will be audited to ensure that all are complete. Business Office Manager/HR educated on properly completing orientation forms by the Executive Director/Designee on 11/30/21. The Executive Director/designee will review new hire employee files for completeness. **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;** QAPI tool Employee Files will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	