STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155684	A. BUILDING 00 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 18, 19, 20, 21, 22, 25 & 26, 2022 Facility number: 002662 Provider number: 155684 AIM number: 200315930 Census Bed Type: SNF/NF: 37 SNF: 14 Residential: 42 Total: 93 Census Payor Type: Medicare: 5 Medicaid: 28 Other: 18 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/2/22.	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop a comprehensive care plan for anticoagulant and an antidepressant medication for 1 of 22 residents whose care plans were reviewed. (Resident 1)	F 0656	The community was alleged to be out of compliance by failing to develop a comprehensive care plan for anticoagulant and an antidepressant medication for 1 of	08/19/2022

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	Finding includes: A clinical record review was completed on 7/20/2022 at 1:37 P.M. Resident 1's diagnoses included, but were not limited to: hypertension, atrial fibrillation, dementia, diabetes, and anxiety. Physician's Orders, dated 7/2/2022, indicated Resident 1 had received Eliquis (anticoagulant) 2.5 mg (milligrams) twice daily since 3/31/2022 and Sertraline (antidepressant) 50 mg daily. A Psychiatric Progress Note, dated 7/11/2022, indicated Resident 1 had anxiety and depression and was receiving Sertraline. The clinical record lacked care plans for the potential bleeding risk for the use of Eliquis and the use of the Sertraline for anxiety. During an interview, on 7/21/2022 at 10:05 A.M., MDS staff indicated there should have been care plans for the anticoagulant and the antianxiety medications if the resident was taking them. On 7/21/2022 at 11:56 A.M., the scheduler provided the policy titled, "Comprehensive Care Plans", dated 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ...It is the policy of this facility to develop and implement a comprehensive person -centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ...." 3.1-35(a)		22 residents. a. A comprehensive care plan was developed for resident #1 b. Residents on anticoagulants and antidepressants were reviewed for comprehensive care plans. Two other residents were identified and comprehensive care plans were created for residents affected. c. Nursing staff was educated on comprehensive care plans. d. An audit will be completed by MDS/Designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review and interview, the facility failed to revise the comprehensive care plans for an arm sling use and falls for 2 of 22 residents reviewed for care plans. (Residents 26 & 35) Findings include: 1. During an observation on 7/18/2022 at 9:32	F 0657	The community was alleged to be out of compliance by failing to revise the comprehensive care plans for an arm sling use and falls for 2 of 22 residents. a. The care plans for residents # 26 and # 35 were revised. b. Care plans for residents with falls for the past 30 days or	08/25/2022

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	A.M. and 7/20/2022 at 9:21 A.M., Resident 26 was observed sitting in her room in her wheelchair. Her left forearm was resting in her lap. She did not have a splint or arm sling in place for her left wrist contracture. On 7/21/2022 at 8:44 A.M., 11:49 A.M., and 7/22/2022 at 8:46 A.M., Resident 26 was observed sitting in the Dining Room with her left forearm resting in her lap. She did not have a splint or arm sling in place. On 7/22/2022 at 9:25 A.M., Resident 26 was observed sitting in her room in her wheelchair, her left forearm was resting in her lap and the left wrist was bent at a 90-degree angle. She indicated she was not able to move her left arm due to a previous stroke. She indicated she has worn a splint in the past, and the area does cause pain at times. Her splint is noted to be placed in her recliner in the room. An arm sling could not be visually found. A clinical record review was completed on 7/20/2022 at 8:48 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia of left side, congestive heart failure, and epilepsy. An Annual Minimum Data Set (MDS) Assessment on 5/27/22, indicated Resident 26 had moderate cognitive impairment. She required extensive assistance with two or more staff members for bed mobility and transferring and extensive assistance with one staff member for toileting. A Care Plan on 1/11/2021, indicated " ...[Resident name] needs assistance with bed mobility, toileting, transfers, eating and bathing/hygiene r/t [related to] history of CVA [Cerebrovascular		slings/splints were reviewed. Care plans for residents identified were revised. c. Nursing staff were educated on care plan revisions. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	Event] with left hemiparesis, muscle weakness, age related cognitive decline, CHF [Congestive Heart Failure], anemia, seizures, impaired mobility and impaired cognitive processes and weakness". The interventions on 1/11/2022, indicated, "Splint to left wrist as ordered. Observe for skin impairments prior to and after removal of device ...." There was not an intervention for the left arm sling recommended by Occupational Therapy. Physician Orders on 1/16/2021, indicated, " ...Left wrist splint to be worn daily when up, on in AM [morning], off in PM [evening] ...." There was not an order for the left arm sling recommended by Occupational Therapy. An Occupational Therapy Discharge Summary on 1/26/2022, indicated, a long-term goal of " ...Occupational Therapy to complete staff training inclusive of her sling for her left arm, the hemi tray, the foot buddy, and transfers prior to discharge from services ...." In the note, it indicated on 12/10/2021, " ...Her sling was not positioned correctly on her left shoulder and trunk ...." The Assessment and Summary of Skilled Services, indicated, " ...She [Resident 26] participated in caregiver training r/t application of the wrist brace and left hemi sling ...." During an interview on 7/22/2022 at 9:59 A.M., Physical Therapy Assistant 13 indicated, Resident 26 had a sling and a brace for her left arm and wrist. On 7/22/2022 at 10:29 A.M., the Director of Nursing (DON) indicated, Resident 26 had been working with therapy for quite some time. She indicated the facility had a brace Resident 26 was using, and believed the brace was for bedtime. Upon reading the Physician Order, the DON			

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	indicated Resident 1 should have the ordered brace on during the day. She indicated she did not know anything about a sling recommended by Occupational Therapy. On 7/22/2022 at 1:36 P.M., The Assistant Director of Nursing (ADON) indicated, Resident 26 should have a splint on her left wrist. She indicated an order and updated care plan should be completed. She indicated that she would be reaching out to therapy to determine if more staff education should be completed. 2. During an observation on 7/18/2022 at 7:31 A.M., Resident 35 was seen outside her room during breakfast. She was observed to have a "V" shaped sutured area to her forehead, and sutures to her right temporal region. She had bruising to her entire left face that was yellow in color with purplish discoloration within the yellowing area under the left eye and behind the left ear/neck. A sign could be observed from the common area in her room by the heating/cooling unit that read, "Remember ask for help and don't fall". During an interview with Resident 35 on 7/19/2022 at 11:06 A.M., Resident 35 indicated she had recently fallen. A clinical record review was completed on 7/21/2022 at 10:49 A.M. Diagnoses included, but were not limited to: Parkinson's disease, vascular dementia with behavioral disturbance, cerebral infarction, chronic kidney disease, anemia, and constipation. A Quarterly Minimum Data Set (MDS) Assessment on 6/2/2022, indicated Resident 35 was cognitively intact. She required extensive assistance with the assistance of one staff			

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	member for bed mobility, transferring, and toileting. She had two falls with no injury and two falls with minor injuries since the last MDS Assessment on 3/2/2022. A Nurse's Note on 5/27/2022 at 12:16 P.M., indicated, " ...Resident found down on the floor in front of her w/c [wheelchair] by CNA [Certified Nursing Assistant]. She was laying on her left side. No injuries. Resident could not tell us why she was getting up. The CNA had just been in [sic] her room a couple minutes earlier so all of the resident's needs were met. Resident requested to be put to bed to lay down. No c/o [complaints of] pain. Family, doctor and manager notified. No new orders ...." On 7/7/2022 9:44 P.M., a Nurse's Note indicated that Resident 35 had an unwitnessed fall at 8:50 P.M. The CNA (Certified Nursing Assistant) found Resident 35 on her left side on the floor. Resident 35 had a laceration on her forehead measuring 5 cm (centimeters) by 2.5 cm, a laceration on her left eyelid measuring 2 cm x 1cm, swelling to the outer aspect of the left eye, and a left knee abrasion. Resident 35 could not communicate what happened to cause the fall. She was transported to the hospital via EMS (Emergency Medical Services). On 7/8/2022 at 10:05 A.M., a Nurse's Note indicated, Resident 35 was admitted to the hospital for a urinary tract infection and observation. The hospital telephone report indicated Resident 35 had her lacerations sutured on the right and left side of the forehead and left eyebrow. On 7/11/2022 at 3:56 P.M., a Nurse's Note indicated that Resident 35 had returned from the			

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	hospital. She was awake but not responding or communicating with staff. Resident 35 had scattered bruising to face with surrounding bruising to bilateral eyes with the left side of the face being worse. She has 4 lacerations on her forehead and left side of the face with stitches. The injuries from the fall were documented as follows: 1. Right forehead laceration, 3 stitches, measuring 3 cm by 0.7 cm with surrounding red/purple bruising 2. Left forehead, 3 lacerations with stitches and surrounding dark purple and red bruising, measuring 4.5 cm by 6 cm 2a. Middle forehead laceration, 5 stitches, measuring 4 cm by 0.1 cm 2b. Left side of face laceration, 9 stitches, measuring 7 cm by 0.1 cm 2c. Left side of face near eye, 2 stitches, measuring 2.5 cm by 0.1 cm 3. Right eye surrounding bruising measuring 4 cm by 6cm, red and yellow in color 4. Left eye surrounding bruising measuring 6.5 cm by 11 cm, red, purple, and yellow in color 5. Left side of neck bruising measuring 12 cm by 11 cm, dark purple and red in color 6. Left ear (behind) bruising measuring 5 cm by 2 cm, red and purple in color 7. Left nare (below) bruising, 1.2 cm by 1.5 cm, red in color 8. Left wrist open area measuring 1.5 cm by 1.2 cm with surrounding bruising measuring 3.8 cm by 3.5 cm, red and purple in color 9. Left knee open area measuring 1 cm by 1.8 cm with surrounding bruising 3 cm by 2.8 cm 10. Left elbow open area measuring 0.7 cm by 0.7 cm with surrounding bruising, red and purple in color On 7/13/202 at 11:59 P.M., a Nurse's Note			

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	indicated, " ...IDT [Interdisciplinary Team] meeting reviewed falls and care plan interventions. Care plan interventions in place. Son POA [Son's name] updated on interventions and in agreement with POC [Plan of Care] ...." A Care Plan on 4/21/2022, indicated, " ... [Resident's name] has potential for falls related to decreased mobility, decreased safety awareness, history of falls, and falling with fracture, history of CVA, Parkinson's, memory deficit, osteoarthritis, muscle weakness, medication usage, disease process and weakness. She has a [sic] history of being non-compliant with asking for assistance with ADL's and care including transferring ...." The goal for the care plan was, " ...[Resident's name] will remain free from injury ...." Interventions for the care were as follows: 4/21/22 Cardinal alert 4/21/22 Encourage use of assistive device and to turn on her call light for assist. Call light within reach at all times. 4/21/22 Provide activities that minimize the potential for falls while providing diversion and distraction 4/21/22 Floors free from spills or clutter 4/21/22 Provide adequate, glare free lighting 4/21/22 Personal items within reach 4/21/22 Assist to wear non-skid footwear 4/21/22 Use gait belt for transfers and ambulation 4/21/22 Therapy has applied and anti-rollback to wheelchair 4/21/22 4/5/20-Tap style call light for ease of pressing 4/21/22 Personal items within reach and verbal reminders to call for transfers from staff 4/21/22 Frequent rounding by staff and verbal reminders to all for assistance with transfers 4/21/22 Encourage protein intake to encourage muscle growth in combination with PT related to			

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	fall on 6/23/21 4/21/22 Resident son to bring in cordless phone for resident use related to fall on 6/23/21 4/21/22 Educate family with Parkinson's hallucinations/medications, often falls are caused by resident seeing things that aren't on the floor and bending over to pick them up 4/21/22 Therapy screen 4/21/22 Scoop mattress as ordered. 4/21/22 Resident re-educated on use of reacher due to her consistently falling due to reaching down to the floor from a sitting position 4/21/22 Resident continues on maintenance therapy program 4/21/22 Command hooks and signage placed on walls as reminder to use reacher 4/21/22 Assist resident in toileting and back to bed for her nap she likes to take after lunch. Resident will attempt to transfer self after lunch for nap. 4/21/22 Therapy screen sent to eval r/t recent fall on 4/3/22 4/21/22 Therapy and Maintenance assessing wheelchair for functional ability 4/21/22 Staff re-educated to offer and provide toileting and resting in recliner or bed after meals 5/2/22 Staff re-educated to provide res with her personal belongings and keep within reach after meals 5/27/22 Continue previous interventions During an interview on 7/22/2022 at 10:31 A.M., the Director of Nursing (DON) indicated, sometimes, what will happen, if the fall root cause is not identified an intervention won't be added. Sometimes, the care plan will revert to what was already there. "We've been at a loss with her and interventions, and other than 1:1, the falls are going to keep happening. Trying to keep her safe is where we are now. She should have had a new			

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	intervention in place after falling on May 27th." The DON indicated that the Assistant Director of Nursing (ADON) has been following the facility falls. An interview on 7/22/2022 at 1:31 P.M., the ADON indicated she was on vacation during Resident 35's fall on 5/27/2022. She was unsure if an IDT meeting was held, and that an IDT note should have been created. She indicated it was not an appropriate intervention to put continue previous interventions. She indicated she was working with the staff on finding the root cause and interventions for falls. A policy was provided by the ADON on 7/22/2022 at 2:31 P.M. The current policy titled, "Care Plan Revisions", indicated, " ...1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. 2. The MDS Coordinator and the Interdisciplinary team will discuss the resident condition and collaborate on intervention options. d. The care plan will be updated with the new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member...." 3.1-35(b)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene; Based on record review, observation and interview, the facility failed to ensure showers were provided timely for 1 of 3 residents reviewed for ADL care (Activities of Daily Living). (Resident 46) Finding includes: During an observation on 7/19/2022 at 10:16 A.M., Resident 46 was observed with facial hair under her chin and along the edges of her mouth. A clinical record review was completed on 7/20/2022 at 2:58 P.M. Resident 46's diagnoses included, but were not limited to: left kidney cancer, hypertension, diabetes, and dementia. An Annual MDS (Minimum Data Set) assessment, dated 6/17/2022, indicated Resident 46 required extensive assist of 2 staff for bed mobility, transfers, toilet use and bathing, and was always incontinent. A current care plan, dated 3/4/2020, indicated the resident needs staff assistance with all ADL's (activities of daily living). Interventions included, but were not limited to: Assist with bathing parts she is unable to do, prefers shower twice weekly in the evening and sometimes refuses due to pain and depressed mood. Hospice will provide additional care and services per resident wishes. Hospice aides' visits on Tuesday and Fridays and assists with ADL's and shower care. During an interview, on 7/21/2022 at 10:10 A.M., CNA 11 indicted she did not know the aides schedule of when they come and indicated the residents should get 2 showers a week, but	F 0677	The community was alleged to be out of compliance by failing to ensure showers were provided timely for 1 of 3 residents reviewed for ADL care a. Resident # 46 was provided a shower, and facial hair removed. b. Female residents were observed for facial hair. Shower documentation was reviewed to determine other residents identified. Residents identified were offered a shower. c. Nursing staff were educated on ADL and personal care. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	08/25/2022

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	155684	A. BUILDING 00 B. WING	07/26/2022

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	sometimes the resident will refuse due to pain, and we will try again. During an observation on, 7/21/2022 at 10:36 A.M., with CNA 11, the facial hair remained on Resident 46. CNA 11 indicated the resident had not been shaved and she should not be like that. Resident 46's shower documentation, dated June 3 through July 19, indicated only 3 bed baths had been documented and 2 bed baths documented from hospice. On 7/21/2022 at 11:56 A.M., the scheduler provided the policy titled, "Personal Care", dated 8/19/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ...1. Residents will receive showers per preferences twice a week and will receive bed bath and other personal care daily as needed. 2. Shower providers shall inspect all skin surfaces during bath/shower, oral care, or other care where skin is exposed and report any concerns to the resident's nurse immediately after the task ...." 3.1-38(a)(3)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review and interview, the facility failed to ensure a therapy recommended splint and sling were worn for 1 of 3 residents reviewed for positioning and mobility. (Resident 26) Finding includes: During an observation on 7/18/2022 at 9:32 A.M. and 7/20/2022 at 9:21 A.M., Resident 26 was observed sitting in her room in her wheelchair. Her left forearm was resting in her lap. She did not have a splint or arm sling in place for her left wrist contracture. On 7/21/2022 at 8:44 A.M. and 11:49 A.M., and 7/22/2022 at 8:46 A.M., Resident 26 was observed sitting in the Dining Room with her left forearm was resting in her lap. She did not have a splint or arm sling in place. On 7/22/2022 at 9:25 A.M., Resident 26 is observed sitting in her room in her wheelchair. The left forearm is resting in her lap and the left wrist is bent at a 90-degree angle. She indicated she was not able to move her left arm due to a previous stroke. She indicated she had worn a splint in the past, and the area does cause pain at times. Her splint is noted to be placed in her recliner in the room. An arm sling could not be visually found.	F 0688	The community was alleged to be out of compliance by failing to ensure a therapy recommended splint and sling were worn for 1 of 3 residents reviewed for positioning and mobility. a. Resident #26 was reassessed by therapy for splint and sling recommendations. Recommendations and orders were updated. b. Residents with orders for splints or slings were reviewed for compliance with orders. No others were identified/Residents identified were reassessed by therapy and recommendations/orders updated if needed. c. Therapy and nursing were educated on splints/slings and preventing decline in range of motion. d. An audit will be completed by Therapy/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy	08/25/2022

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	A clinical record review was completed on 7/20/2022 at 8:48 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia of left side, congestive heart failure, and epilepsy. An Annual Minimum Data Set (MDS) Assessment on 5/27/22, indicated Resident 26 had moderate cognitive impairment. She required extensive assistance with two or more staff members for bed mobility and transferring and extensive assistance with one staff member for toileting. A Care Plan on 1/11/2021, indicated " ...[Resident name] needs assistance with bed mobility, toileting, transfers, eating and bathing/hygiene r/t [related to] history of CVA [Cerebrovascular Event] with left hemiparesis, muscle weakness, age related cognitive decline, CHF {Congestive Heart Failure], anemia, seizures, impaired mobility and impaired cognitive processes and weakness". The interventions on 1/11/2022, indicated, "Splint to left wrist as ordered. Observe for skin impairments prior to and after removal of device ...." There was not an intervention for the left arm sling recommended by Occupational Therapy. Physician Orders on 1/16/2021, indicated, " ...Left wrist splint to be worn daily when up, on in AM [morning], off in PM [evening] ...." There was not an order for the left arm sling recommended by Occupational Therapy. An Occupational Therapy Discharge Summary on 1/26/2022, indicated, a long-term goal of " ...Occupational Therapy to complete staff training inclusive of her sling for her left arm, the hemi tray, the foot buddy, and transfers prior to discharge from services ...." In the note, it indicated on 12/10/2021, " ...Her sling was not		and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	positioned correctly on her left shoulder and trunk ...." The Assessment and Summary of Skilled Services, indicated, " ...She [Resident 26] participated in caregiver training r/t application of the wrist brace and left hemi sling ...." During an interview on 7/22/2022 at 9:59 A.M., Physical Therapy Assistant 13 indicated, Resident 26 had a sling and a brace for her left arm and wrist. On 7/22/2022 at 10:29 A.M., the Director of Nursing (DON) indicated, Resident 26 had been working with therapy for quite some time. She indicated the facility had a brace Resident 26 was using, and believed the brace was for bedtime. Upon reading the Physician Order, the Don indicated Resident 26 should have the ordered brace on during the day. She indicated she did not know anything about a sling recommended by Occupational Therapy. On 7/22/2022 at 1:36 P.M., The Assistant Director of Nursing (ADON) indicated, Resident 26 should have a splint on her left wrist. She indicated an order and updated care plan should be completed. She indicated that she would be reaching out to therapy to determine if more staff education should be completed. A policy was provided by the ADON on 7/25/2022 at 9:15 A.M. The current policy titled, "Prevention in Decline of Range of Motion" indicated, " ...3. Appropriate Care Planning a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but not limited to: ii.			

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	Appropriate equipment [braces or splints]. d. Interventions will be documented on the resident's person centered care plan. Documentation should include, but not limited to: i. Type of treatments; ii. Frequency and duration of treatments; iii. Measurable objectives; iv. Resident goals ...." 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure that a resident remain free from injury from a fall for 1 of 3 residents reviewed for accidents, (Resident 35) Finding includes: During an observation on 7/18/2022 at 7:31 A.M., Resident 35 was seen outside her room during breakfast. She was observed to have a "V" shaped sutured area to her forehead, and sutures to her right temporal region. She had bruising to her entire left face that was yellow in color with purplish discoloration within the yellowing area under the left eye and behind the left ear/neck. A sign could be observed from the common area in her room by the heating/cooling unit that read, "Remember ask for help and don't fall".	F 0689	The community was alleged to be out of compliance by failing to ensure that a resident remain free from injury from a fall for 1 of 3 residents reviewed for accidents. a. Fall for resident #35 on 5/27/22 was reviewed and an intervention identified. Care plan updated b. Falls for last 30 days were reviewed for root cause and updated interventions. Interventions were updated for residents identified/No other residents were identified to have been affected. c. Nursing staff were educated on falls, fall interventions and care	08/25/2022

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	During an interview with Resident 35 on 7/19/2022 at 11:06 A.M., Resident 35 indicated she had recently fallen. A clinical record review was completed on 7/21/2022 at 10:49 A.M. Diagnoses included, but were not limited to: Parkinson's disease, vascular dementia with behavioral disturbance, cerebral infarction, chronic kidney disease, anemia, and constipation. A Quarterly Minimum Data Set (MDS) Assessment on 6/2/2022, indicated Resident 35 was cognitively intact. She required extensive assistance with the assistance of one staff member for bed mobility, transferring, and toileting. She had two falls with no injury and two falls with minor injuries since the last MDS Assessment on 3/2/2022. A Nurse's Note on 5/27/2022 at 12:16 P.M., indicated, " ...Resident found down on the floor in front of her w/c [wheelchair] by CNA [Certified Nursing Assistant]. She was laying on her left side. No injuries. Resident could not tell us why she was getting up. The CNA had just been in [sic] her room a couple minutes earlier so all of the resident's needs were met. Resident requested to be put to bed to lay down. No c/o [complaints of] pain. Family, doctor and manager notified. No new orders ...." On 7/7/2022 9:44 P.M., a Nurse's Note indicated, that Resident 35 had an unwitnessed fall at 8:50 P.M. The CNA (Certified Nursing Assistant) found Resident 35 on her left side on the floor. Resident 35 had a laceration on her forehead measuring 5 cm (centimeters) by 2.5 cm, a laceration on her left eyelid measuring 2 cm x 1cm,		plan revisions. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	swelling to the outer aspect of the left eye, and a left knee abrasion. Resident 35 could not communicate what happened to cause the fall. She was transported to the hospital via EMS (Emergency Medical Services). On 7/8/2022 at 10:05 A.M., a Nurse's Note indicated, Resident 35 was admitted to the hospital for a urinary tract infection and observation. The hospital telephone report indicated Resident 35 had her lacerations sutured on the right and left side of the forehead and left eyebrow. On 7/11/2022 at 3:56 P.M., a Nurse's Note indicated that Resident 35 had returned from the hospital. She was awake but not responding or communicating with staff. Resident 35 had scattered bruising to face with surrounding bruising to bilateral eyes with the left side of the face being worse. She has 4 lacerations on her forehead and left side of the face with stitches. The injuries from the fall were documented as follows: 1. Right forehead laceration, 3 stitches, measuring 3 cm by 0.7 cm with surrounding red/purple bruising 2. Left forehead, 3 lacerations with stitches and surrounding dark purple and red bruising, measuring 4.5 cm by 6 cm 2a. Middle forehead laceration, 5 stitches, measuring 4 cm by 0.1 cm 2b. Left side of face laceration, 9 stitches, measuring 7 cm by 0.1 cm 2c. Left side of face near eye, 2 stitches, measuring 2.5 cm by 0.1 cm 3. Right eye surrounding bruising measuring 4 cm by 6cm, red and yellow in color 4. Left eye surrounding bruising measuring 6.5 cm by 11 cm, red, purple, and yellow in color			

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	5. Left side of neck bruising measuring 12 cm by 11 cm, dark purple and red in color 6. Left ear (behind) bruising measuring 5 cm by 2 cm, red and purple in color 7. Left nare (below) bruising, 1.2 cm by 1.5 cm, red in color 8. Left wrist open area measuring 1.5 cm by 1.2 cm with surrounding bruising measuring 3.8 cm by 3.5 cm, red and purple in color 9. Left knee open area measuring 1 cm by 1.8 cm with surrounding bruising 3 cm by 2.8 cm 10. Left elbow open area measuring 0.7 cm by 0.7 cm with surrounding bruising, red and purple in color On 7/13/202 at 11:59 P.M., a Nurse's Note indicated, " ...IDT [Interdisciplinary Team] meeting reviewed falls and care plan interventions. Care plan interventions in place. Son POA [Son's name] updated on interventions and in agreement with POC [Plan of Care] ...." A Care Plan on 4/21/2022, indicated, " ... [Resident's name] has potential for falls related to decreased mobility, decreased safety awareness, history of falls, and falling with fracture, history of CVA, Parkinson's, memory deficit, osteoarthritis, muscle weakness, medication usage, disease process and weakness. She has a [sic] history of being non-compliant with asking for assistance with ADL's and care including transferring ...." The goal for the care plan was, " ...[Resident's name] will remain free from injury ...." Interventions for the care were as follows: 4/21/22 Cardinal alert 4/21/22 Encourage use of assistive device and to turn on her call light for assist. Call light within reach at all times. 4/21/22 Provide activities that minimize the potential for falls while providing diversion and			

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	distraction 4/21/22 Floors free from spills or clutter 4/21/22 Provide adequate, glare free lighting 4/21/22 Personal items within reach 4/21/22 Assist to wear non-skid footwear 4/21/22 Use gait belt for transfers and ambulation 4/21/22 Therapy has applied and anti-rollback to wheelchair 4/21/22 4/5/20-Tap style call light for ease of pressing 4/21/22 Personal items within reach and verbal reminders to call for transfers from staff 4/21/22 Frequent rounding by staff and verbal reminders to all for assistance with transfers 4/21/22 Encourage protein intake to encourage muscle growth in combination with PT related to fall on 6/23/21 4/21/22 Resident son to bring in cordless phone for resident use related to fall on 6/23/21 4/21/22 Educate family with Parkinson's hallucinations/medications, often falls are caused by resident seeing things that aren't on the floor and bending over to pick them up 4/21/22 Therapy screen 4/21/22 Scoop mattress as ordered. 4/21/22 Resident re-educated on use of reacher due to her consistently falling due to reaching down to the floor from a sitting position 4/21/22 Resident continues on maintenance therapy program 4/21/22 Command hooks and signage placed on walls as reminder to use reacher 4/21/22 Assist resident in toileting and back to bed for her nap she likes to take after lunch. Resident will attempt to transfer self after lunch for nap. 4/21/22 Therapy screen sent to eval r/t recent fall on 4/3/22 4/21/22 Therapy and Maintenance assessing wheelchair for functional ability			

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	4/21/22 Staff re-educated to offer and provide toileting and resting in recliner or bed after meals 5/2/22 Staff re-educated to provide res with her personal belongings and keep within reach after meals 5/27/22 Continue previous interventions 7/8/22 Res admitted to hospital for UTI (Urinary Tract Infection) 7/12/22 Assess resident for possible UTI if resident falls 7/13/22 Request for low bed to be placed 7/13/22 Padding (foam) to window ledge to avoid injury 7/13/22 Remove over the bed table 7/13/22 Provide 3 drawer plastic dresser for belongings and fluids 7/13/22 Request for small plastic table During an interview on 7/22/2022 at 10:31 A.M., the Director of Nursing (DON) indicated, sometimes, what will happen, if the fall root cause is not identified an intervention won't be added. Sometimes, the care plan will revert to what was already there. "We've been at a loss with her and interventions, and other than 1:1, the falls are going to keep happening. Trying to keep her safe is where we are now. She should have had a new intervention in place after falling on May 27th." The DON indicated that the Assistant Director of Nursing (ADON) has been following the facility falls. An interview on 7/22/2022 at 1:31 P.M., the ADON indicated she was on vacation during Resident 35's fall on 5/27/2022. She was unsure if an IDT meeting was held, and that an IDT note should have been created. She indicated it was not an appropriate intervention to put continue previous interventions. She indicated she was working with the staff on finding the root cause and			

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	interventions for falls. A policy was provided on 7/22/2022 at 1:47 P.M. by the ADON. The current policy titled, "Fall Prevention Program Policy" indicated, " ...Each resident will be assessed for the risk of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed ...." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			

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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
	Based on observation, record review and interviews, the facility failed to ensure interventions to address significant weight loss were implemented timely (Resident 29) and revised timely (Resident 26) Findings include: 1. During the initial tour of the facility, conducted on 7/18/2022, lying in her bed awake. The resident was noted to be thin in stature. The clinical record for Resident 29 was reviewed on 7/20/22 at 2:36 PM. Resident 29 was admitted to the facility on 4/14/2022 with diagnoses, including but not limited to: Alzheimer's disease, dementia without behavioral disturbances, diabetes mellitus, mixed hyperlipidemia and osteoporosis. The resident's weight on admission to the health care facility, was 122.6. Her physician's orders, on admission, indicated she was to receive a Glucerna nutritional supplement. The resident's weight on 5/1/2022 was 122.4 pounds. However, on 6/1/2022, the resident's weight had dropped to 114.3 pounds, a loss of 9.34 percent in one month. The resident's weight on 7/1/2022 was 111.4 pounds, another 2.96% of weight loss. The resident's nutritional assessment, completed on admission, on 4/19/2022, by the Registered Dietician, indicated the resident's meal acceptance was approximately 50% since moving to the healthcare facility. The assessment indicated the resident was at moderate risk for nutritional problems related to her therapeutic diet for diabetes mellitus, fragile weight for frame and cognitive deficits. The assessment indicated	F 0692	The community was alleged to be out of compliance by failing to ensure interventions to address significant weight loss were implemented timely and revised timely. a. The Registered Dietician was educated to the policy Weight Management and ensuring interventions to prevent weight loss are timely. b. Residents with weight loss in the last 30 days were reviewed. Residents identified to have weight loss were reviewed for appropriate and timely interventions/No other residents were identified to be missing timely interventions. c. Registered Dietician was educated regarding weight management and timely interventions. d. An audit will be completed by the RD/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary	08/25/2022

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	155684	A. BUILDING 00 B. WING	07/26/2022

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	Resident 29's weights were to be monitored as well as her diet acceptance. A quarterly nutritional progress note, completed on 7/19/22 by the Registered Dietician, acknowledged the resident's weight loss in the past 30 days and compared it to the resident's weight 6 months ago when she resided in the assisted living facility. The dietician only recognized the 2.96% weight loss in the past 30 days and no significant weight loss was acknowledged. The intervention implemented on 7/19/22 by the dietician was for weekly weights but there was no additional intervention to attempt to improve the resident's nutritional status. During an interview with the Director of Nursing, conducted on 7/22/22 at 10:17 A.M., she indicated the facility policy was to reweigh a resident with a weight loss and/or gain noted from the previous weight. The DON indicated if a significant weight loss was determined to have occurred, per the facility policy parameters, the Dietician should reassess and the resident's physician and responsible party was to be notified. The DON indicated the Registered Dietician was at the facility weekly and was made aware of the current resident weights. The DON agreed the facility policy regarding weight management was not followed in regards to Resident 29's weight loss.2. A clinical record review was completed on 7/20/2022 at 8:48 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia of left side, congestive heart failure, and epilepsy. An Annual Minimum Data Set (MDS) Assessment on 5/27/22, indicated Resident 26 had moderate cognitive impairment. She required extensive assistance with two or more staff		frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	members for bed mobility and transferring and extensive assistance with one staff member for toileting. She had significant weight loss. A Quarterly MDS Assessment on 4/4/2022 indicated Resident 26 did not have significant weight loss. A review of Resident 26's weight indicated on 4/16/2022 a weight of 131.0 pounds, on 6/16/2022, a weight of 118.2 pounds, and on 7/16/2022, a weight of 113.0 pounds. An Annual Nutrition Assessment on 5/31/2022 at 4:26 P.M., indicated, "...Regular diet, and diet acceptance recorded at 52% average over this observation. This is a decline from her usual adequate intake...She has been on supplement, 2 cal [calorie and protein dense nutrition of 2 calories per milliliter] in past, and didn't like it...WT: 120.4 Height 5'1" BMI [Body Mass Index] =22.9. Weight is acceptable for frame. Weight loss 7.8% in 30 days, significant weight loss in 30 days...Estimated daily requirement: Calories 1200 calories, Protein: 60 G [Grams], Fluids: 1700 cc [cubic centimeter]...Nutrition status is at risk related to decline in meal acceptance and significant weight loss...Recommendations: 2 cal 120 cc BID [twice daily] ...." A Physician Order on 5/31/2022, indicated, " ...2 cal supplement 120 cc BID ...." A Nurse's Note on 6/1/2022 at 6:09 P.M., indicated, " ...During AM [morning] med pass the 2 cal was offered to res [resident] she immediately told me that she was not drinking that stuff ...." A Care Plan on 1/12/2021, indicated, " ... [Resident's name] is at risk for weight fluctuations			

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	and nutrition problems r/t chronic dx [diagnosis], functional deficits, and need for supervision and provision of nutrition care ...." The goal was " ... [Resident's name] will maintain present weight [plus/minus] 5lbs [pounds] of 125 lbs. through next review. An intervention of 2 cal supplement 120 cc BID was added on 5/31/2022. A review of the Medication Administration Record on 7/22/2022 at 9:10 A.M., indicated that Resident 26 had refused the 2 cal supplement 11 times and consumed less than 50 per cent six times. In June, Resident 26 refused the 2 cal supplement 22 times and consumed less than 50 per cent 11 times. During an interview on 7/22/2022 at 2:10 P.M., the Dietary Manager indicated, the Regional Dietician (RD) follows the residents for weight loss. He indicated the RD visited the buildings every Tuesday, and documents in the Nutrition Assessment Note how often the resident should have a follow up. The Dietary Manager would not indicate if taking 2 cal supplement was appropriate after it was identified Resident 26 did not like taking the 2 cal supplement in the past. On 7/25/2022 at 2:23 P.M., the Dietary Manager provided a response from the RD to an email sent regarding the 2 cal supplement recommendation. The email indicated, " ...Regarding someone who will occasionally refuse a supplement, as long as they continue to benefit from it 50-75% of the time, I prefer to maintain it. Sometimes, the eMAR [electronic Medication Administration Record] will reflect refusal at a specific time, like evening and I will ask the nurse why, and usually the resident is asleep, and I will either DC [discontinue] it or change to a better time. My recollection of [Resident's name], I asked the			

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	nurse regarding her weight and intake, and we both agreed it would be beneficial to try the supplement again. If the nursing staff don't inform me of a resident's supplement refusal, or intolerance, I don't pick that up until I open their record for a quarterly or Annual ...." A policy was provided by the Administrator on 7/22/2022 at 8:56 A.M. The current policy titled, "Weight Management" indicated, " ...Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary ...5. Interventions will be identified, implemented, monitored and modified 9 as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standard to maintain acceptable parameters of nutritional standards ...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to ensure oxygen tubing and distilled water was dated and continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) mask and tubing placed in a bag when not in use for 2 out of 2 residents reviewed for respiratory. (Resident 6 & 198) Findings include: 1. A clinical record review was completed, on 7/21/2022 at 9:44 A.M., and indicated the Resident 6's diagnoses included, but were not limited to: chronic respiratory failure with hypoxia, atrial fibrillation, hypertension, cerebral atherosclerosis, and chronic kidney disease stage 3. During an observation, on 7/18/2022 at 11:33 A.M., BIPAP mask was hanging from the bed post and tubing was lying on the machine. During an observation, on 7/20/2022 at 10:00 A.M., portable oxygen tank tubing was not dated and hanging on the floor lamp switch uncovered. Her BiPAP mask was hanging on the bed post and the tubing was on the machine uncovered. During an observation, on 7/21/2022 at 9:25 A.M., her portable oxygen tubing hang from the floor lamp switch, it was not in a bag, her mask for the BiPAP was hanging on the bed post and the tubing on the machine. There was a gallon of distilled water on the floor open and undated, some fluid was gone, and the lid was on a slant.	F 0695	The community was alleged to be out of compliance by failing to ensure oxygen tubing and distilled water were dated and continuous positive airway pressure (CPAP)/ bi-level positive airway pressure (BIPAP) mask and tubing were placed in a bag when not in use for 2 out of 2 residents reviewed for respiratory. a. O2 tubing and distilled water for resident # 198 was changed and dated. CPAP/BIPAP mask and tubing for resident # 6 were placed in a bag while not in use. b. Residents with oxygen, CPAP/BIPAP were reviewed for compliance with dated tubing, distilled water, and bags for masks when not in use. No other residents were identified/Residents affected were corrected. c. Nursing staff were educated to change weekly and date O2 tubing, dating of distilled water, Oxygen Administration, CPAP/BIPAP cleaning. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is	08/25/2022

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	During an interview, on 7/21/2022 at 2:31 P.M., the Assistant Director of Nursing (ADON) indicated there was no date on the tubing or an open date on the distilled water and the tubing for both oxygen and BIPAP should have been place in a plastic bag. 2. A clinical record review was completed, on 7/20/2022 at 10:45 A.M., and indicated the Resident 198's diagnoses included, but were not limited to: Alzheimer's Disease, dementia, hypertension, neoplasm of the right female breast. During an observation, on 7/19/2022 at 9:18 A.M., CPAP mask and tubing was lying on top of the CPAP machine uncovered. During an observation on 7/20/2022 at 9:50 A.M., CPAP mask and tubing was lying on top of the CPAP machine uncovered. During an observation on 7/21/2022 at 9:37 A.M., CPAP mask and tubing was laying on top of the machine uncovered. During an interview on 7/21/2022 at 2:36 P.M., the Assistant Director of Nursing indicated that her CPAP mask and tubing should have been in a bag. On 7/21/2022 at 3:10 P.M., the Assistant Director of Nursing provided a policy titled, "CPAP/BIPAP Cleaning Policy", date revised 6/5/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use...." And a policy titled,		overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	"Oxygen Administration", date revised 6/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...5. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use...." 3.1-47(a)(6)			
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 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			

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	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 the AIMS evaluation was completed for 2 of 2 residents reviewed, gradual dose reduction (GDR) and appropriate diagnoses for an antipsychotropic medication for 1 of 2 residents reviewed for unnecessary medication. (Resident 38 & 41) Findings include: 1. A clinical record review was completed on 7/21/2022 at 10:59 A.M. Diagnoses included, but were not limited to: Parkinson's disease, dementia, generalized anxiety and hypertension. A Quarterly MDS Assessment on 6/10/22 indicated Resident 41 had severe cognitive impairment. She took an antipsychotic medication for seven of the seven-day look back period of the assessment.	F 0758	The community was alleged to be out of compliance by failing to ensure the AIMS evaluation was completed for 2 of 2 residents reviewed, gradual dose reduction (GDR) and appropriate diagnoses for an antipsychotropic medication for 1 of 2 residents reviewed for unnecessary medication. (Resident 38 & 41) a. An AIMS was completed for resident # 38 and # 41. The MD was notified for a GDR for resident #38. Resident #38 was reviewed for an appropriate diagnosis for an antipsychotic. b. Residents on antipsychotics were reviewed for appropriate diagnoses, AIMs, and GDRs. Residents identified to have been	08/25/2022

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	A Physician's Order on 1/24/2022, indicated Nuplazid 34 mg (milligrams) daily for other mental disorders. An AIMS (Abnormal Involuntary Movement Scale) Assessment was completed on 3/9/2021. A Care Plan indicated, " ...[Resident's name] utilizes an antipsychotic medication for symptoms of hallucinations such as seeing children, parades and little people that are not there, having episodes of paranoia, and believing that others are stealing her belongings when items are actually present, delusion that her mother is still living and will go to peers room looking for her mother. Resident will inform family of mood distress and not inform staff ...." During an interview on 7/22/2022 at 10:38 A.M., the Director of Nursing (DON) indicated, the diagnosis for the use of Nuplazid needs to be changed. She also indicated, "I'm going to tell you the AIMS is probably not there." 2. A clinical record review was completed, on 7/20/2022 at 1:30 P.M., and indicated Resident 38's diagnoses included, but were not limited to: Dementia without behavioral disturbances, vascular dementia, depression, hypertension, anxiety disorder, unsp psychosis not due to a substance or known physiological condition, vitamin D deficiency. The record indicated she was admitted on 12/16/2020. During an observation on 7/18/2022 at 10:06 A.M., resident 38 hands kept moving down the side to her hip then back to center as if smoothing/rubbing her legs. During an observation on 7/21/2022 at 11:11 A.M.,		affected were reviewed and updated/No other residents were affected. c. Nursing staff was educated on psychotropic use to include AIMs, GDR, appropriated diagnosis. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	resident 38 moved both hands down the side of her legs and back to the middle and noted a tremor to her hands/arms. During an interview, on 7/21/2022 at 11:12 A.M., the resident indicated she has had the tremors and moving her hands across her legs helps, her psychiatrist told her it is from the medication that she takes. Physician Order, dated 3/24/2021, indicated Resident 38 received zyprexa 10 mg (milligram) one tablet at bedtime for psychosis and physician order, dated 12/16/2020 celexa 20 mg one tablet a day for depression. Review of Psychiatry Progress notes for the past year did not indicate any attempts made for a gradual dose reduction of either medication. And indicated her diagnoses for her medication were major depressive disorder, generalized anxiety disorder, vascular disorder with behavioral disturbances. Review of behavior health meetings progress noted dated 11/16/2021 and 1/8/2022 lack documentation of gradual dose reduction. Review of assessments indicated an Abnormal Involuntary Movement Scale (AIMS) was not completed. During an interview on 7/22/2022 at 9:47 A.M., the Director of Nursing indicated that the resident did not have any Abnormal Involuntary Movement Scale completed as well as no dose reduction attempted for zyprexa until 7/19/2022 and none for celexa and she should have had. She indicated that psychosis was an appropriate diagnosis for an antipsychotropic.			

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	On 7/22/2022 at 8:00 A.M., the Director of Nursing provide a policy titled, "Antipsychotic Use", revised 5/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 8. Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN or as per facility policy...." Policy titled, "Gradual Dose Reduction Policy revised 5/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated...." And a policy titled, "Unnecessary Drugs Policy"' revised on 4/2019, and indicated the policy was the one currently used by the facility. The policy indicated, "... 3. Documentation will be provided in the resident's medical record to show adequate indications for medication's use and the diagnosed condition for which it was prescribed...." 3.1-48(a)(2)(4)(5)(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§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 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 record review, interview and observation, the facility failed to ensure medications were labeled appropriately and dated when opened in 1 of 2 medication storage observations. (RN 7 100 hall medication cart) Finding includes: On 7/21/2022 at 10:25 A.M., a medication storage observation was completed with RN 7 on the 100-medication cart. The following was observed: A loose pill was observed in the second drawer and another loose pill was in the 3rd drawer. There was an undated opened vial of Humalog insulin in a plastic bag with no resident identifiers on the bag. An opened box with a bottle of Colace (stool softener) with no resident identifiers on the bottle or the box.	F 0761	The community was alleged to be out of compliance by failing to ensure medications were labeled appropriately and dated when opened in 1 of 2 medication storage observations. a. Undated medications were discarded and new medications opened and dated. Medications without appropriate labels were labeled. Med carts were cleaned and all loose pills and/or debris discarded. b. Medication and treatment carts and medication storage rooms were assessed. Any medications identified to be out of compliance were discarded, new medications opened and dated. Medication carts were cleaned.	08/25/2022

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	155684	A. BUILDING 00 B. WING	07/26/2022

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	During an interview, on 7/21/2022 at 10:30 A.M., RN 7 indicated there should be no loose pills in the cart and the insulin and Colace should have had labels on them. On 7/21/2022 at 11:50 A.M., the scheduler provided the policy titled." Labeling of Medications and Biologicals", dated 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ...All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Labels for over the counter (OTC) medications must include a. The original manufactures or pharmacy - applied label indicating the medication name; b. The strength, quantity, lot, and control number; c. The expiration date when applicable; d. Appropriate accessory and precautionary statements; and direction for use ...." On 7/21/2022 at 10:56 A.M., the scheduler provided the policy titled, "Medication Administration", dated 5/2021, and indicated the policy was the one currently used by the facility. The policy indicated" ...1. Keep medication cart clean, organized and stocked with adequate supplies ...." 3.1-25(j)(k)		c. Nursing staff were educated on medication storage and labeling. d. An audit will be completed by the DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form			

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	designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure recipes were followed for puree diets for 3 of 3 residents who receive a puree diet. Finding includes: During an observation, on 7/19/2022 at 10:33 A.M., Cook 2 put 3 scoops of a readymade chicken salad into a food processor, then added mayonnaise, and milk to the mixture. Cook 2 did not measure the mayonnaise or the milk prior to adding it to the chicken salad. She ran the food processor until the mixture was of a puree consistency. Cook 2 added 3 scoops of a readymade Cole slaw into another food processor. She then added mild to the slaw and ran the food processor until the mixture was of a puree consistency. Cook 2 added a packet of thickener to the mixture to thicken it up. Cook 2 did not measure the milk prior to adding it to the Cole slaw mixture. During an interview, on 7/19/2022 at 11:27 A.M., the Cook 2 indicated that she did not have the recipe out but followed the spread sheet. She indicated there was a red binder that had recipes in it but could not locate it and indicated she did not follow the recipes. On 7/19/2022 at 3:56 P.M., the Administrator provided a policy titled, "Puree Food Prep Policy", revised 3/1/2022 and indicated the policy was the one currently used by the facility. The policy indicated " ...5. Do not use water as an additive to prepare puree foods. Refer to your department's Dietary Services manual for additional policy and procedures. ...7. Puree Food Preparation	F 0805	The community was alleged to be out of compliance by failing to ensure recipes were followed for puree diets for 3 of 3 residents who receive a puree diet. a. Dietary staff were educated to follow recipes for pureed foods. b. No other residents were identified to have been affected. c. Dietary staff were educated to follow recipes for pureed foods d. An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	08/25/2022

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	Guidelines per Serving: Meats: Add 1 teaspoon beef broth or beef gravy. Poultry: Add 1 teaspoon chicken broth or chicken gravy. Fish: Add 1 teaspoon mayonnaise ...." 1.3-21(a)(3)			
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. §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 food items in the freezer were dated/labeled and sealed securely after opening and failed to ensure used by dates on foods, failed to dispose of expired foods, failed to ensure cooking utensils/puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were clean and in good condition. Failed to	F 0812	The community was alleged to be out of compliance by failing to ensure the facility failed to ensure food items in the freezer were dated/labeled and sealed securely after opening and failed to ensure used by dates on foods, failed to dispose of expired foods, failed to	08/25/2022

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	have fans without a buildup of dust in 1 of 1 kitchen observed. This deficient practice had the potential to affect 51 of 51 residents who received meals out of the kitchen. Findings include: 1. During an observation of the kitchen on 7/18/2022 at 6:45 A.M., with dietary staff 5 the following was observed in the walk-in freezer: 6 large containers of ice cream sitting on the floor. An opened unsealed and undated bag of fish sticks. An opened bag of chopped celery undated. Box of green beans not sealed. Boxes of foods sitting on the top shelf too close to the ceiling. The ceiling, a wire food rack, and the freezer door had areas of ice buildup. The floor had large pieces of food underneath the food racks and the thermometer was not registering a temperature. The following was observed in the walk -in cooler: 2 opened containers of sliced onions dated 7/7/2022. Two containers of strawberries with no used by date. An opened container of tomato juice dated 6/9/2022. An opened container of med pass (fortified nutritional shake) undated. The thermometer was not registering a temperature. The following was observed: numerous ceiling tiles that were stained, vents with rust and light fixtures with insects in the light cover. During an interview, on 7/18/2022 at 10:15 A.M., the Dietary manager indicated the foods should have been dated, sealed appropriately, the thermometers should be working, and the lights should not have bugs in them. He indicated the vents should not be rusty, the ceiling tiles should be cleaned or replaced, and the freezer should not have an ice buildup.		ensure cooking utensils/puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were clean and in good condition. Failed to have fans without a buildup of dust in 1 of 1 kitchen observed. This deficient practice had the potential to affect 51 of 51 residents who received meals out of the kitchen. a. Undated and/or opened, and expired food items were discarded. Cooking utensils/puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were cleaned. Ice build up was removed from the freezer door, floor under food racks were cleaned, inoperable thermometers were replaced, Ceiling tiles were replaced/cleaned. The fan near the tray line and the exhaust box fan was cleaned. The ice machine was cleaned and calcium/lime buildup removed. The reach in freezer was also cleaned. b. Entire kitchen was observed for cleanliness and areas of deficiency corrected. c. Dietary staff was educated on food storage, dating and food safety, food prep, monitoring of cooler/freezer temps, sanitary tray line, sanitation inspection. d. An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly	

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	2. On 7/19/2022 at 10:30 A.M., during an observation of preparing pureed foods by Cook 3, following was observed: Cook 3 was observed to put 3 scoops of chicken salad into the Robo mixer. She started the mixer and scraped the sides of the container. She then added mayonnaise and milk to the pureed chicken salad and mixed it again and did not measure the mayonnaise and or the milk prior to adding them to the food. Cook 3 added 3 scoops of coleslaw to another Robo mixer. She mixed the slaw and then added milk to the mixed slaw. Cook 3 did not measure the milk prior to adding it to the pureed slaw. She indicated the slaw was not thick enough and added a package of thickener. 3. During a follow up observation in the main kitchen with Cook 3, on 7/19/2022 at 10:45 A.M. to 11:14 A.M., the following were observed: a fan attached to the wall above the dishwasher tray line was observed to have a buildup of dust with the fan pointed towards the tray line. There was an exhaust fan box attached to the wall underneath the attached fan had a filter with a large buildup of dust. The ice machine was dirty on the front side and in the inside was a brown substance along the top edge. There was a large buildup of calcium/lime along the front and side edges of the ice machine lid. Six of 6 cooking utensil drawers had accumulation of crumbs, sticky substances along the drawer edges and dried areas on the outside of the drawers. There was a large, holed scoop with specs of dried foods; a small, holed scoop with dried foods on it; 2 measuring cups with dried food specs on them; 2 spatulas that had burned areas on the back with small holes; plastic spoon with dried food specs and an egg slicer with grease on it. A single door reach- in freezer had a large accumulation of crumbs along the bottom and along the rubber		for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	seal on the door. The sandwich cooler had crumbs along the bottom, along the seal and a brown stain running down the left side inside the cooler. The dry storage area had an opened package of batter mix not sealed or dated and an opened bag of vanilla pudding mix not sealed. During an interview, on 7/19/2022 at 11:15 A.M., Cook 3 indicated the ice machine should have been cleaned, the utensil drawers and utensils should have been cleaned along with the reach in freezer and sandwich cooler. On 7/19/2022 at 3:57 P.M., the Administrator provided the policy titled, "Food Safety Requirements Policy", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ... Refrigerated storage: Practices to maintain safe refrigerated storage include: ...iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its used-by date, or frozen (where applicable) /discarded; and v. Keeping foods covered or in tight containers. ...6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner t prevent contamination ... b. Clean dishes shall be kept separate from dirty dishes. ...8. Additional strategies to prevent foodborne illness include but are not limited to: ...e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines ...." On 7/19/2020 at 3:57 P.M., the Administrator provided the policy titled, "Date Marking for Food Safety Policy", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ...2. The food shall be clearly marked to indicate the date or day by			

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	which the food shall be consumed or discarded. ...4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded ...." On 7/19/2022 at 3:57 P.M., the Administrator provided the policy titled," Monitoring of Cooler/Freezer Temps", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ... 2. Thermometers shall be placed inside each cooler/freezer and calibrated at least once per week. ...7. All food items will be stored at least 6 inches off the ground and 18 inches from the ceiling. ...11. Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded whichever is applicable ...." 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, 21, 22, 25 and 26, 2022 Facility number: 002662 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review the facility failed to ensure that cooking utensils were clean and in good condition. This deficient practice had the potential to affect 51 of 51 residents who received meals out of the kitchen. Finding includes:. During a follow up observation in the main kitchen with Cook 3, on 7/19/2022 at 10:45 A.M. to 11:14 A.M., the following were observed: 6 of 6 cooking utensil drawers had accumulation of crumbs, sticky substances along the drawer edges and dried areas on the outside of the drawers. There was a large, holed scoop with specs of dried foods; a small, holed scoop with dried foods on it; 2 measuring cups with dried food specs on them; 2 spatulas that had burned areas on the back with small holes; plastic spoon with dried food specs and an egg slicer with grease on it. During an interview, on 7/19/2022 at 11:15 A.M., Cook 3 indicated the utensil drawers and utensils should have been cleaned. On 7/19/2022 at 3:57 P.M., the Administrator provided the policy titled, "Food Safety Requirements Policy", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ... 6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner t	R 0154	The community was alleged to be out of compliance by failing to ensure ensure that cooking utensils were clean and in good condition. a. Utensil drawers and utensils were cleaned. b. Entire kitchen was observed for cleanliness and areas of deficiency corrected. c. Dietary staff was educated on Food Safety and Sanitation d. An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, one a week for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future	08/25/2022

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	prevent contamination ... b. Clean dishes shall be kept separate from dirty dishes...." 410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.		compliance.	
R 0214 Bldg. 00	Based on record review and interview, the facility failed to ensure that the resident had a pre-admission assessment for 1 of 5 residents reviewed for admission assessments. (Residents C) On 7/25/2022 at 9:24 A.M., a clinical record review was completed for Resident C. Diagnoses included, but were not limited to: diabetes mellitus type 2, end stage renal disease with dialysis, and hypertension. A pre-admission assessment could not be located in the resident's paper file. During an interview on 7/25/2022 at 2:15 P.M., the Resident Service Coordinator indicated that a pre-admission assessment had not been completed. A policy was provided on 7/26/2022 at 9:10 A.M., by the Resident Service Coordinator. The current policy, titled, "Pre and admission assessment for Licensed Assisted Living" indicated, " ...Prior to admission 1. An evaluation of each prospective resident shall be made prior to admission. This may include personal and/or telephone interviews	R 0214	The community was alleged to be out of compliance by failing to provide pre-admission assessments for 1 of 5 records reviewed. A. The resident identified has been admitted and has resided in the facility for since February 2022. B. A house wide audit was completed and no other residents were identified. C. Staff was educated to ensure pre-admission assessments were completed prior to admission D. An audit will be completed by the Assisted Living Director/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary	08/25/2022

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	with the resident, and or family/responsible party for the purpose of service care planning ...."		recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure an admission weight was completed for 1 out of 7 residents reviewed for weights. (Resident D) Finding includes: A clinical record review was completed on 7/25/2022 at 10:00 A.M., for resident D. Diagnoses included, but not limited to: hypertension, chronic obstructive pulmonary disease, anxiety,	R 0216	The community was alleged to be out of compliance by failing to ensure admission weighs were completed for 1 of 7 residents. A. The residents identified have received recent weights. B. A house wide audit was completed and no other residents were identified. C. Nursing was educated to ensure admission weights are	08/25/2022

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	and atrial fibrillation. During an interview on 7/25/2022 at 11:21 A.M., the Resident Service Coordinator indicated that resident D did not have an admission weight and should have had one. On 7/26/2022 at 9:10 A.M., the Resident Service Coordinator provided a policy titled, "Pre and admission assessment for Licensed Assisted Living", dated 5/1/2005, and indicated the policy was the one currently used by the facility. The policy indicated "...Upon Admission: 3. Each resident's weight will be taken on admission, as ordered and semiannually thereafter...."		obtained and documented for all residents. D. An audit will be completed by the Assisted Living Director/Designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and			

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	revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure that the resident reviewed and signed the service plan for 3 of 5 residents reviewed for semi-annual service plan revisions. (Residents C, F, and D) 1. On 7/25/2022 at 9:24 A.M., a clinical record review was completed for Resident C. Diagnoses included, but were not limited to: diabetes mellitus type 2, end stage renal disease with dialysis, and hypertension. Resident C had a service plan revision on 7/18/2022. The service plan review indicated that the resident had not signed the service plan. During an interview on 7/25/2022 at 1:44 P.M., Resident C reviewed a copy of her service plan, and indicated she had never seen her service plans, nor had she ever signed a service plan. On 7/25/2022 at 2:15 P.M., the Resident Service Coordinator indicated, Resident C had not signed	R 0217	The community was alleged to be out of compliance by failing to ensure service plans were signed by 3 of 5 records reviewed A. Residents # C, D, and F received and signed copies of their service plans. B. A house wide audit was completed and no other residents were identified. C. All staff were educated to ensure service plans are printed and signed by residents upon admission. D. An audit will be completed by the Assisted Living Director/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review	08/25/2022

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	her service plan, even though there is a signature line on the form. 2. On 7/25/2022 at 10:57 A.M., a clinical record review was completed for Resident F. Diagnoses included, but were not limited to: diabetes mellitus type 2, depression, and anxiety disorder. Resident F had an admission service plan on 12/6/2022, and semi-annual service plan on 7/19/2022. Neither service plan had a resident signature. During an interview on 7/25/2022 at 2:29 P.M., the Resident Service Coordinator indicated, the service plan should be signed by the resident. 3. A clinical record review was completed on 7/25/2022 at 10:00 A.M., for resident D. Diagnoses included, but not limited to: hypertension, chronic obstructive pulmonary disease, anxiety, and atrial fibrillation. During an interview on 7/25/2022 at 11:13 A.M., the Resident Service Coordinator indicated that the residents service plans dated 8/2/2021, 3/2/2022 and 7/20/2022 were not signed by the resident and should have been. On 7/26/2022 at 9:10 A.M., the Resident Service Coordinator provided a policy titled, "Service Plan", dated 6/1/2004, and indicated the policy was the one currently used by the facility. The policy indicated "...To require the development of a Service Plan for each resident designed to meet the resident's medical, nursing and psychosocial needs...." And "...The facility must develop a service plan for each resident which should be completed within 24 hours of admission...Service plans will be reviewed and/or revised every six (6) months, when the resident's condition change or		the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	services change...." 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			
R 0273 Bldg. 00	Based on observation, interview and record review, the facility failed to ensure food items in the freezer were dated/labeled and sealed securely after opening, failed to ensure used by dates were on foods, failed to dispose of expired foods, failed to ensure puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were clean and in good condition, failed to have fans without a buildup of dust in 1 of 1 kitchen observed. This deficient practice had the potential to affect 51 of 51 residents who received meals out of the kitchen. Findings include: 1. During an observation of the kitchen on 7/18/2022 at 6:45 A.M., with dietary staff 5 the following was observed in the walk-in freezer: 6 large containers of ice cream sitting on the floor. An opened unsealed and undated bag of fish sticks. An opened bag of chopped celery undated. Box of green beans not sealed. Boxes of foods sitting on the top shelf too close to the ceiling. The ceiling, a wire food rack, and the freezer door had areas of ice buildup. The floor had large pieces of food underneath the food racks and the thermometer was not registering a temperature. The following was observed in the walk -in cooler: 2 opened containers of sliced onions dated 7/7/2022. Two containers of strawberries with no used by date. An opened	R 0273	The community was alleged to be out of compliance by failing to ensure the facility failed to ensure food items in the freezer were dated/labeled and sealed securely after opening and failed to ensure used by dates on foods, failed to dispose of expired foods, failed to ensure cooking utensils/puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were clean and in good condition. Failed to have fans without a buildup of dust in 1 of 1 kitchen observed. This deficient practice had the potential to affect 51 of 51 residents who received meals out of the kitchen. a. Undated and/or opened, and expired food items were discarded. Cooking utensils/puree mixers/ice machine/refrigerators/reach in freezer/sandwich cooler were cleaned. Ice build up was removed from the freezer door, floor under food racks were cleaned, inoperable thermometers were replaced, Ceiling tiles were replaced/cleaned. The fan near the	08/25/2022

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	container of tomato juice dated 6/9/2022. An opened container of med pass (fortified nutritional shake) undated. The thermometer was not registering a temperature. The following was observed: numerous ceiling tiles that were stained, vents with rust and light fixtures with insects in the light covered. During an interview, on 7/18/2022 at 10:15 A.M., the Dietary manager indicated the foods should have been dated, sealed appropriately, the thermometers should be working, and the lights should not have bugs in them. He indicated the vents should not be rusty, the ceiling tiles should be cleaned or replaced, and the freezer should not have an ice buildup. 2. On 7/19/2022 at 10:30 A.M., during an observation of preparing pureed foods by Cook 3, the following was observed: Cook 3 was observed to put 3 scoops of chicken salad into the Robo mixer. She started the mixer and scraped the sides of the container. She then added mayonnaise and milk to the pureed chicken salad and mixed it again and did not measure the mayonnaise and or the milk prior to adding them to the food. Cook 3 added 3 scoops of coleslaw to another Robo mixer. She mixed the slaw and then added milk to the mixed slaw. Cook 3 did not measure the milk prior to adding it to the pureed slaw. She indicated the slaw was not thick enough and added a package of thickener. 3. During a follow up observation in the main kitchen with Cook 3, on 7/19/2022 at 10:45 A.M. to 11:14 A.M., the following were observed: a fan attached to the wall above the dishwasher tray line was observed to have a buildup of dust with the fan pointed towards the tray line. There was an exhaust fan box attached to the wall		tray line and the exhaust box fan was cleaned. The ice machine was cleaned and calcium/lime buildup removed. The reach in freezer was also cleaned. b. Entire kitchen was observed for cleanliness and areas of deficiency corrected. c. Dietary staff was educated on food storage, dating and food safety, food prep, monitoring of cooler/freezer temps, sanitary tray line, sanitation inspection. d. An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	

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	underneath the attached fan had a filter with a large buildup of dust. The ice machine was dirty on the front side and in the inside was a brown substance along the top edge. There was a large buildup of calcium/lime along the front and side edges of the ice machine lid. A single door reach-in freezer had a large accumulation of crumbs along the bottom and along the rubber seal on the door. The sandwich cooler had crumbs along the bottom, along the seal and a brown stain running down the left side inside the cooler. The dry storage area had an opened package of batter mix not sealed or dated and an opened bag of vanilla pudding mix not sealed. During an interview, on 7/19/2022 at 11:15 A.M., Cook 3 indicated the ice machine, reach in freezer and sandwich cooler should have been cleaned. On 7/19/2022 at 3:57 P.M., the Administrator provided the policy titled, "Food Safety Requirements Policy", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ... Refrigerated storage: Practices to maintain safe refrigerated storage include: ...iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its used-by date, or frozen (where applicable) /discarded; and v. Keeping foods covered or in tight containers. ...6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner t prevent contamination ... b. Clean dishes shall be kept separate from dirty dishes. ...8. Additional strategies to prevent forborne illness include but are not limited to: ...e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines ...."			

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	On 7/19/2020 at 3:57 P.M., the Administrator provided the policy titled, "Date Marking for Food Safety Policy", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ...2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. ...4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded ...." On 7/19/2022 at 3:57 P.M., the Administrator provided the policy titled," Monitoring of Cooler/Freezer Temps", dated 3/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated" ... 2. Thermometers shall be placed inside each cooler/freezer and calibrated at least once per week. ...7. All food items will be stored at least 6 inches off the ground and 18 inches from the ceiling. ...11. Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded whichever is applicable ...."			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure that the resident had a diet order for 1 of 5 residents reviewed for dietary needs. (Residents C) On 7/25/2022 at 9:24 A.M., a clinical record review was completed for Resident C. Diagnoses included, but were not limited to: diabetes mellitus type 2, end stage renal disease with dialysis, and	R 0275	The community was alleged to be out of compliance by failing to ensure diet orders were ordered by the physician for 1 of 5 residents reviewed for physician orders. A. Diet orders were obtained for residents C B. House wide audit was completed to ensure all residents	08/25/2022

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	hypertension. A review of Resident C's orders indicated, Resident C did not have a diet order. During an interview on 7/25/2022 at 2:15 P.M., the Resident Service Coordinator indicated that Resident C should have a diet order. A policy was requested on 7/25/2022 for diet orders. A policy had not been provided by the time of survey exit.		had diet orders. No other residents were identified. C. Nursing staff was educated to ensure all residents received diet orders upon admission.. D. An audit will be completed by Assisted Living Director/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interview, the facility failed to ensure 1 of 1 staff observed administering medication followed the	R 0296	The community was alleged to be out of compliance by failing to ensure 1 of 1 staff observed administering medication followed the facility's policy and	08/25/2022

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	facility's policy and professional standards in regards to insulin administration for 1 of 5 residents observed receiving medications. (Resident G) Finding includes: During an observation of the residential medication pass, conducted on 7/25/2022 at 10:45 A.M.., LPN (Licensed Practical Nurse) 16 was observed preparing insulin for Resident G. Prior to entering Resident G's room, LPN 16 had placed a disposable needle on the end of an insulin pen containing Humalog. She then dialed the pen to 14 units. Next, LPN 16 entered Resident G's room and obtained his blood glucose reading. LPN 16 then moved the dial on the insulin pen to 16 units and after wiping the resident's arm with an alcohol swab, she then administered the insulin via the pen to Resident G. During an interview with LPN 16, on 7/25/2022 at 11:00 A.M., she confirmed she had not primed the insulin pen and indicated she had never been taught to prime the pen. Review of the current facility policy and procedure, titled, "Insulin Pens", provided by the Assistant Director of Nursing on 7/25/2022 at 3:20 P.M. the following procedure was noted: "...h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at lease on drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears...."		professional standards in regard to insulin administration for 1 of 5 residents observed receiving medications a. Staff member was educated on insulin administration. b. No other residents were affected. c. Nursing staff received education on medication and use of insulin pens. d. An audit will be completed by Assisted Living Director/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall			

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	be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure that all the required information was provided in the Emergency Information File for 2 of 5 residents reviewed for emergency services. (Resident F and G) Findings include: 1.On 7/25/2022 at 10:57 A.M., a clinical record review was completed for Resident F. Diagnoses included, but were not limited to: diabetes mellitus type 2, depression, and anxiety disorder. A review of the Emergency Information File indicated, that a photograph for identification and allergies were not available in the file. During an interview on 7/25/2022 at 2:29 P.M., the Resident Service Coordinator indicated, a photograph and allergies should have been available in the Emergency Information File for	R 0356	The community was alleged to be out of compliance by failing to ensure that all the required information was provided in the Emergency Information File for 2 of 5 residents reviewed for emergency services. a. Emergency files for Resident # F and Resident # G were updated and are complete. b. A house wide AL audit was completed. All residents with incomplete emergency files were updated and complete./No other residents were identified. c. The AL director was educated to ensure completeness of all AL resident files. d. An audit will be completed by DON/designee three times a week for 4 weeks, twice a week	08/25/2022

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	Resident F. 2. On 7/25/2022 at 11:45 A.M., a clinical record review was completed for Resident G. Diagnoses included, but were not limited to: early onset Alzheimer's disease, dementia, diabetes mellitus type 2, and hypothyroidism. A review of the Emergency Information File indicated that a photograph for identification of Resident G was not available in the file. During an interview on 7/25/2022 at 11:55 A.M., the Resident Service Coordinator, indicated the identification photograph, should have been available in the Emergency Information File for Resident E. A policy was requested on 7/25/2022 for Emergency File Information. A policy was not provided.		for 4 weeks, weekly for 4 weeks. Audits will be submitted to the QAPI committee which is overseen by the Administrator. The QAPI committee will review the audits for completion/accuracy and make necessary recommendations to obtain 100% substantial compliance, as defined by the federal or state requirement, for a period not to be less than three months. At that time, the QAPI Committee, may recommend to continue the audits and the necessary frequency to maintain compliance, or recommend a another method to assure future compliance.	