STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 00 B. WING	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Survey dates: May 21, 22, 23, 24, 25, and 26 2023. Facility number: 000393 Provider number: 155383 AIM number: 100289340 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 6 Medicaid: 37 Other: 11 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 6, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by Washington Healthcare Center of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
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.			

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

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	(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, interview and record review, the facility failed to ensure person-centered comprehensive care plans were reviewed and revised in a timely manner to accurately reflect the resident's conditions for 3 of 5 residents reviewed for care plans (Resident 18, 21, and 52). Findings include: 1. On 5/22/23 at 10:50 a.m., Resident 52 was observed lying in bed with the sheet off of his lower legs. Resident 52 did not have any wound dressings on his feet. Resident 52 indicated he did not have any wounds on his feet. A comprehensive record review was completed on 5/24/23 at 12:30 p.m. He had the following diagnoses, but not limited to acute infarction of	F 0657	**F657 (D) Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 18, 21, and 52 care plans were reviewed and updated based on resident assessment/condition. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	06/20/2023

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	the spinal cord, muscle weakness, anxiety, orthostatic hypotension, neurogenic bowel, neuropathic bladder, and paraplegia. The record lacked documentation of any physician's orders for treatments and current wound measurements to Resident 52's feet. Resident 52 had a care plan dated 3/13/23 that indicated he admitted to the facility with a pressure injury to his left heel. He was at risk for impaired healing due to paraplegia state, mechanical lift, neurogenic bladder and bowel, hypotension, alcohol abuse, need for assistance with personal care, anxiety, and tethering equipment against skin. The goal, dated 6/13/23, indicated the wound would be free of signs and symptoms of infection. Interventions included to notify the physician of worsening or no change in wound or for signs and symptoms of infection and to assess wound weekly including documenting measurements and the description of the wound. 2. During an observation on 5/22/23 at 9:30 a.m., Resident 18 was observed wheeling himself in a wheelchair near the front entrance of the facility. He was wearing headphones and indicated he was having a great day. A comprehensive record review was completed on 5/25/23 at 2:30 p.m. Resident 18 had the following diagnoses but not limited to type 2 diabetes mellitus, end stage renal disease, weakness, seizures, neuropathy, absence of left leg below knee, benign prostatic hypertrophy, anemia, essential hypertension, chronic obstructive pulmonary disease, depression, and myocardial infarction.		**corrective action will be taken?** · All residents have the potential to be affected by this deficient practice. · The interdisciplinary team was re-educated on care plan development and revision policy. · A daily review of resident changes will be completed in daily clinical meeting and care plans updated as indicated. Also, a quarterly care plan review will be completed for each resident to ensure accuracy and updated as indicated. · Resident care plans were reviewed by IDT to ensure care plans were person centered and reflected resident's current condition. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The interdisciplinary team was re-educated on care plan development and revision policy. · A daily review of resident changes will be completed in daily clinical meeting and care plans updated as indicated. Also, a quarterly care plan review will be completed for each resident to ensure accuracy and updated as indicated. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Resident 18 had a care plan, dated 1/26/23, that indicated he was at risk for elopement per the elopement risk assessment. The goal, dated 7/19/23, indicated resident was to remain safely in the facility through the next review. An intervention, dated 1/26/23, indicated to redirect resident to activities of interest such as going to the dining area for activities. During an interview with the Executive Director on 5/26/23 at 11:26 a.m., she indicated Resident 18 was not at risk for elopement. She indicated he wheeled himself around with his headphones on listening to music. 3. On 5/23/23 at 2:08 p.m., Resident 21's record was reviewed. His diagnoses, included but were not limited to chronic obstructive pulmonary disease (COPD), diabetes mellitus (blood sugar disorder), depressive episodes, chronic pain, cellulitis (inflammation of subcutaneous tissue) of bilateral (both) lower limb and right upper limb, insomnia (sleepless), pruritis (itching), anxiety disorder, and cognitive impairment. A self-administration care plan, revised 4/13/23, indicated Resident 21 chose to self-administer topical medication. The goal was to safely self-administer medications. The nursing approaches were to complete the "ASC (American Senior Communities) Medication Self Administration Request/Evaluation" quarterly as needed, keep the medications out of reach of other residents, notify the MD of any problems, and provide education to resident on proper use of medication. A nursing progress note written by the Director of Nursing (DON), dated 5/4/23 at 8:11 a.m., indicated the pharmacy notified the facility of a non-covered medication: Temovate (clobetasol).		**assurance program will be put into place?** ·The POC QAPI Tool will be utilized by DNS/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	The physician was updated and the was order was discontinued due to non-compliance. The resident was notified. A physician order, discontinued on 5/4/23, indicated to apply Temovate (clobetasol) (a highly potent steroid that helps reduce inflammation in the body to treat inflammation and itching caused by skin conditions) 0.05 % ointment topically every shift to the bilateral lower extremities. The April and May Medication Administration Records (MARs) were reviewed. Resident 21 had continuous use of Temovate (clobetasol) until it was discontinued on 5/4/23. On 5/26/23 at 10:56 a.m., the Clinical Regional Consultant 24 indicated Resident 21 did not have a self-administration assessment for medications. A current policy, titled, "IDT (Interdisciplinary Team) Comprehensive Care Plan Policy," dated 10/2019, was provided by the Executive Director (ED), on 5/24/23 at 12:22 p.m. A review of the policy indicated, " ...Each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident need ...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input ...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(c)(2)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents received appropriate nail care for 3 of 3 residents reviewed for nail care (Residents 20, 211, and 212). Findings include: 1. On 5/21/23 at 11:30 a.m., 5/22/23 at 9:40 a.m., and 5/23/23 at 11:20 a.m., Resident 211 was observed lying in bed. His fingernails were long with a dark brown substance under his nails. During an observation on 5/24/23 at 10:59 a.m., Resident 211 was sitting up in the dining room with a hospital gown on. He indicated he wanted to keep his facial hair and wound like a haircut. His nails were trimmed and clean. A record review was completed on 5/25/23 at 11:09 a.m. Resident 211 had the following diagnoses, but not limited to sepsis, protein-calorie malnutrition, benign prostatic hypertrophy, obstructive uropathy, weakness, cognitive communication deficit, malignant neoplasm of the bronchus of the lung, malignant neoplasm of the brain, and pulmonary embolism. His care plan, dated 5/15/23, indicated he was a new admission to the facility, and he required implementation of services to promote physical, emotional, and psychosocial well-being including assistance with activities of daily living related to muscle weakness. An intervention indicated to	F 0677	**F677 (D) ADL for dependent residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 20, 211, and 212 received necessary ADL nail care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who require ADL nail care have the potential to be affected by the alleged deficient practice. · All residents were observed to ensure residents were well groomed, appropriate nail care and personal hygiene was provided by each resident care companion. · All nursing staff re-educated on ADL care including nail care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	06/20/2023

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	assist with transfers, ambulation, bed mobility, toileting and/or incontinent care, eating, drinking, and bathing/hygiene including oral/dental care. 2. During an observation on 5/21/23 at 11:35 a.m., Resident 212 was lying in bed with his feet elevated off the bed. His television was turned off and the room was dark. His nails were long and had a dark substance under the nails. During an observation of 5/22/23 at 9:42 a.m., Resident 212 was observed lying in bed. His nails were long with a dark brown substance under the nails. During an observation on 5/23/23 at 11:15 a.m., Resident 212 was observed lying in bed. His nails were long with a dark brown substance under them. During an observation on 5/24/23 at 10: 54 a.m., Resident 212 was observed lying in bed. His nails were trimmed and clean. A record review was completed on 5/25/23 at 11:20 a.m. Resident 212 had the following diagnoses, but not limited to sepsis, type 2 diabetes mellitus, essential hypertension, protein-calorie malnutrition, hyperlipidemia, obstructive uropathy, pressure ulcer right heel, weakness and depression. His care plan, dated 5/11/23, indicated he was a new admission to the facility, and he required implementation of services to promote physical, emotional, and psychosocial well-being including assistance with activities of daily living related to muscle weakness. An intervention indicated to assist with transfers, ambulation, bed mobility, toileting and/or incontinent care, eating, drinking,		**practice does not recur?** · All nursing staff re-educated on ADL care including nail care. · A daily rounding tool including resident hygiene to be utilized by Care Companions/Department managers to ensure good grooming and personal hygiene, including nail care. · A review of Care Companion rounds will be completed in daily CQI meeting. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	and bathing/hygiene, including oral/dental care. During an interview with the Executive Director (ED) on 5/23/23 at 2:10 p.m., she indicated nursing staff were to perform nail care for the residents. 3. On 5/21/23 at 11:29 a.m., Resident 20 was observed with long, uncut fingernails with brown debris under them. He indicated he was on hospice and was showered about a week ago. On 5/22/23 at 10:32 a.m., Resident 20 was observed with long, uncut fingernails with brown debris under them. On 5/25/23 at 9:31 a.m., Resident was observed with long, uncut fingernails with brownish debris under them. On 5/23/23 at 10:26 a.m., Resident 20's record was reviewed. His diagnoses included, but were not limited to, Metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), end-stage renal disease (kidney failure), diabetes mellitus (blood sugar disorder) with diabetic neuropathy (type of nerve damage that can occur with diabetes), acute (sudden onset) respiratory failure with hypoxia (low oxygen levels in the blood). On 5/23/23 at 10:29 a.m., Resident 20's care plan goals were reviewed. One indicated the resident was to have their ADL (activities of daily living) needs met, another goal was for the resident to achieve the highest desired practicable level of physical, emotional, and psychosocial well-being. A policy was not provided for ADL care, however a Skills Competency was provided. It was dated 2/2010. A review of the Skills Competency indicated to, " ...assist resident with toileting or			

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	perineal care as needed ...assist resident to wash face, hands, and under arms ..assist resident with oral hygiene ...have resident, if needed ...assist resident with dressing, including applying make-up and /or jewelry as requested ...comb and style resident's hair per preference ...." 3.1-38(a)(2)(A)			
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on observations, interviews and record review, the facility failed to ensure non-pressure wounds on a resident's toes were treated in a timely manner and failed to follow up on an arterial doppler causing a delay in treatment of the wounds which resulted in osteomyelitis, gangrene, and cellulitis for 1 of 3 reviewed for quality of care (Resident 45). B. Based on observation, interview, and record review, the facility failed to ensure residents had appropriate skin assessments and interventions in place to address non-pressure wounds for 2 of 3 residents reviewed for skin management (Residents 31 and 21). The immediate jeopardy began on 4/25/23 when Resident 45 was noted to have developed new wounds on his left and right toes. No treatments	F 0684	**F684 (J)** **Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 45 no longer resides at facility. · Residents 21 and 31 had new skin assessments completed and all interventions were updated as indicated to address non-pressure wounds. **How will you identify other residents having the potential to be affected by the same**	06/02/2023

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	were ordered until 4/27/23. The wound doctor observed the wounds on 4/28/23 and diagnosed the resident with osteomyelitis. A bilateral doppler ultrasound was ordered on 4/28/23 and completed on 5/1/23. However, the facility failed to follow up in a timely manner to receive the results which were not on the resident's file until 5/24/23. The resident went to the podiatrist on 5/22/23 where she was able to probe to the bone on both first and fifth digits. The podiatrist sent the resident to the hospital. The hospital admitted the resident with osteomyelitis of the left hallux and left fifth digit, cellulitis of the left foot, exposed bone on left hallux, and gangrene of left fifth digit. The resident would need amputations of the toes. The Executive Director (ED), the Director of Nursing (DON), the Regional Support for Social Services (RSS), and Regional Director of Operations (RDO) were notified of the immediate jeopardy on 5/24/23 at 2:28 p.m. The immediate jeopardy was removed on 5/26/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: A. On 5/23/23 at 10:00 a.m., Resident 45's medical record was reviewed. Resident 45 was transferred from another skilled nursing facility and admitted to Washington Healthcare on 3/3/23. He admitted with diagnoses which included, but were not limited to, a history of non-ST elevation myocardial infarction (heart attack), cerebral infarction (stroke), congestive heart failure, type II diabetes mellitus (a blood sugar disorder), and need for assistance with personal care. A Transition of Care (TOC) document, dated 3/3/23, from the previous nursing facility indicated		**deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · A facility wide skin sweep was conducted to determine any resident with skin alterations/wounds- MD notified immediately and new treatment orders obtained for any newly identified skin alterations. · Any resident with current wounds will be assessed for changes/worsening of wound and/or signs and symptoms of wound infection- MD will be notified immediately with any noted changes/concerns in wound appearance. · All resident records were reviewed for radiology results to ensure results are received, monitored, and physician is notified. · In-service/education-all nursing staff regarding admission procedure, skin management procedure, physician notification of change and lab/radiology monitoring. C.N.A.s were educated on ADL care/skin monitoring and shower sheets/skin monitoring as it relates to both. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	he had admitted to their facility with a diagnosis of osteomyelitis (inflammation or swelling that occurs in the bone. It can result from an infection somewhere else in the body that has spread to the bone, or it can start in the bone). A nursing admission assessment, dated 3/3/23 at 3:21 p.m., indicated Resident 45 admitted with two areas of compromised skin integrity. One ulcer was noted on his left great toe which measured 1.5 centimeters (cm) long by (x) 1 cm wide. A second ulcer was noted on his left 5th toe which measured 1 cm long by 1 cm wide. An option to "proceed with wound care observation," was marked, "no." A nursing admission progress note, dated 3/3/23 at 3:39 p.m., indicated Resident 45 was noted to have a 1.5 cm x 1 cm "dark scab" to his left great toe and a 1 cm x 1 cm "area" to the lateral side of his 5th toe which was "red in color." A baseline care plan, initiated 3/5/23, indicated Resident 45 was at risk for further skin break down due to, " ...osteomyelitis to L [left] foot and arterial ulcers to L toes ...." A second baseline care plan, initiated, 3/5/23, indicated Resident 45 was at risk for pain, also related to arterial ulcers on his left foot. The record lacked documentation of interdisciplinary team (IDT) follow up related to the areas noted on admission. The record lacked documentation the physician was notified of osteomyelitis in his left foot and/or the areas on his toes noted upon admission. On 3/15/23 Resident 45 was initially seen by the Medical Director (MD). The evaluation indicated		· In-service/education-all nursing staff regarding admission procedure, skin management procedure, physician notification of change and lab/radiology monitoring. C.N.A.s were educated on ADL care/skin monitoring and shower sheets/skin monitoring as it relates to both. · All pending radiology results will be followed in daily clinical until results are received, and physician is notified. · Weekly skin sweeps of all residents will be completed and reviewed by members of nurse management. · Nurses will review shower sheets for impaired skin integrity. Nurses will take appropriate action as necessary. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	no issues with the resident's skin and lacked a review of his history of osteomyelitis and the two areas noted on his toes upon admission. A follow up was conducted by the MD on 3/27/23. The evaluation lacked a review of his history of osteomyelitis and the two areas noted on his toes upon admission. Resident 45's shower sheet/bathing records were reviewed and revealed he had only received bed baths, and no skin issues were noted until 4/25/23 when the aide noted, "right foot and left foot had open areas." A nursing progress note, dated 4/25/23 at 2:26 p.m., indicated Resident 45 was noted to have redness and drainage to his left 5th toe and great toe. The MD was onsite and made aware. The Nurse and MD observed Resident 45's left foot. The MD gave no new orders at that time. A new Skin Event was opened on 4/25/23 at 2:47 p.m. which indicated, yellowish drainage on the left great and 5th toes and bright red. Measurements were not recorded. The MD was made aware and gave no new orders. The skin event indicated, "Resident noted to have redness and drainage to the left 5th and great toe ...MD on site and was made aware. MD and writer observed resident left foot. No new orders given at this time." During an interview on 5/24/23 at 10:21 a.m., LPN 52 indicated she was working on 4/25/23 when a CNA notified her, Resident 45 had open areas on his right and left foot which she found during a bed bath. LPN 52 immediately went to assess the areas and upon her observation she was very concerned. His toes were black and had a lot of			

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	drainage. The MD was in the facility at that time, and she asked him to come look. LPN 52 and the MD observed Resident 45's feet. When LPN 52 and the MD left his room, the MD told her it looked like he had osteomyelitis. He showed her a picture example on his phone and indicated the resident would probably lose his foot. The MD did not give LPN 52 any orders at that time. During an interview on 5/25/23 at 6:40 p.m., CNA 53 indicated she worked weekend option and had only worked with the resident once before but not on a shower day. So 4/25/23 was the first time giving him a bath. He was really pleasant and cooperative. While giving him a bed bath she did the top area first and kept his socks on to keep him warm. When she got to the bottom, "it was horrible." It was not a situation where she felt comfortable finishing the bath, dressing the resident and changing the bed. She "needed to get help right way! It startled me to the point, I thought his toes are falling off, this is scary!" She could not identify which toe was the problem as it was his whole foot. "It scared me to death." His whole foot was pale. The doctor was there that day, and he came down to look at it. He pressed on the resident's foot, the resident said he could not feel the pressure. The foot was white and did not turn pink with pressure. CNA 53 was surprised he was not sent to the hospital. She indicated she had been a CNA "long enough" to know that his foot did not get that way in just a couple of days. She indicated there was no way his toes and foot could have been missed if the socks were being taken off during bed bath and it was important to inspect residents' feet. During an interview on 5/24/23 at 10:11 a.m., Licensed Practical Nurse (LPN) 51 indicated she did not recall any issues with Resident 45's feet			

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	until the new areas were found in April. She had returned to work after a weekend and saw a new skin event had been initiated by another nurse. She went to Resident 45 to inspect the area and was alarmed at the condition of his left foot. She asked LPN 52, (the nurse who opened the event on 4/25/23) about the areas. LPN 52 told her, a CNA found the areas and let her know. When she assessed the area, she was also concerned and even observed the foot with the MD, but he did not give any orders at that time. LPN 51 indicated, since she was told the MD was already aware, she notified the DON who instructed her to open additional events, get measurements, call the MD, and ask orders. LPN 51 described his toes as, "very icky." The 5th digit was macerated with eschar and had yellow slough and drainage. There was a new area to the top of his great toe that was flattened and black. The top of his right great toe had redness and warmth and appeared possibly infected. LPN 51 indicated, the condition of his feet was advanced, and the areas could not have developed overnight. Resident 45 always wore the non-skid socks and did not complain about pain. He was in a regular bed, and it was not until the area were found that the footboard of the bed was removed. LPN 51 indicated Resident 45 usually only got bed baths, and the CNAs should have been removing his socks to observe his feet. A nursing progress note dated 4/27/23 at 3:25 p.m., indicated, Resident 45 was in bed and received a full assessment. New orders were noted for areas to top of his 5th toe, bottom of 5th toe, top of great left toe, inside 1st big toe, and right great toe. The corresponding Skin Events were reviewed: On 4/27/23 at 2:54 p.m., a new area located on the			

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	left 5th to which measured 1.3 cm long by 3.4 cm wide. Yellow slough was present as well as redness/warmth (a sign of infection). On 4/27/23 at 3:01 p.m., a new area located on the left bottom of the 5th toe which measured 1.5 cm long by 1 cm long with redness and warmth present. Also noted to be back/brown/dark. On 4/27/23 at 3:08 p.m., the top of the left great toe measured 2.8 cm wide by 2.7 cm long. It was an open area with yellow drainage, redness, and warmth were present. Also noted to be black/brown/dark, (two days prior had been right red). On 4/27/23 at 3:15 p.m., a new area located on the left inner 5th toe which measured 5 cm long by 2.1 cm wide. Yellow slough, redness, and warmth were present. On 4/27/23 at 3:05 p.m., a new area located on the right great toe which measured 1.5 cm long by 1.5 cm wide. It was noted to be bright red with warmth present. Physician's orders, initiated on 4/27/23 (2 days after wounds were found) indicated to cleanse the areas with wound cleanser, apply Xeroform (a type of wound dressing/treatment) and cover, daily. A physician's order was initiated on 4/28/23 to obtain a bilateral doppler ultrasound, (a noninvasive test that can be used to estimate the blood flow through your blood vessels). A nursing IDT progress note, dated 4/28/23 at 2:14 p.m., indicated, the DON, the Minimum Data Set Coordinator (MDSC), Unit Manager (UM) and			

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	Wound MD were present. Wounds were described as arterial ulcer on the left great toe with 25% epithelial 35% slough 40% eschar, mild serosanguineous exudate, edges intact, necrotic tissue removed. The Left 5th toe had no drainage, edges intact, 70% eschar and 30% epithelial. Treatments were in put in place, antibiotics, podiatry referral, and arterial doppler. A nursing progress note, dated 4/28/23 at 2:44 p.m., indicated the Wound MD was in to evaluate Resident 45's left foot. A new order was received to start a Peripherally Inserted Central Catheter (PICC) and antibiotic for 6 weeks. A nursing progress note, dated 5/1/23 at 1:21 p.m., indicated a contracted mobile diagnostic and imaging company was noted at the facility to obtain an arterial doppler for Resident 45's left foot. Results were pending. A physician's order for intravenous (IV) meropenem (an antibiotic medication) was obtained on 4/29/23 with the indication for osteomyelitis in the left great toe. A referral was made for Resident 45 to be evaluated and treated by a podiatrist and a nursing progress note, dated 5/22/23 at 10:00 a.m., indicated the doctor from the podiatrist office phoned to inform the facility that Resident 45 was being transferred to the Emergency Room (ER) for further evaluation and treatment and possible admission for amputation. On 5/24/23 at 8:30 a.m., a copy of a SOAP (subjective/objective/assessment/plan) evaluation conducted by the Doctor of Podiatric Medicine (DPM) was provided. The evaluation indicated, " ...patient states that for the past 6 months he has			

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	had ulcers on his left foot ... Ulcer #1: located on the left great toe is Wagner Grade 3 [deep ulcer with abscess or osteomyelitis) arterial. Wound is full thickness and measured 1.5 cm long by 1.2 cm wide and 0.3 cm deep with moderate serous drainage, undermining noted and was able to be probed to the bone. Ulcer #2: located on the left 5th toe is Wagner Grade 3 arterial, full thickness and measured 2 cm long by 1.5 cm wide but depth could not be measured. Ulcer #2 had heavy purulent drainage, tan in color with 25% eschar and tunneling noted. Ulcer #2 was also noted with Erythema and fluctuant tracking along the planter aspect of the arch in line with the 5th flexor tendon. When lanced, purulent material expressed from the fluctuant area in the arch .... Plan: discussed bone infection and the implications it has on healing and limb loss ... I stressed the need to treat the problem aggressively. Recommended excision of the infected hone with culture and biopsy of the area ... I am very concern with the appearance of the left foot. As there is purulent drainage and he is already on IV antibiotics with a PICC line. He also had exposed bone to 1st and 5th toes of the left foot necessitating amputation of both. He has non-palpable pulses which will need vascular work up before any surgery can be completed. He will also need an MRI. Advised he be sent to the hospital ...." A hospital ER evaluation, dated 5/22/23, indicated Resident 45 came to the Emergency Department (ED) from the podiatrist for a possible arterial occlusion and osteomyelitis of left foot. The podiatrist could not find a pulse in his left foot there was evidence of first and fifth digit dry gangrene. There was drainage out of the planter aspect of the left foot. A CTA (Computed Tomography Angiography- a type of medical test that combines a CT scan with an injection of a			

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	special dye to produce pictures of blood vessels and tissues in a part of your body) indicated, " ...left superficial femoral artery multiple tandem high-grade stenoses, occlusions and minimal reconstruction of the popliteal artery and runoff vessels, the posterior tibial artery is opacified across the ankle on delayed phase imaging ...." A hospital podiatrist consult indicated the DPM was able to get quite a bit of pus out of the foot at bedside from the digit and extending into the medial arch concerning for abscess. She was also able to probe to the bone on both right and fifth digits. The DPM was concerned about blood flow as pulses were not palpated to the left foot, fifth digit had dry gangrene to the planter lateral aspect of the digit. There was a small area in plantar medial arch of necrotic ulcer. The report indicated, "...patient has exposed bone on left hallux and gangrene of left fifth digit so will need amputation of these digits but would prefer to optimize perfusion first to help with healing of surgery, per DPM there was concern of infection tracking down flexor tendon, so I did order an MRI to assess for extent of infection...." During an interview on 5/23/23 at 12:54 p.m., Resident 45's Power of Attorney (POA) indicated, she was unaware Resident 45 had been sent to the hospital or that he had new wounds on his feet. She was concerned about how it would affect his ability to recover, since he was a diabetic and had a history of wounds. He had been doing so well and was recovering from the stroke, she had even planned to make arrangements to have her POA revoked so that he could be independent again. During an interview on 5/23/23 at 2:00 p.m., the MD indicated he rounded at the facility on a weekly basis and was usually in the facility every Tuesday from 10:00 a.m.- 6:00 p.m. He would visit			

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	residents upon their admission and conduct comprehensive assessment and evaluation. This assessment would include a "comprehensive" skin assessment, but only of exposed skin. He indicated, "I only look at skin I can see, just the exposed parts. I do not typically check unexposed skin unless the resident and/or staff indicated there was a need, if there is a treatment or bandage in place, I don't remove it." During an interview on 5/23/23 at 2:06 p.m., Certified Nursing Assistant (CNA) 50 indicated, Resident 45 was complaint with his care and treatments. He was pleasant and agreeable. He was interactive and enjoyed conversations. CNA 50 only worked with Resident 45 in the previous couple of weeks, so she was unable to visualize his foot before he left, but she remembered that there was quite a bit of redness to his whole left foot and the start of redness to his right foot. His feet were tender, so she tried to be careful. During an interview on 5/23/23 at 2:51 p.m., the DON indicated Resident 45 never had a doppler ultrasound as a resident at the facility. The above stated physician order and progress notes were reviewed with DON at this time, and she indicated she would "double check." During a follow up interview on 5/23/23 at 2:51 p.m., the DON indicated when Resident 45 admitted to the facility, he did not have any open areas that she could recall. Several weeks later, his toes "didn't look right" and they had begun to change color, so the wound doctor was called in for an evaluation. The DON indicated it was her expectation that upon admission and identification of any skin integrity issues, the areas should be reported to the IDT team, so that the IDT team could review, evaluate and			

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	determine if the areas needed to be followed up with or not. During an interview on 5/24/23 at 9:16 a.m., the DON provided a copy of the doppler results and indicated she logged onto the website and found that the results were uploaded so she was able to obtain a copy. Until that time, the results had not been obtained by the facility. It was the DON's expectation for nursing staff to follow up on tests results in a timely manner. The results of the doppler, dated 5/2/23, were reviewed and revealed, " ...1. Left dorsal pedis artery not visualized may not exclude occlusion. 2. Segmental stenosis in the rest of bilateral lower extremity arteries especially in bilateral superficial femoral and the visualized infrapopliteal arteries. Further examination suggested which may include CT angiography among other workup...." During an interview on 5/24/23 at 10:03 a.m., the Minimum Data Set Coordinator (MDSC) indicated she had conducted the nursing admission assessment on Resident 45. When the MDSC inspected his feet, she noted the two areas on his toe. She indicated as a nurse she could not "diagnosis" because that was out of her scope of practice. She did not know what to classify the areas as and that was why she put a follow up progress note in with more details about the areas. Additionally, it was important to note skin integrity issues on the admission assessment so that IDT could follow up as needed. The MDSC indicated, the areas were not open or draining at that time, and she indicated they looked more like "scabs." When skin areas were noted on the admission assessment, it should trigger the IDT team to review and determine if further follow up was warranted or not. She did not know why the IDT team did not review his feet after admission.			

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	On 5/24/23 at 2:50 p.m., a visit was attempted with Resident 45 at the hospital. He was out of the room at that time. His nurse, a Registered Nurse (RN) for the hospital indicated, he was undergoing a stress test as a part of pre-surgery preparations. She indicated his left foot was in "very bad" condition and amputation was a certainty. The doctors were concerned about the extent and spread of the infection, as it may have traveled up his leg through the tendon in his foot. If they were unable to restore "good enough" blood flow to the leg, he may require an amputation below the knee. On 5/25/23 at 11:16 a.m., Resident 45 was observed while in-patient at the hospital. He was reclined in bed. His left foot was wrapped. When asked what happened to his foot, Resident 45 indicated, "it's F----- up!" When asked what happened, he indicated, "I don't know I guess I just have wounds, I think they are going to take my foot off." When asked if the nurses and aids were checking his feet while he was at the facility, he indicated, he thought they were, but when he got bed baths he could not remember if they took his socks off or not. During an interview on 5/25/23 at 11:20 a.m., Resident 45's hospital nurse indicated he was receiving IV heparin due to the occlusions as a blood thinner to try and prevent another stroke. He was also on IV meropenem for the osteomyelitis. She checked his most recent physician notes and indicated, he was going to be transferred to another hospital for more extensive testing and procedures. An MRI performed the day before was positive for osteomyelitis to his whole left foot.			

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	On 5/25/23 at 11:30 a.m., Resident 45's left foot was observed. His 5th digit was observed to be fully black from the base of the toe to the tip of his toe, dry and looked like a stone. The tip of his great toe was observed. It was swollen and bulged outward with an oval shaped wound. The wound bed was noted with scant yellow slough, the edges were rolled over and macerated. The top/right side of his great toe had a scabbed, irregular shaped area with reddish-brown dried crust. There was a small puncture wound on the bottom of his foot, in the middle of his arch. Purulent drainage was noted. During an interview on 5/25/23 at 12:40 p.m., the Wound Doctor (WMD) indicated he was asked to see Resident 45 for new areas on his foot. He saw Resident 45 on 4/28/23. By the time, the WMD saw his foot, there was already exposed bone, and he was certain it was infected with osteomyelitis. He was not the doctor who ordered the arterial doppler therefore did not follow up for the results. If he had ordered the test, he would except results and follow up within a couple of days. On a follow up visit on 5/19/23 the WMD indicated it appeared to have worsened and if there had not already been a podiatrist referral scheduled, he would have sent him out. At this time, the WMD provided copies of his wound notes for review. An initial wound evaluation, dated 4/28/23, indicated wounds present on the left 5th toe and great toe. They were classified as arterial ulcers with osteomyelitis of the left great toe and the resident had a history of osteomyelitis of the left great toe and had a history of stroke and heart attack. The peripheral pulse was palpable but weak, his feet were pale, and the left great toe was erythematous and warm. Wound #1 was classified as full thickness with exposed bone and etiology			

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	of arterial insufficiency, located on the left 5th toe. The wound measured 1.5 cm long by 3.2 cm wide and 0.1 cm deep with subcutaneous tissue exposed and a small amount of serosanguineous drainage. There was a large (67%-100%) amount of necrotic tissue within the wound bed including eschar. Wound #2 was also classified as a full thickness arterial wound with exposed bone. The wound measured 4.2 cm long by 3.7 cm wide and 0.6 cm deep. There was bone, muscle and subcutaneous tissue exposed. There was a small amount of serosanguineous drainage noted and there was a large amount of necrotic tissue within the wound bed including eschar and adherent slough. At that time, the WMD gave new orders to start IV antibiotic of meropenem for osteomyelitis of the right great toe and also gave a general note, " ...refer to outside podiatrist regarding possible need for amputation of left toe/s." A WMD note, dated 5/5/23, indicated healing was unlikely and to anticipate then need for surgical intervention per podiatry. A WMD note, dated 5/19/23, indicated the left great toe area was stable but slightly enlarged. Plan was to continue IV meropenem for osteomyelitis but there was a concern that the antibiotic may not reach target tissue in a sufficient concentration to be effective given arterial insufficiency. "Await input from podiatry consultant on 5/22. I am concerned the distal left foot remains at risk and amputation may yet be indicated ..." During a follow up interview on 5/25/23 at 3:10 p.m., the MD indicated he only visited with the resident on 3/14 upon his admission. At that time, he indicated there were no issues with his feet or			

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	legs. The MD indicated he did not recall anything significant about the resident's foot or toes. When the nursing progress note from 4/25/23 was read to MD, he indicated he did not recall seeing the resident's foot. On 5/24/23 at 2:15 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Nursing Admission/Return Admission Policy and Procedure," revised 2/2019. The policy indicated, "It is the policy of American Senior Communities to provide baseline and accurate documentation of the mental and physical condition of each resident admitted ... Initial Nursing Assessment: Admission Observation ... a thorough head to toe assessment (including skin) must be done at admission. Any altercations in skin integrity must be identified on nursing assessment. They physician must be notified for specific treatment orders ... After completion of the admission nursing assessment a Baseline care plan will be initiated for all new admissions ...." On 5/24/23 at 2:15 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Skin Management Program," revised 5/2022. The policy indicated, " ...Procedure for altercations in skin integrity- Pressure and non-pressure ... altercations in skin integrity will be reported to the MD/NP... Treatment will be obtained from MD/NP. All altercations in skin integrity will be documented on the admission observation in the medical record on the admission observations ... The wound nurse/designee will be notified of altercations in skin integrity ... the wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day...."			

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	155383	A. BUILDING 00 B. WING	05/26/2023

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	On 5/24/23 at 2:15 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Labs and Diagnostics," dated 11/2017. The policy indicated, "It is the policy of American Senior Communities to provide or obtain laboratory and diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services ...." On 6/1/23 at 2:39 p.m., Resident 45's family member indicated he had his leg surgically amputated above the knee and was recovering. The immediate jeopardy that began on 4/25/23, was removed on 5/26/23, when the facility provided education to all nursing staff for admission process, skin management, and follow up for labs and diagnostics. Further, a facility wide skin-sweep was conducted for all residents as well as an audit of ordered labs/diagnostics to ensure timely follow up. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. B1. On 5/26/23 at 11:18 a.m., Resident 31 was randomly selected for review during the IJ removal. At that time, he was observed seated in his wheelchair beside his bed in his room. He was agreeable and allowed Licensed Practical Nurse (LPN) 23 to remove his socks and shoes, so that an observation of his feet could be conducted. Upon removal of his socks, his bilateral (both right and left) feet, were observed to be discolored. They were ashy and dusky dark purple. The discoloration continued up both of his legs to just below his knees. His legs were very dry, flakey, and scaley with shedding skin.			

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	His legs were also deep purple in color. When asked about the discoloration, LPN 23 indicated his legs were not discolored, he only had dry skin. On 5/26/23 at 12:40 a.m., Resident 31's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, cellulitis (bacterial skin infection) and peripheral vascular disease (PVD- A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs and can cause the color of the legs and feet to change which can be a sign that not enough nutrients or oxygen are able to be supplied to the legs and feet by the blood). He had a comprehensive care plan, initiated 1/30/21 and revised 5/23/23, which indicated he was at risk for ineffective tissue perfusion related to PVD. The care plan lacked person-centered revision and/or interventions that identified the discoloration of his bilateral lower extremities (BLE). He had a comprehensive care plan, initiated 8/12/202 and revised 5/23/23, which indicated he was at risk for further skin breakdown due to concerns which included, but were not limited to, cellulitis, history of venous ulcers and limited sensory perception. The care plan lacked person-centered revision and/or interventions to identify the discoloration of his BLE. He had a comprehensive care plan, initiated 8/12/20 and revised 5/23/23, which indicated he was at risk for pain related to a left hip fracture, decreased ambulation, PVD and refusal to bear weight on his left lower extremity. The care plan lacked person-centered revision and/or interventions to identify the discoloration of his			

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	BLE. Resident 31's weekly skin assessments were reviewed. The assessments completed between 1/27/23 - 5/19/23 all lacked documentation, indication, and/or intervention to identify and/or address the discoloration of his legs. A weekly skin assessment dated 4/21/23, indicated, a podiatry referral was needed. The record lacked documentation of follow up to schedule the podiatrist visit. The record lacked documentation of identification of his chronic discoloration, therefore no additional monitoring or interventions were in place. On 5/26/23 at 12:11 p.m., the DON provided a copy of a skin-sweep tool for Resident 31. She indicated, as a part of the IJ removal process, a facility-wide skin-sweep had been conducted to ensure residents had not developed new skin integrity issues which had not already been identified, and to ensure previously identified areas had appropriate treatments in place. The DON indicated she had conducted the skin assessment on Resident 31, and there were no areas of concern that she recalled. On 5/26/23 at 12:18 p.m., Resident 31's BLE were observed with the DON and Regional Clinical Consultant (RCC) 24. Upon visualization, the DON indicated, the discoloration of Resident 31's BLE were chronic and had always been there because of his PVD. He did not have any new open areas. His legs were always discolored and appeared to be very dry and flakey.B2. On 5/22/23 at 10:48 a.m., Resident 21 was observed in his room. He			

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	had 3 circular wounds to his face: one on his forehead, one between his eyebrows, and one on the end of his nose. He pulled up the sleeves of his shirt to show multiple circular wounds on his bilateral (both) arms. No dressings were observed. On 5/24/23 at 12:37 p.m., Resident 21's wounds were observed. He continued to have the three circular wounds to his face and six circular wounds to his bilateral anterior arms. He raised his shirt and indicated he had wounds on his belly button. He raised his shirt, exposing his lower back exposing 4 wounds. He pulled up his pant legs, exposing his bilateral lower legs. There were numerous wounds, approximately 50 small wounds. He had no dressings on any of these wounds. On 5/24/23 at 12:39 p.m., Resident 21 indicated he received his shower the day before. At the end of the shower he indicated he was "all bloody." On 5/23/23 at 2:08 p.m., Resident 21's record was reviewed. His diagnoses, included but were not limited to chroni c obstructive pulmonary disease (COPD), diabetes mellitus (blood sugar disorder), depressive episodes, chronic pain, cellulitis (inflammation of subcutaneous tissue) of bilateral (both) lower limb and right upper limb, insomnia (sleepless), pruritis (itching), anxiety disorder, and cognitive impairment. Resident 21's Minimum Data Set (MDS) assessment was reviewed. His initial entry into the facility was 12/24/21. On 9/2/22, he was discharged, his returned was not anticipated. On 9/27/23, he was re-admitted			

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	to the facility. His quarterly Assessment, dated 3/21/23, indicated he had no open lesions on his skin.The Admission Observation/Assessment, dated 9/27/22, indicated his skin was warm, dry, with a normal skin color and texture. He had no alterations to his skin. In the Comments section, it indicated he had multiple bite marks on his bilateral upper and lower extremities around his ankles. Dry and scabbed areas, some had Band-Aids covering them. Resident history indicated he had difficulty sleeping. On 9/27/22 at 08:00 a.m., the facility's Medical Director (FMD) indicated in his psychiatric note, the resident had good judgment with normal mood and affect, active and alert. He was oriented to time, place and person. His memory showed recent and remote memory normal. Inspection and palpation of the skin showed good skin turgor (skin elasticity) and no jaundice (yellowing of the skin).On 10/3/22 at 3:23 p.m., the Initial MD visit indicated the resident reported scattered open lesion to bilateral upper arms, restless sleep and anxiety. His psychiatric note indicated the resident had poor insight, anxious, only oriented to place and person. The skin inspection indicated no rash, lesions, ulcer or jaundice. On 10/10/22 at 3:11 p.m., the FMD indicated the resident reported scattered open lesion to bilateral upper			

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	arms, restless sleep and anxiety. His psychiatric note indicated the resident had poor insight, anxious, only oriented to place and person. The skin inspection indicated no rash, lesions, ulcer or jaundice.His physician orders included, but were not limited to:a. Apply xeroform (dressing) to areas on bilateral arms and legs, wrap with kerlix and tape, change three days a week for pruritus (itching). Order started on 4/19/23.b. Betadine (antiseptic for skin disinfection) Surgical Scrub (povidone-iodine) 7.5 % solution, BID. Wash hand and scrub nails twice a day for pruritus (itching). Started 4/19/23. c. Hibiclens (strong antiseptic used to kill bacteria) (chlorhexidine gluconate) 4 % liquid. Give hibiclens showers 3 days a week, on Monday, Wednesday, and Friday. Order started on 4/19/23.d. Buspirone (antianxiety)15 mg tablet, TID (three times a day) for anxiety. e. Aspirin 81 mg chewable tablet, daily for chronic obstructive pulmonary disease (COPD).f. Trazodone (antidepressant/sedative) 150 mg tablet at bedtime for insomnia. g. Sertraline (antidepressant) 100 mg tablet, daily for depressive episodes. h. Temovate (clobetasol) (treats eczema and psoriasis) 0.05 % ointment. One topical application, every shift, apply to bilateral lower extremities. This order was discontinued on			

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	5/4/23. A risk for skin breakdown, dated 4/13/23, indicated he picked at his skin, had poor hand hygiene which placed him at greater risk for infection. He had a history of cellulitis for bilateral lower extremities. Approaches included apply hydrocortisone cream to bilateral arms and legs and back. Barrier cream at bedside. A self-administration for topical medications care plan was dated 4/13/23. It indicated Resident 21 had chosen to self-administer topical medications. An approach to this care plan was to complete the, "ASC Medication Self Administration Request/Evaluation." The facility was unable to provide a self-administration assessment.A mental health care plan, dated 4/13/23, indicated Resident 21 was mentally ill according to the pre-admission screening and record review (PASRR) assessment. A behavioral care plan, dated 4/13/23, indicated Resident 21 was at risk for signs and symptoms of anxiety, such as shortness of breath, increased worried repetitive verbalizations or question, and irritability. Approaches included to assess for unmet needs, encourage resident to talk about concerns, reassure, and validate him and assist him to a less stimulating environment as needed. A risk for bleeding/bruising related to use of antiplatelet medication, dated 4/13/23, indicated Resident 21 will			

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	remain free from adverse effects, observe for increased bleeding. On 4/11/23 at 11:29 a.m., Facility Medical Doctor (FMD) visited Resident 21 for an acute visit. He indicated the resident had a history of neurotic excoriations (skin is scraped or abraded) and resident said it was getting worse. Excoriations noted on extremities. His psychiatric note indicated the resident had good judgment with normal mood and affect, active and alert. He was oriented to time, place, and person. His memory showed recent and remote memory was normal. In a progress note, dated 4/18/23 at 8:09 p.m., the DON indicated a MD (medical doctor) was in to evaluate Resident 21 for complaints of itching to bilateral arms and legs. The resident was known to pick at his skin, education provided to the resident. A new order was received to wash hands and nails daily with betadine, skin cleanser ordered for three days week with dressing changes. Resident was further educated on hand and personal hygiene, awaiting dermatology acceptance for referral. A progress note, dated 4/19/2023 at 2:03 p.m., indicated Resident 21 continued to have areas noted to his skin. Resident 21 refused a shower today indicating he only wanted a male staff care giver to provide showers. On a progress note, dated 4/19/2023 at 3:32 p.m., the DON indicated			

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	Resident 21 was sitting up in bed, he denied pain or discomfort. He refused a shower at this time. Education was provided regarding personal hygiene and benefits of taking showers to help with the scabbed areas to bilateral arms and legs. He was non-compliant this time with not picking at skin, A progress note, dated 4/20/23 at 8:51 p.m., indicated Resident 21 was resting in bed during this shift. He indicated he had a shower during the day shift. No complaints of pain nor distress noted at this time. A progress note, dated 4/21/2023 at 5:55 a.m., Resident 21 had no signs of symptoms of pain, anxiety, or agitation this shift. The resident had no complaints of itching or scratching this shift. Progress notes, dated 4/21/2023 at 1:54 p.m., 4/22/2023 at 09:29 p.m., and 4/23/23 at 9:15 p.m., indicated Resident 21 had no complaints of pain nor distress at this time.A progress note, dated 4/25/23 at 9:13 a.m., LPN 4 called a local dermatology provider to check on appointment, still pending Medicaid approval prior to scheduling appointment. A progress note, dated 4/27/23 at 2:23 p.m., indicated the local hospital called to schedule Resident 21's dermatology appointment for 5/22/23 at 3:20 p.m.On a progress note, dated 4/29/23 at 12:52 p.m., Resident 21 was alert and could verbalize needs clearly. When writer offered his treatment, the			

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	Resident refused and said he would do it later. He was noted up in his wheelchair (WC) at the bedside. He was free from distress. On a progress note, dated 4/30/23 at 10:53 a.m., Resident 21 refused to wash his hands in the Betadine solution as ordered. A nursing progress note written by the Director of Nursing (DON), dated 5/4/23 at 8:11 a.m., indicated the pharmacy notified the facility of a non-covered medication: Temovate (clobetasol). The physician was updated and the was order was discontinued due to non-compliance. The resident was notified. On 5/26/23 at 10:58 a.m., Clinical Regional Consultant indicated no alternative medication was provided for the Temovate.The April and May Medication Administration Records (MARs) were reviewed. Resident 21 had continuous use of Temovate (clobetasol) until it was discontinued to 5/4/23. During an interview, on 5/24/23 at 1:55 p.m., Licensed Practical Nurse (LPN) 4 indicated prior to arriving at the facility on 9/27/22, he had been living in the woods. He had bites all over and he picked at them. His skin treatments have included topical and oral medications, including antihistamines. She indicated the Wound Medical Doctor (MD) did everything that he could, then referred him to a dermatology appointment. It was scheduled 3/31/23. Resident 21 had refused			

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	geri-sleeves (protective fabric over skin) in the past but would wear long sleeve shirts. During an interview, on 5/25/23 at 12:41 p.m., the Wound MD indicated he was not aware of caring for Resident 21.On 5/25/23 at 9:51 a.m., Resident 21 was observed in the dining room. He had on a short sleeve shirt. Bilateral forearm dressing was observed. He indicated he had bilateral dressings on his bilateral lower legs too. He indicated he slept much better last night because of the dressings. Usually when he tried to sleep, he would feel tearing and burning sensations in his legs. After the dressing were applied, he slept much better. On 5/25/23 at 10:55 a.m., the Wound Management area of Resident 21's electronic medical record lacked documentation of wound management including Wound MD consultation notes. During an interview, on 5/26/23 at 9:26 a.m., Certified Nursing Aide (CNA) 25 indicated he was the only staff member allowed to give showers to Resident 21. On the shower sheets, for skin condition, he only put, "rashes," but they were actually scabbed sores. The scabs were stuck to his clothes and started bleeding when he removed the resident's clothes for a shower. He indicated Resident 21 did not scratch at his skin. On 5/25/23 at 2:40 p.m., Resident 21's shower sheets were provided by the			

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	Executive Director (ED) and indicated the following:a. There were two shower sheets for 5/2/23. One indicated he had a rash. Special soap was used. The outlined on his BUE and BLE. For his scalp it indicated a spot where he was bald. The second shower sheet indicated he refused the shower, but special soap was used. b. On 5/5/23, the shower skin notes indicated rash on BUE and BLE, with special soap used. c. On 5/9/23, the shower skin notes indicated rash on BUE and BLE, with special soap used. d. On 5/12/23, the shower skin notes indicated rash on 3 places on the face, BUE and BLE, with special soap used. e. On 5/19/23, the shower skin notes indicated rash on 3 places on the face, BUE and BLE, with special soap used. f. On 5/23/23, the shower skin notes indicated rash on 3 places on the face, BUE and BLE, with special soap used.g. On 5/25/23, the shower skin notes indicated rash on 3 places on the face, BUE and BLE, with special soap used.A progress note, dated 5/1/23 at 1:00 p.m., indicated Resident 21 remained non-compliant with the Betadine hand washing. He had no noted distress and was free from anxiety.On a progress note, dated 5/3/23 at 3:34 p.m., Resident refused Betadine rinse to hands.On 5/4/23 at 6:24 a.m., the Nurse practitioner (NP) had a psychology (psych) visit with Resident 21			

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	for depression, insomnia, and anxiety. The history of patient information (HPI) indicated the resident went home with his family (9/2/23), ended up homeless, and not taking his medications. He was re-admitted to the facility (9/27/23) for long-term care. He reported sleeping poorly, A review of his systems (ROS) indicated regarding his skin, he had skin lesions (tissue which had suffered damage) from scratching. Treatment included Silvadene 1% topical and Temovate (clobetasol) 0.05% topical ointment. The plan was to increase Trazodone to 150 mg orally every night at bedtime. The NP ordered a Buspar increase to 15 mg orally three times a day (TID).On 5/24/23 at 2:53 p.m., the facility provided Resident 21's Weekly Skin and Vital Sign Assessments (weekly skin assessment). The documents indicated: in order to complete staff were to obtain and record vital signs, perform a pain assessment and a complete head to toe skin assessment, paying particular attention to area of bony prominence and the feet. Staff were to indicate any areas of skin integrity alteration the resident currently has: (Options: skin tears, open areas, marks, bruises, discoloration/rashes (redness and spots on the skin), dry/cracked lips, dry mucous membranes and none of the above.a. On 10/04/22, the weekly skin assessment			

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	indicated he did not have skin tears, open areas, marks, bruises, discoloration/rashes, dry/cracked lips, or dry mucous membranes.b. The weekly skin assessment for 10/11/22 was not completed. c. The weekly skin assessment for 10/18/22 was not completed. d. On 10/25/22, , the weekly skin assessment indicated he did not have skin tears, open areas, marks, bruises, discoloration/rashes, dry/cracked lips, or dry mucous membranes.e. On 11/1/22, the weekly skin assessment indicated marks on both arms.f. On 11/8/22, the weekly skin assessment indicated open areas: scabs to bilateral upper extremities (BUE) with no signs or symptoms of infection. g. The weekly skin assessment for 11/15/22 was not completed. h. On 11/22/22, the weekly skin assessment indicated self-inflicted open areas of small scabs to BUE and nose, i. On 11/29/22, the weekly skin assessment indicated self-inflicted open areas of small scabs to BUE and nose, j. On 12/6/22, the weekly skin assessment indicated open areas of scabs to BUE, nose and face with no signs or symptoms of infection. k. The weekly skin assessment for 12/13/22 was not completed. l. On 12/20/22, the weekly skin assessment indicated self-inflicted marks: scabs to BUE and face with no signs or symptoms of infection.m. On 12/27/22, the weekly skin assessment indicated			

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	self-inflicted marks: scabs to BUE and face with no signs or symptoms of infection.n. On 1/3/23, the weekly skin assessment indicated marks: scratches on ankles and arms.o. On 1/10/23, the weekly skin assessment indicated open areas: scabs to BUE, no signs or symptoms of infection.p. On 1/17/23, the weekly skin assessment indicated discoloration/rashes: rash on arm and ankles. q. On 1/24/23, the weekly skin assessment indicated he did not have skin tears, open areas, marks, bruises, discoloration/rashes, dry/cracked lips, or dry mucous membranes.r. On 1/31/23, the weekly skin assessment indicated self-inflicted marks: scabbed areas to nose, BUE, BLE. and back with no signs or symptoms of infection.s. On 2/7/23, the weekly skin assessment indicated marks: scabs to the BUE and BLEt. On 2/14/23, the weekly skin assessment indicated: open areas, scratches and scabs.u. On 2/21/23, the weekly skin assessment indicated marks, scratches to the BLE and BLEv. On 2/28/23, the weekly skin assessment indicated he did not have skin tears, open areas, marks, bruises, discoloration/rashes, dry/cracked lips, or dry mucous membranes.w. On 3/7/23, the weekly skin assessment indicated he did not have skin tears, open areas, marks, bruises, discoloration/rashes, dry/cracked lips, or dry			

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	mucous membranes.x. On 3/14/23, the weekly skin assessment indicated self-inflicted open areas: scabs to nose, BUE, and BLE with no signs or symptoms of infection. y. On 3/21/23, the weekly skin assessment indicated skin discoloration/rashes: self-inflicted scabs to BUE, BLE and nose with no signs or symptoms of infection.z. On 3/28/23, the weekly skin assessment indicated skin discoloration/rashes: rashes on arms and legs/ankles.aa. On 4/4/23, the weekly skin assessment indicated skin discoloration/rashes: rashes on legs and arms. Did not include open areas. bb. On 4/11/23, the weekly skin assessment indicated skin discoloration/rashes: rashes on arms and legs. Did not include open areas. cc. On 4/18/23, the weekly skin assessment indicated discoloration/rashes: rashes and spots on legs and arms. Did not include open areas.dd. On 4/25/23, the weekly skin assessment indicated discoloration/rashes: rashes on legs and arms. Did not include open areas.ee. The weekly skin assessment for 5/2/23 was not completed. ff. On 5/9/23, the weekly skin assessment indicated discoloration/rashes: continued to have rashes on legs and arms. Did not include open areas.gg. On 5/16/23, the weekly skin assessment indicated discoloration/rashes: rashes on legs and			

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	arms. Did not include open areas.hh. On 5/23/23, the weekly skin assessment indicated discoloration/rashes: rashes on legs and arms. Did not include open areas.A concluding statement on the Weekly Skin Assessment indicated if any new areas were found during the weekly skin assessment process, please complete a New Skin Event. All existing areas of skin alteration will be assessed at least weekly by the designated IDT (interdisciplinary team member) and documented in the electronic medical record under Wound Management or on a Non-Ulcer Skin Event. A current policy, titled, "Procedure for Alteration in Skin Integrity - Pressure and Non-Pressure," was provided by the DON, on 5/25/23 at 3:10 p.m. A review of the policy indicated, " ...Alterations in skin integrity will be reported to the MD/NP ...Treatment orders will be obtained from MD/NP ...A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate intervention implemented ...interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors ...any skin alterations noted by direct care given during daily care and/or shower days must be reported to the licensed nurse for further assessment ...."A current policy, titled, "IDT			

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	(Interdisciplinary Team) Comprehensive Care Plan Policy," dated 10/2019, was provided by the Executive Director (ED), on 5/24/23 at 12:22 p.m. A review of the policy indicated, " ...Each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident need ...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input ...."3.1-37(a)			
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 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.			

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	Based on observation, interview, and record review, the facility failed to assess a resident who had limitations in his right shoulder related to a history of falling on his shoulder with surgery and provide necessary treatment and services to prevent potential worsening of the limitation and injury of his right shoulder for 1 of 1 resident reviewed for physical limitations (Resident 9). Findings include: During an interview with Resident 9 on 5/22/23 at 11:08 a.m., he indicated he had a fall prior to admitting to the facility and fractured his right arm and tore his rotator cuff. Resident 9 demonstrated his limitations to the right arm by attempting to raise his arm above his head and he could not raise his arm completely. Resident 9 indicated he was right-handed. During an interview with Resident 9 on 5/23/23 at 2:13 p.m., he indicated he had a shower the evening prior. The unidentified aide caring for him sat in the shower room and did not assist him with his shower. He indicated he needed help due to the limitation and pain of his right shoulder. On 5/23/23 at 2:30 p.m., a record review was completed for Resident 9. He had diagnoses, which included but were not limited to atrial fibrillation, gout, benign prostatic hypertrophy, weakness, repeated falls, obstructive sleep apnea, depression, and hypertension. Resident 9's Minimum Data Set (MDS) assessment section G, dated 3/7/23, indicated he did not have limitations with any range of motion of his extremities. The MDS indicated Resident 9 required extensive assistance of two persons with bathing and extensive assistance of one with	F 0688	**F688 (D) Increase/Prevent Decrease in ROM/Mobility** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 9 was assessed for limitations in his right shoulder and necessary treatment and services have been provided to prevent potential worsening of the limitation and injury of his right shoulder. Care plans were updated as indicated. · Resident 9 had a right shoulder x-ray, MRI completed, therapy evaluation completed, and completed a follow-up with Orthopedic Physician. Treatment and services provided per MD orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by this deficient practice. · MDS coordinator was educated on coding as related to range of motion.	06/20/2023

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	personal hygiene. Resident 9's care plans were reviewed. His care plan indicated he required assistance with Activities of Daily Living (ADLs) related to muscle weakness, history of falls, atrial fibrillation, and CHF (Congestive Heart Failure). The goal indicated he wanted to improve in his current functional status. Interventions included to assist him with dressing, grooming, hygiene as needed, assist with bathing as needed per resident's preference, and offer showers two times per week with partial baths in between. During an interview with the MDS Coordinator on 5/24/23 at 10:32 a.m. she indicated she did not code Resident 9 as having limitations because it did not affect his ability to perform ADLs. During an interview with the Executive Director (ED) and Director of Nursing (DON) on 5/24/23, they indicated they were not aware of Resident 9's history of surgery to his right shoulder. Resident 9 was referred to therapy. Therapy recommended restorative nursing upon completion of treatment. The aides were to complete restorative nursing for Resident 9 as recommended by therapy. The ED indicated the aides were not documenting restorative nursing for the resident. A policy titled, "Restorative Nursing Program," dated 3/2011, was provided by ED on 5/22/23 at 2:31 p.m., it indicated ... "Purpose, to provide a nursing program for residents who no longer need skilled therapy, but still have functional goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function as his or her optimal level withing the given environment. These programs facilitate the use of		· All residents were reviewed to ensure coding as it relates to range of motion is accurate. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · MDS coordinator was educated on coding as related to range of motion. · Residents will be reviewed quarterly and upon significant change to ensure proper treatment and services are provided to prevent potential worsening of limitations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	skills that are present but not utilized unless compensations or adaptations are provided and designed to foster maximum independence in functional activities. 3.1-42(a)(1)			
F 0689 SS=F 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, interview, and record review, the facility failed to ensure hot water temperatures were safe for 4 of 7 resident rooms reviewed for excessive hot water temperatures, and failed to ensure a resident who was at risk for falls with a history of repeated falls had appropriate fall interventions in place to prevent the potential for additional falls (Resident 2). Findings include: 1. During a tour with the Maintenance Supervisor, on 5/21/23 at 2:14 p.m., several resident rooms were checked for excessive hot water temperatures in resident bathrooms. a. Room 109 water temperature was 125.3 degrees Fahrenheit (F). b. Room 111 water temperature was 133.1 degrees F. c. Room 321 water temperature was 128.4 degrees F.	F 0689	**F689 (F) Free of Accident Hazards/Supervision/Devices accommodation of needs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All facility mixing valves were replaced and water temps tested to ensure water temperatures were within safe range in all areas of the	06/20/2023

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	d. Room 322 water temperature was 131 degrees F. On 5/21/23 at 2:28 p.m., the Maintenance Supervisor indicated he knew the facility needed the mixing valves rebuilt. At least he was hoping to get the mixing valves rebuilt. They have been "acting up" for the last few months. If he turned the mixing valve clockwise it should cool down the resident water temperatures. He indicated he adjusted the mixing valve "a little bit" and for the most part that worked. On 5/21/23 at 2:30 p.m., Resident 32 indicated the water in his bathroom was "way too hot." On 5/21/23 at 2:32 p.m., the water monitoring maintenance logs were reviewed with water temperatures above the normal parameters on the following dates: a. On 2/17/23, Room 315's hot water temperature was 123.6 degrees F. No water adjustments were indicated. b. On 2/24/23, Room 208's hot water temperature was 121.2 degrees F. No water adjustments were indicated. c. On 3/3/23, Room 322's hot water temperature was 123.2 degrees F. No water adjustments were indicated. d. On 3/7/23, Room 109's hot water temperature was 128 degrees F, Room 111's hot water temperature was 126 degrees F, and Room 318's hot water temperature was 122 degrees F. No water adjustments were indicated. e. On 3/14/23, Room 309's hot water temperature was 130.5 degrees F and Room 317's hot water temperature was 132.8 degrees F. No water adjustments were indicated. f. On 3/24/23, Room 106's hot water temperature was 121.4 degrees F, Room 109's hot water temperature was 126.6 degrees F, and Room 319's		facility. · The correct wheelchair was provided to resident 2 which had anti-rollbacks and auto lock brakes. The incorrect chair was removed from the resident room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All water temperatures were tested after repair was complete to ensure safe water temperatures throughout facility. · Maintenance Director/Designee will conduct an all-staff in-service on water temperature guidelines, notification, and work. · An audit of all fall interventions was completed to ensure appropriate interventions are in place. · All C.N.A. assignment sheets and care plans updated to ensure proper DME, and interventions are in place. · DNS/Designee conducted an in-service for all nursing staff on fall interventions and proper DME. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	hot water temperature was 121.5 degrees F. Water adjustments were indicated. g. On 3/29/23, Room 311's hot water temperature was 121.4 degrees F. No water adjustments were indicated. h. On 4/4/23, Room 205's hot water temperature was 120.2 degrees F. No water adjustments were indicated. i. On 5/2/23, Room 111's hot water temperature was 123.6 degrees F, Room 202's hot water temperature was 127.7 degrees F, Room 203's hot water temperature was 125.9 degrees F, Room 208's hot water temperature was 121.8 degrees F, Room 304's hot water temperature was 122.9 degrees F, Room 305's hot water temperature was 123.6 degrees F, and Room 322's hot water temperature was 125.2 degrees F. Water adjustments were indicated. j. On 5/18/23, Room 102's hot water temperature was 122.8 degrees F, Room 103's hot water temperature was 124.6 degrees F, Room 106's hot water temperature was 125.4 degrees F, Room 202's hot water temperature was 125.1 degrees F, and Room 206's hot water temperature was 120.2 degrees F. Water adjustments were indicated. On 5/21/23 at 2:51 p.m., the Executive Director (ED) indicated the Maintenance Supervisor would adjust the mixing valves and recheck the resident hot water temperatures again. On 5/21/23 at 2:53 p.m., the Mechanical Room 1 was observed. The Maintenance Supervisor indicated the boiler temperature was set at 189 degrees Fahrenheit (F). The water from the boiler went directly to the hot water heaters. They had no temperature gauges. From the hot water heaters, the water went to the mixing valve, then the kitchen and the rest of the building. The mixing valve was set at 133 degrees F. He		· DNS/Designee will conduct an in-service with nursing staff regarding fall interventions and care plans. · A daily rounding tool to be utilized by Care Companions/Department managers to ensure proper interventions are in place. · Maintenance Director/Designee will conduct an all staff in service on water temperature guidelines, notification, and work orders. · Maintenance Supervisor/designee will conduct water temperature checks weekly to ensure temperatures are between 100-120 degrees. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	indicated he would turn the mixing valve clockwise to turn the hot water temperature down. On 5/21/23 at 2:58 p.m., the Mechanical Room 2 was observed. The Maintenance Supervisor indicated it had no boiler. The water came in through the recirculation lines. There were 2 mixing valves, one temperature gauge read 127 degrees F, and the second read 128 degrees F. The water went directly to the residents' rooms from there. If the hot water temperatures were too hot he would adjust the mixing valves and wait for the water to recirculate, but he did not log the temperature rechecks for the resident rooms. The facility had many EDs recently, and it made it difficult to get the company to pay for expensive mixing valves. He did not have enough in his budget to buy them himself. On 5/21/23 at 3:06 p.m., the shower rooms were checked. a. The 300 Hall shower area sink temperature was 133 degrees F, and the shower was 133.5 degrees F. b. The 100 Hall shower area sink temperature was 126.7 degrees F, and the shower was 121 degrees F. On 5/22/23 at 9:37 a.m., the ED indicated a plumbing services company was in the building checking on the mixing valves. On 5/22/23 at 9:40 a.m., the Maintenance Supervisor indicated the plumbing services company replaced one mixing valve on 5/21/23 in the boiler room. On 5/22/23 at 9:45 a.m., the Maintenance Supervisor provided documentation of checked and rechecked hot water temperatures from			

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	5/21/23 evening and the morning of 5/22/23. Two resident rooms' 321 and 322 were too hot. The Maintenance Supervisor adjusted the mixing valve. The plumbing services company arrived at 6:40 p.m. Left to get a mixing valve at 9:30 p.m. and finished the repair at 10:25 p.m. Eight resident rooms were checked after the mixing valve was replaced and all were within normal parameters. On 5/22/23, starting at 6:00 a.m., 12 resident rooms were checked and were all within normal parameters. On 5/22/23 at 2:45 p.m., four resident rooms were rechecked with the Maintenance Supervisor. Room 109's water temperature was still above the acceptable level at 123.2 degrees F. The Maintenance Supervisor indicated he did not understand why it was too high and he would adjust the mixing valve again. On 5/23/23 at 10:45 a.m., the ED indicated the plumbing services company was at the facility to determine long term fixes for the old building. On 5/25/23 at 12:19 p. m., the ED provided a copy of the Maintenance Supervisor job description. A review of the document indicated, " ...The Maintenance Supervisor is responsible for providing maintenance services to create a safe, sanitary, and homelike environment for residents, staff, and the public ...Essential Position Functions ...Tests facility hot water system on regular basis to evaluate water temperatures in essential location of facility ...." A current policy titled, "Water Borne Pathogen Prevention Policy, dated April 2018, was provided by the Maintenance Supervisor, on 5/26/23 at 1:34 p.m. A review of the policy indicated the, " ...The facility utilizes its preventive program and Water			

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	Management team to monitor the building water system. The facility has an on-call maintenance program so that when issues are identified staff is able to contact a member of the water management team ...."2. On 5/23/23 at 9:15 a.m., Resident 2's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, weakness, repeated falls, abnormal posture and need for continuous supervision. As of the review date of 5/23/23, Resident 2 had current physician's order for anti-roll backs and an auto-lock brake system to be installed on her wheelchair. A nursing progress note, dated 5/21/23 at 5:48 a.m., indicated Resident 2 was observed by staff as she self-transferred onto her wheelchair. "Wheelchair flipped and resident sat on floor." The resident stated she did not know how the wheelchair flipped but she was ok. An interdisciplinary team (IDT) progress note, dated, 5/22/23 at 10:57 a.m., reviewed Resident 2's fall. A description of the fall: "Resident was seen transferring self into wheelchair when the wheelchair tipped causing resident to sit on the floor in front of wheelchair. Resident immediately assessed with no injuries noted, resident did not hit her head. Resident has been approved by therapy to transfer self." Determined root cause of fall: "Appears that wheelchair was not locked, and wheelchair was not stable for resident to transfer into wheelchair." Intervention put in place to address root cause of fall: "Auto-lock brakes to be placed on wheelchair." Resident 2 had a comprehensive care plan, initiated 5/19/16 and revised 5/22/23. The care plan			

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	indicated Resident 2 was at risk for falls related to her age, her history of falls, generalized weakness and that was unaware of her physical limitation at times. Interventions for the plan of care included, but were not limited to anti-roll backs, auto-lock brakes, and dycem to wheelchair. On 5/22/23 at 11:13 a.m., Resident 2 was initially observed. She was seated in a regular wheelchair, in the main dining room. The wheelchair did not have anti-roll backs and/or an auto lock brake system in place. There was no pressure reducing cushion, and no dycem (a thin rubber layer to help prevent cushion from sliding) in place. On 5/22/23 at 2:16 p.m., Resident 2 was observed in the same wheelchair, without anti-roll back or auto-locks in place. On 5/23/23 at 9:06 a.m., Resident 2 was observed as she independently maneuvered in the same wheelchair. She was in the front main entrance lobby at that time. There were no anti-roll backs or an auto-lock brake system in place. On 5/23/23 10:10 a.m., Resident 2 remained in the same wheelchair. She was in the main dining room area. She used her foot to push herself slowly back and forth, which created a rocking motion in her wheelchair. There were no anti-roll backs, or an auto-lock brake system in place. On 5/2423 at 2:00 p.m., Resident 2 was observed with the Director of Nursing (DON). The DON looked at the back of the wheelchair and underneath the seat. She indicated there were no anti-roll backs or an auto-lock brake system installed on the wheelchair. On 5/24/23 as 2:06 p.m., The Regional Clinical			

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	Consultant (RCC) 20, the DON, and Executive Director (ED) indicated Resident 2 was not in the proper wheelchair. They found Resident 2's wheelchair which was sitting outside of a room in the hallway. Upon observation, her wheelchair did have anti-roll backs and an auto-lock brake system installed. The DON indicated she did not know why Resident 2 was not in the appropriate wheelchair. On 5/24/23 at 2:15 p.m., the DON provided a copy of current facility policy titled, "Fall management Policy," revised 8/2022. The policy indicated, "It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls ... the residents specific care requirements will be communicated to the assigned caregiver utilizing resident profile or CNA assignment sheet ...." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to ensure residents' respiratory tubing and equipment was functional, dated, and stored properly for 2 of 2 residents reviewed for	F 0695	**F695 (D) Respiratory/Tr**	06/20/2023

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	respiratory care (Residents 17 and 40), and the facility failed to ensure a resident's oxygen was administered at the proper liters per minute for 1 of 2 residents reviewed for respiratory care (Resident 40). Findings include: 1. On 5/21/23 at 11:32 a.m., Resident 17 was observed receiving oxygen at 4 liters per minute (lpm) via nasal cannula (NC). The humidity bottle on the oxygen concentrator was undated and the tubing was twisted and kinked closed. His nebulizer mouthpiece was uncovered. On 5/22/23 at 10:37 a.m., Resident 17 was observed receiving oxygen at 4 lpm via nasal cannula. The humidity bottle on the oxygen concentrator was undated and the tubing was twisted and kinked closed. On 5/23/23 at 10:01 a.m., Resident 17 was observed receiving oxygen at 4 lpm via nasal cannula. His nebulizer mask was uncovered. On 5/23/23 at 10:58 a.m., Resident 17's record was reviewed. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation (sudden onset worsening), acute respiratory failure with hypoxia (reduced oxygen levels in the blood), diabetes mellitus (blood sugar disorder), acute kidney failure, and heart failure. His physician's orders included, but were not limited to: a. Albuterol sulfate 90 mcg/actuation aerosol inhaler. Use every 6 hours as needed, 2 puffs, inhalation for wheezing b. Albuterol sulfate 2.5 mg /3 mL (0.083 %)		**acheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 17 and 40 had humidity bottles and tubing changed, dated, and ensured equipment was functional. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents on oxygen have the potential to be affected by the alleged deficient practice. · DNS/Designee will conduct an in-service related to Oxygen therapy and devices. · An audit of all humidity bottles and tubing was conducted and ensured all equipment was functional, appropriately dated, and stored properly. · An audit of all residents who receive oxygen was reviewed to ensure the oxygen was administered per MD order. · A daily rounding tool to be utilized by Care Companions/Department managers to ensure proper interventions are in place.	

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	solution for nebulizer. Every 6 hours, 3 mL, inhalation, for COPD. c. Mucinex (guaifenesin) 600 mg tablet extended release, every 12 hours, twice a day for acute respiratory failure with hypoxia. d. Hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg tablet. Every 6 hours as needed for moderate to severe pain. His care plan goals as of 5/23/23 included: a. He will have adequate respiratory functions as evidenced by decreased or absence of dyspnea (labored breathing), improved breath sounds, decreased or absence of shortness of breath, improved oximetry (oxygen saturation) results. B. He will maintain adequate tissue perfusion as evidenced by blood pressure within normal limits for resident, no change in mental status, no complaints of dizziness, lightheadedness, syncope, and no edema. c. He will achieve the highest desired practicable level of physical, emotional, and psychosocial well-being. On 5/24/23 at 9:28 a.m., Resident 17 was observed in the common area lounge. The resident indicated he was out of his room because they were changing out his mattress. He indicated he was out of breath. He had to lay still in bed so he would not be out of breath. He was dressed in a gown tied closed in the back. On 5/24/23 at 9:37 a.m., Licensed Practical Nurse (LPN) 51 checked on Resident 17 after someone else noted he was short of breath. His oxygen (O2) saturation was 90. Resident 17 indicated it usually ran at 92. He was on 4 lpm of O2. On 5/24/23 at 9:42 a.m., LPN 52 provided albuterol sulfate 3 mL for a nebulizer treatment for Resident		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS/Designee will conduct an in-service related to Oxygen therapy and devices. · A daily rounding tool to be utilized by Care Companions/Department managers to ensure oxygen is functional, dated and properly stored. · A daily rounding tool to be utilized by DNS/designee to ensure resident oxygen flow is per MD order. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	17. His physician's orders indicated to provided O2 at 3 lpm per NC and 3 to 5 lpm per NC as needed. To change the nebulizer tubing set and change O2 tubing and humidity on Sundays.2. On 5/21/23 at 11:35 a.m., Resident 40 was observed sitting up on the side of her bed. She had oxygen via a nasal cannula. The tubing was connected to a water bottle that was attached to liquid oxygen. The oxygen was set at 8 liters per minute (lpm). Her tubing was not dated. She had an oxygen concentrator not in use that had a humidified water bottle connected to the concentrator. It was not dated. On 5/22/23 at 10:55 a.m., Resident 40 was observed sitting up in her chair. She had oxygen via a nasal cannula. The tubing was connected to a water bottle that was attached to the liquid oxygen tank. The water bottle was dated 5/20/23 and she had a plastic equipment bag attached to the tank with a date of 5/21/23. There were no contents in the bag. On 5/23/23 at 1:51 p.m., Resident 40 was observed in bed. She no longer had the liquid tank. She received oxygen via nasal cannula that was connected to a water bottle and the oxygen concentrator. The humidified water bottle was not dated. A record review was completed on 5/23/23 at 12:57 p.m. Her diagnoses included, but were not limited to chronic obstructive pulmonary disease, vitamin B12 deficiency, hyperlipidemia, severe protein calorie malnutrition, congestive heart failure, muscle weakness, hearing loss, seasonal allergies, hypertension, and unsteadiness on feet. Resident 40 had current orders for oxygen at 4 to 6 liters per			

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	minute routinely. The care plan, dated 4/4/23, indicated she had the potential for impaired gas exchange related to chronic obstructive pulmonary disease (COPD) which required the head of bed to be elevated to alleviate shortness of breath while lying flat. Interventions included to administer oxygen as ordered and monitor oxygen saturation rates as needed. A policy titled, "Oxygen Therapy and Devices," was provided by the Executive Director (ED) on 5/22/23 at 2:08 p.m. It indicated, " ...Oxygen devices, change out weekly and as needed ...." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to complete a pre and post dialysis observation and ordered weight monitoring for 1 of 1 resident reviewed for dialysis (Resident 18). Findings include: A record review was completed on 5/25/23 at 2:30 p.m. Resident 18 had the following diagnoses, which included, but were not limited to type 2 diabetes mellitus, end stage renal disease, anemia,	F 0698	**F698 (D) Dialysis** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 18 pre and post dialysis observation was	06/20/2023

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	essential hypertension, chronic obstructive pulmonary disease, and myocardial infarction. Resident 18 had current orders to receive hemodialysis every Monday, Wednesday, and Friday. Resident 18's dialysis events were reviewed from March 1, 2023, thru May 25, 2023. The majority of pre and post Dialysis assessments had not been completed. The record lacked documentation of additional pre and/or post dialysis assessments. Resident 18 had previous physician's orders to be weighed daily revised on 5/22/23 This order was changed on 5/22/23 to weigh every Monday, Wednesday, and Friday. Resident 18's weights were reviewed from March 1, 2023, thru May 25, 2023. Multiple weights were missing. Documentation for pre/post dialysis assessments and weights were requested on 5/25/23 at 3:00 p.m. from the Director of Nursing (DON). The documents were not provided by exit. On 5/25/23 at 1:30 p.m., an interview was conducted with the Executive Director (ED) and DON. They were unable to provide the pre and post events and weights requested. A policy titled, "Weights," dated 8/98 was provided by the ED on 5/22/23 at 2:08 p.m. It indicated, " ...It is the policy of this facility to have resident weights reviewed routinely by the Registered Dietician and the Nursing Department. An interdisciplinary team will review any resident who has weight or nutritional concerns ...." A policy titled "Dialysis Care" dated 2/03 was provided by the ED on 5/22/23 at 2:03 p.m. It indicated, " ...Ongoing assessment and oversight		completed, and weights completed as ordered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents receiving dialysis have the potential to be affected by the alleged deficient practice. · There are no other residents on dialysis. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS/Designee will conduct an in-service with all nursing staff related to pre and post dialysis observation completion and obtaining weights as ordered. · DNS/Designee will review previous day dialysis records daily in clinical meeting. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director	

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	of the resident's condition before, during and after treatments, monitoring for complication, implementing appropriate interventions, and using appropriate infection control practice. A dialysis event will be initiated in EMR (Electronic Medical Record) to include the time of transfer and completed on return to the unit ...." 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'		·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0726 SS=D Bldg. 00				

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	needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the nursing staff failed to follow-up with a resident who was short of breath, allowing his oxygen saturation to get to 76% for 1 of 1 random observation of a resident short of breath (Resident 17), and failed to ensure the medication cart was locked and supervised while residents, visitors and staff walked by for 1 of 1 random observation of nursing staff. Finding include: On 5/24/23 at 9:28 a.m., Resident 17 was observed in the common area lounge with his catheter tubing on the floor. The resident indicated he was out here because they were changing out his mattress. He indicated he was out of breath. He indicated he had to lay still in bed, so he was not out of breath. He was dressed in a gown tied closed in the back. On 5/24/23 at 9:37 a.m., Licensed Practical Nurse (LPN) 51 checked on Resident 17 after someone else noted he was short of breath. His oxygen (O2) saturation was 90. Resident 17 indicated it usually ran at 92. His O2 was on at 4 lpm. On 5/24/23 at 9:41 a. m., LPN 52 turned the resident and moved him about 6 feet forward before realizing Foley urinary tubing was dragging the floor. On 5/24/23 at 9:42 a.m., LPN 52 removed an albuterol sulfate 3 mL for a nebulizer treatment for Resident 17. She did not lock the medication cart when she walked away and off the unit. There was no nurse in line of sight of the cart, the nurse's	F 0726	**F726 (D) Competent Nursing Staff** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 17 was provided oxygen at 5 lpm and monitored until 02 saturation was at 90%. · Resident 17 had foley tubing placed so it was not touching the floor. · The medication cart was locked. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · DNS/Designee will conduct an in-service with licensed nurses on proper procedure for follow up of a resident with SOB and monitoring of oxygen saturation. · DNS/Designee will conduct an in-service with nursing staff to ensure foley catheter tubing does not touch the floor. · DNS/Designee will conduct	06/20/2023

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	station was empty. On 5/24/23 at 9:44 a.m., the DON was notified that Resident 17 was not looking well. His head had dropped closer to her chest, and he was not moving or talking. On 5/24/23 at 9:45 a.m., the DON acquired Resident 17's oxygen saturation (O2 sat), it was down to 76%. His heart rate was down to 49 beats per minute (BPM). She tried a different finger, his O2 sat was 81%. On 5/24/23 at 9:47 a.m., the DON changed his O2 to 5 lpm. A few minutes later, his O2 sat was 90%. On 5/24/23 at 10:04 a.m., LPN 52 came out of Resident 17's room and locked the medication cart. She indicated the medication cart should have been locked when she was away. During the 22 minutes the medication cart was unlocked 4 staff members, residents, and visitors had passed by the unlocked, unattended medication cart. On 5/23/23 at 10:58 a.m., Resident 17's record was reviewed. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation (sudden onset worsening), acute respiratory failure with hypoxia (reduced oxygen levels in the blood), diabetes mellitus (blood sugar disorder), acute kidney failure, and heart failure. His physician's orders included, but were not limited to: a. Albuterol sulfate 90 mcg/actuation aerosol inhaler. Use every 6 hours as needed, 2 puffs, inhalation for wheezing. b. Albuterol sulfate 2.5 mg /3 mL (0.083 %) solution for nebulizer. Every 6 hours, 3 mL,		an in-service with nursing staff to ensure all medication carts remain locked when unattended. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS/Designee will conduct an in-service with licensed nurses on proper procedure for follow up of a resident with SOB and monitoring of oxygen saturation. · DNS/Designee will conduct an in-service with nursing staff to ensure foley catheter tubing does not touch the floor. · DNS/Designee will conduct an in-service with nursing staff to ensure all medication carts remain locked when unattended. · DNS will round daily to ensure medication carts are locked, and resident is monitored for oxygen saturation at 90% or more. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	

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	inhalation, for COPD. c. Mucinex (guaifenesin) 600 mg tablet extended release, every 12 hours, twice a day for acute respiratory failure with hypoxia. d. Hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg tablet. Every 6 hours as needed for moderate to severe pain. Current care plan goals as of 5/23/23 included but were no limited to: a. He will achieve the highest desired practicable level of physical, emotional, and psychosocial well-being. b. He will have adequate respiratory functions as evidenced by decreased or absence of dyspnea (difficulty breathing), improved breath sounds, decreased or absence of shortness of breath, improved oximetry (blood oxygen levels) results. c. He will maintain adequate tissue perfusion as evidenced by (AEB) blood pressure within normal limits for Resident 17. He will have no changes in mental status, no complaints of dizziness, lightheadedness, syncope (fainting), and no edema (swelling). d. He will have catheter care managed appropriately AEB not exhibiting signs of urinary tract infection or urethral trauma. A care plan, dated 5/17/23, indicated Resident 17 was at risk for impaired gas exchange related to COPD. He will have adequate respiratory functions as evidenced by decreased or absence of dyspnea (labored breathing), improved breath sounds, decreased or absence of shortness of breath, improved oximetry (O2 sat) results. Nursing approaches were to administer oxygen as ordered, monitor oxygen sat rates as needed/ordered, nebulizer treatments as ordered, observe for non-verbal signs of anxiety such as furrowed brows, pacing, change in mental status,		Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	behaviors. Resident 17's current physician's orders, as of 5/23/23, indicated to provided O2 at 3 lpm per NC and 3 to 5 lpm per NC as needed, to change the nebulizer tubing set, and change O2 tubing and humidity on Sundays. A current policy, titled, "Storage and Expiration Dating of Medications, Biologicals," was provide by the Executive Director (ED), on 5/25/23 at 12:19 p.m. A review of the policy indicated, " ...Facility should ensure that all medication and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors ... A current policy, titled, "Indwelling Urinary Catheters - Suprapubic or Urethral," was provided by the Executive Director (ED), on 5/22/23 at 2:03 p.m. A review of the policy indicated no nursing instructions to keep the catheter bag or tubing off of the floor. 3.1-14(i)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring;			

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	or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to administer a medication for high blood pressure as needed when a resident's blood pressure was elevated for 1 of 5 residents reviewed for medications (Resident 18). Findings include: A record review was completed on 5/25/23 at 2:30 p.m. Resident 18 had the following diagnoses but not limited to type 2 diabetes mellitus, end stage renal disease, weakness, seizures, neuropathy, absence of left leg below knee, benign prostatic hypertrophy, anemia, essential hypertension, chronic obstructive pulmonary disease, depression, and myocardial infarction. As of the review date of 5/25/23, Resident 18 had a current order to administer hydralazine 10 milligrams (mg) daily as needed for a systolic blood pressure greater than 150 and a diastolic blood pressure (BP) greater than 90. Review of the April 2023 and May 2023 Medication Administration Records indicated Resident 18 did not receive the medication when	F 0757	**F757 (D) Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 18 received a new order. Order reads: Obtain BP, if greater than 150 SBP or greater than 90 DBP, administer PRN hydralazine, if no relief notify MD and make progress note. · Resident 18 is receiving all medications as ordered. Care plan updated. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	06/20/2023

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	his blood pressure (BP) was documented as elevated on the following days: 5/25/23 with a BP of 164/94 5/22/23 with a BP of 158/90 5/21/23 with a BP of 160/95 5/19/23 with a BP of 158/96 5/18/23 with a BP of 168/90 5/17/23 with a BP of 158/90 5/15/23 with a BP of 157/98 5/12/23 with a BP of 156/92 5/11/23 with a BP of 158/98 5/8/23 with a BP of 160/90 5/6/23 with a BP of 179/91 5/5/23 with a BP of 162/90 5/4/23 with a BP of 160/90 5/3/23 with a BP of 160/98 5/2/23 with a BP of 168/90 4/30/23 with a BP of 168/92 4/29/23 with a BP of 168/90 4/20/23 with a BP of 162/90 4/15/23 with a BP of 162/92 4/7/23 with a BP of 179/94 During an interview with the Executive Director (ED) and Director of Nursing (DON) on 5/25/23 at 2:45 p.m., the DON indicated she was unaware of the order to administer the medication for an elevated blood pressure. A policy was requested, and the ED indicated they did not have a policy for physician orders. 3.1-48(a)(1)-(6) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)		**corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Full audit of medication administration for blood pressure to be completed by DNS/Designee. · DNS/Designee will conduct an in-service with all licensed nurses and QMAs on medication administration. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The DNS/designee will review the previous day medication administration records daily in clinical meeting to ensure residents received blood pressure medication based on parameters per MD order. · DNS/Designee will conduct an in-service with all licensed nurses and QMAs on medication administration related to blood pressure parameters. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality	

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			Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a medication cart remained locked while unauthorized residents and visitors passed it for 1 of 1 random	F 0761	**F761 (E) Label Store Drugs**	06/20/2023

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	observation, and further failed to ensure a resident did not have medications in his room without a self-administration assessment for 1 of 1 resident reviewed for self-administration assessments (Resident 17). Findings include: 1. On 5/24/23 at 9:42 a.m., Licensed Practical Nurse (LPN) 52 was observed removing a 3 milliliter (mL) albuterol nebulizer treatment medication for Resident 17. She did not lock the medication cart when she walked away and off the unit. There was no nurse in line of sight of the cart, the nurse's station was empty. On 5/24/23 at 9:42 a.m., Mattress Company Employee 71 was at the facility to change out several mattresses. He was observed standing near the unlocked and unattended medication cart. On 5/24/23 at 9:44 a.m., Resident 17 was observed outside his room in a wheelchair, waiting for his nebulizer treatment and new mattress. On 5/24/23 at 9:45 a.m., the DON acquired Resident 17's oxygen saturation (O2 sat) near the unlocked medication cart. On 5/24/23 at 9:49 a.m., LPN 52 returned with PPE (personal protective equipment), took Resident 17 into his room for an albuterol nebulizer treatment. The medication cart was still observed to be unlocked and unattended. Resident 4 was observed in her wheelchair in the hall. LPN 4 walked past the unlocked medication cart. On 5/24/23 at 9:52 a.m., Mattress Company Employee 71 was observed going in the out of		**and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:** · The medication cart was locked. · A Room sweep was conducted to ensure no medications are at bedside. · All licensed nurses and QMA's were educated on medication storage policy. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy. · All resident rooms were searched with permission to ensure no medications were at bedside by DNS/Designee. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:**	

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	resident rooms facilitating the mattress changes. He remained on the hallway with the unlocked and unattended medication cart. On 5/24/23 at 9:53 a.m., Resident 4 was observed to stop in front of the unlocked and unattended medication cart for several seconds, then she continued self-propelling herself down the hallway. On 5/24/23 at 9:55 a.m., Mattress Company Employee 71 passed in front of unlocked and unattended medication cart again. On 5/24/23 at 10:01 a.m., the DON passed in front of the unlocked and unattended medication cart. On 5/24/23 at 10:02 a.m., the DON passed in front of the unlocked and unattended medication cart going the other way. On 5/24/23 at 10:03 a.m., Clinical Dietitian Assistant 72 passed by the unlocked and unattended medication cart. On 5/24/23 at 10:04 a.m., LPN 52 came out of Resident 17's room and locked the medication cart. She indicated the medication cart should have been locked when she was away. 2. On 5/24/23 at 11:02 a.m., Allergy Relief (diphenhydramine - antihistamine) 25 mg bottle was found on the floor, in front of his bedside table, of Resident 17's room. On 5/24/23 at 11:20 a.m., showed LPN 5 the bottle of Allergy Relief pills on the floor in front of his bedside table. She indicated they should not have been in his room. She asked Resident 17 why they were in his room. He indicated he forgot he had		· DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage. · A daily rounding tool including medication storage will be utilized by nurse managers to ensure medications are properly stored. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **The facility respectfully requests a face-to-face IDR of this deficiency related to scope and severity.**	

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	them. A current policy titled, "Storage and Expiration Dating of Medications, Biologicals," was provide by the Executive Director (ED), on 5/25/23 at 12:19 p.m. A review of the policy indicated, "...Facility should ensure that all medication and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors...." 3.1-25(i)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure supplies and	F 0812	**F812 (E) Food**	06/20/2023

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	foods were stored appropriately, food was dated and labeled, the kitchen was sufficiently cleaned, sinks were not leaking in kitchen area, and the dumpster lids were closed for 1 of 1 days of kitchen observation. Findings include: On 5/21/23 at 10:14 a.m., Cook 12 provided a tour of the kitchen. In the dry storage area: a. Two boxes of plastic utensils were open to the air with the inner plastic bag around the outside of the boxes. b. A bag of pork flavored gravy mix was open to the air. c. A bag of Quaker grits, with no open date, was rolled down and not sealed. The reach-in refrigerator: a. A large plastic container of gravy had no label or date. b. A large container of American cheese was not dated. c. Five single serving containers of pureed bread were not dated. Cook 12 indicated he did not know when they were prepared. d. A container of ham salad was dated to expire on 4/28/23. e. A container of romaine lettuce was open to the air. f. A foil wrapped cheddar cheese was opened, the edges of the cheese had dried out. There was no date. The bottom front of the reach-in refrigerator was observed to be spilled upon and had unidentifiable food debris on it. The unused grill portion of the stove top was observed to be		**Procurement, Store/Prepare/ Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · A complete audit of supplies and food items stored in the kitchen was completed. All unlabeled or outdated items were disposed of. · The reach-in refrigerator was cleaned and sanitized. · The stove top and steamer were cleaned and sanitized. · The drywall, grout, and broken tile were repaired. · The three-compartment sink was repaired. · The handwashing sink was repaired. · Trash was removed from around the dumpster and dumpster lid and gate was closed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** · All residents have the potential to be affected by alleged deficient practice. · All dietary staff were in-serviced by the Dietician regarding labeling, dating, and	

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	unclean. The steam catch pan under the steamer was ½ full of dirty, lime water with white residue at the bottom. Cook 12 indicated the kitchen should have been cleaned every evening. The walk-in freezer had a large sausage on the freezer floor. The breadsticks were open with no open date on them. The walk-in refrigerator had hot dogs and sausage in a large container with no dates. A container of shredded carrots was open with no date. A large container the shredded lettuce did not have a date on it. Under the stainless steel table by the dishwasher, drywall, grout, and broken tiles were observed on the floor. The three-compartment sink was leaking and there was standing water on the kitchen floor near the dishwasher. Cook 12 indicated he notified the Maintenance Supervisor three days ago. A handwashing sink near the dishwasher was loose from the wall. A wooden board was observed on the floor. Cook 12 indicated the wooden board was used to hold the handwashing sink against the wall. He turned on the water and indicated the sink leaked water onto the floor because the drain had separated from the wall. The handwashing sink was observed to be very dirty. Cook 12 indicated the MM was well aware of the handwashing sink issues. A full trash bag was observed still open, outside at the back door. Cook 12 picked it up and took it to the dumpster. The recycle dumpster was observed with the lid		storage of non-food and food items in kitchen. · All dietary staff were in-serviced by the Dietician regarding daily cleaning schedule and sanitation practices. · All dietary staff were in-serviced on hand hygiene. · The Maintenance Director conducted an in-service on reporting needed repairs and use of work orders. · The dietary manager/designee inspected the storage of foods to ensure proper storage, kitchen was clean, sinks were in good repair, and dumpster lids were closed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** · Dietary Manager/Designee will do a daily walk through of kitchen to ensure labeling and dating are completed. · Dietary Manager/Designee will check daily cleaning schedule to ensure tasks are completed. · Dietary will check daily to ensure dumpster area is free of trash and lid is closed. · Maintenance Director will complete daily facility rounds to follow up with repairs. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	open. The trash dumpster was observed with the lid open and a lot of trash on the ground. The gate to the dumpster area was not closed. Cook 12 indicated there was so much trash on the ground because the raccoon's get in there and drag out the trash.. On 5/25/23 at 9:37 a.m., Dietary Aide (DA) 56 was observed to wash his hands, he dried them with a paper towel, then turned the faucet off with his bare hand. He was observed making green bean casserole soup. On 5/21/23 at 1:08 p.m.,. the Executive Director (ED) indicated if the Maintenance Supervisor was qualified to do repairs in the building, then he would do it. On 5/21/23 at 1:56 p.m., the Dietary Manager (DM) indicated the plastic utensils should have been covered in box. She indicated the facility really did not use plastic utensils. All foods should have been dated, labeled, and sealed. The kitchen should have been cleaned. The dishwasher area should have been in good repair regarding the drywall, grout, and tile. A current policy titled, "Food Storage," dated 5/23, was provided by the Executive Director (ED), on 5/21/23 at 3:20 p.m. A review of the policy indicated, " ...Leftover prepared foods and processed meats such as lunch meat, are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded ...Refrigerated, ready-to-eat, potentially hazardous food		**recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	155383	A. BUILDING 00 B. WING	05/26/2023

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	purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded ...All foods shall be covered or wrapped tightly, labeled, and dated ...." A current policy titled, "Food Safety," dated 10/22, was provided by the ED, on 5/22/23 at 1:58 p.m. A review of the policy indicated, " ...The Culinary Manager is responsible for providing safe food to all residents ...." A current policy titled, "Cleaning Schedules," dated 5/23, was provided by the ED, on 5/22/23 at 2:27 p.m. A review of the policy indicated, " ...The culinary staff will maintain the sanitation of the culinary department ...." A current policy titled, "Food Storage," dated 5/23, was provided by the ED, on 5/26/23 at 2:37 p.m. A review of the policy indicated, " ...Culinary employees with facial hair must also wear a beard restraint ...." A current policy titled, "Water, Plumbing and Waste," dated 5/23, was provided by the ED, on 5/22/23 at 1:58 p.m. A review of the policy indicated, " ...Refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0882 SS=E Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s)			

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	(IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to designate a qualified person to fulfill the role of the Infection Preventionist (IP) at least part-time. This deficient practice had the potential to effect 54 of 54 residents who resided at the facility. Findings include: During an interview with the and DNS on 5/26/23 at 11:46 a.m., she indicated she had earned a certificate for IP in July of 2019. She indicated she was performing the role of the IP nurse for the facility. The facility assessment was reviewed on 5/26/23 at 12:00 p.m. It indicated there was a position of an IP nurse and next to the position it indicated, "Based on characteristics of facility, does this role need to be dedicated solely to the IPCP (Infection Prevention Control Program)?" A policy titled COVID-19 Policy, dated 9/27/22, was provided by the ED on 5/22/23 at 11:06 a.m.,	F 0882	**F 882 (E) Infection Preventionist Qualifications/ Role** **What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:** · Facility LPN completed the Infection Prevention Certification **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:** · All residents have the	06/20/2023

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	indicated, " ...The facility will follow CMS and IDOH guidelines."		potential to be affected by the alleged deficient practice. · The facility will continue to employ a designated qualified person to fulfill the role of the Infection Preventionist, at least part-time. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** · ED and DNS were educated on the requirement of a designated, qualified person to fulfill the role of the Infection Preventionist, at least part-time. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ·POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **The facility respectfully requests a face-to-face IDR of this deficiency regarding scope and severity.**	

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