STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00406095, IN00407646, and IN00408060. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00406095 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00407646 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00408060 - Federal/state deficiencies related to the allegations are cited at F600. Survey dates: May 15, 16, 17, 18, 19, and 22, 2023 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 40 Other: 5 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 24, 2023	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Hestand	Regional Director of Clinical Operations	06/05/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to provide a speciality cup as ordered by the physician, failed to provide a straw to drink with, failed to keep fluids within reach, and failed to provide a whirlpool bath as preferred for 1 of 2 residents reviewed for hydration and 1 of 5 residents reviewed for shower preferences. (Resident 3 and Resident E). Finding include: 1. During an interview with Resident 3's family member on 5/15/23 at 11:57 a.m., indicated when the family visits the resident does not always have fresh water and the resident would not have a straw to drink out of (no speciality cup observed). The family member indicated the resident could not drink without a straw. Resident 49 was observed to have a styrofoam cup with water and a lid, with no straw to drink from. During an observation on 5/16/23 at 3:25 p.m., Resident 3 was laying in bed with a styrofoam cup with a lid on it and no straw (no speciality cup observed). . During an observation on 5/18/23 at 10:24 a.m., Resident 3 was laying in bed, the resident's water was out of her reach on her bedside table (no speciality cup observed). The resident's call light	F 0558	**Reasonable Accommodations Needs/Preferences** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3: Review completed and resident has fluids in reach with specialty cup and straw. Resident E: preference for whirlpool has been reviewed with resident and updated per plan of care and Kardex. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit and interview of all residents that receive oral hydration and specialty cups to ensure availability of hydration between meals. Any concerns or discrepancies identified were corrected. Initial audit of all residents to	06/05/2023

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	was activated, QMA 11 came in the room. QMA 11 placed the resident's bedside table where the resident could reach her water. During an observation on 5/18/23 at 12:31 p.m., Resident 3 was laying in bed eating lunch. The resident had a styrofoam cup with a lid and no straw (no speciality cup observed). Review of the record of Resident 3 on 5/18/23 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, hypertensive heart disease, age related osteoporosis, dysphagia, hypertension, dementia, muscle weakness and age related debility. The Quarterly Minimum Data Set (MDS) for Resident 3, dated 5/3/23, indicated the resident was severely impaired for daily decision making. The resident required limited assistance of one person for drinking. The plan of care for Resident 3, dated 2/7/23, indicated the resident had the potential for alteration in hydration related to episodes of edema, needing assistance with fluids and poor fluid intake. The physician order for Resident 3, dated 4/14/23, indicated the resident was ordered an adaptive cup with cover/lids. During an interview with the Regional Vice President on 5/18/23 at 1:35 p.m., indicated dietary was responsible to provide Resident 3's speciality cup. The Dietary Manager reported there were new staff in the kitchen and Resident 3's speciality cup got missed. 2. The clinical record for Resident E was reviewed		determine preference related to bathing and showering and updated clinical record to reflect preference. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical staff (Nurse/QMA/CNA) and Dietary staff were educated on the guidelines for Hydration to include but not limited to offering the residents a variety of fluids during and between meals, provide assistance with drinking, ensure specialty cups are available as ordered, and ensure beverages are available and within reach. Education: Clinical staff were educated on the guideline for bathing/showering to include but not limited to ensuring plan of care reflects resident preference. On-going monitoring DNS or Designee will round twice a day to observe and/or interview residents (at least 5/day) to ensure hydration is provided and showers/bathing is completed per residents preference. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.	

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	on 5/17/2023 at 2:33 p.m. The medical diagnoses included local infection of the skin tissue and weakness. A quarterly minimum data set assessment, dated 4/20/2023, indicated Resident E was cognitively intact and was totally dependent on staff for assistance with bathing. A profile task for Resident E, dated 12/7/2022, indicated for Resident E to have whirlpool baths Tuesday evening and Saturday morning. No whirlpool baths were given in the last 30 days upon review. An interview with Resident E on 5/15/2023 at 1:56 p.m. indicated that Resident E preferred to have whirlpool baths due having skin conditions. She felt like this helped with her skin, but she had not had a whirlpool bath in the last 6 weeks per her recall. A policy entitled, "Accommodation of Needs", was provided by the Area Vice President on 5/22/2023 at 4:25 p.m. The policy indicated, " ...Facility staff shall make efforts to reasonably accommodate the needs and preferences of the residents ..." 3.1-3(v)(1)		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,			

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	§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to ensure a physical and verbal abuse event was reported to the Administrator and state agency timely for 1 of 4 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B waas reviewed on 5/16/23 at 9:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, arthritis, cerebral infarction, muscle weakness, and symptoms and signs involving cognitive functions and awareness. Resident B was	F 0607	**F607 Develop/Implement Abuse/Neglect Policies** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B: No longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be**	06/05/2023

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	admitted to the facility on 2/16/23. An Admission Minimum Data Set (MDS) assessment, dated 2/23/23, noted Resident B with moderate cognitive impairment, physical behavioral symptoms directed towards others occurred 1-3 days, verbal behavioral symptoms directed towards others occurred 1-3 days, other behavioral symptoms not directed towards others occurred 1-3 days, "yes" to it interfering with resident's care, "yes" to significantly intruding on the privacy or activity of others, "yes" to significant disruption of care or living environment, and rejection of care within 1-3 days. Resident B required the need of extensive assistance with 2 staff person for bed mobility, transfers, dressing, toilet use, and personal hygiene. A progress note, dated 4/30/23 at 1:43 p.m., indicated the following, "...CNA brought camera from resident room that was positioned to point at his bed. Camera was hidden near TV. Camera removed from resident room, brought to nurses station and battery removed...." An interview conducted with Family Member 8 during the survey indicated Resident B requested his Alexa device to utilize while he was at the facility. He utilized the device at home and since there was no roommate there wasn't the concern for others privacy. During the last week of being at the facility prior to being hospitalized, Resident B had fallen and acting extra anxious while also picking at his arms. Resident B was having behaviors but Family Member 8 wondered why Resident B was yelling and so upset. The facility staff kept mentioning it was dementia, but it seemed like something else was wrong. Family Member 8 had the ability to review the camera		**identified and what corrective action will be taken?** All residents that reside in the facility have the potential to be affected by the same alleged action. The facility completed a 30 day look back and all other allegations of abuse that occurred within the past 30 days were reported per guidelines. No other residents were identified as being affected by the alleged event. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Facility staff in-serviced on the guidelines related to Abuse, Neglect Prevention and Reporting to include but not limited to timely notification to the ED/Abuse Coordinator of any allegation or suspected Abuse. ED or Designee will conduct a random interview/audit of 5 residents weekly x 4 weeks, then 3 Residents x 4 weeks. The residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to the guidelines.	

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	footage that was located on the Alexa device in Resident B's room. Someone was holding Resident B's wrists and when the "other girl" applied a shirt on Resident B he commented "quit holding my arm" and he [male caregiver] didn't. Resident B ended up with bruises to his wrists. The male caregiver commented "I'm so high I could burn you up for supper" and admitted to "being high". He was a new CNA and worked night shift. The male CNA also mentioned "I'm going to put my 10.5 up your butt". The staff were being rough and in a hurry while caring for him. Resident B became sensitive and had distrust with others during his stay. It appeared to be a trauma response. Family Member 8 noticed Resident B was sleeping a lot more recently. Family Member 8 reported the incident when she observed it on the camera footage a couple days after it occurred on 4/30/23. An incident reported to the Indiana State Department of Health survey report system, reported on 5/5/23, indicated Resident B's daughter presented to the facility to pick up a camera located in Resident B's room on 4/30/23 while staff were providing care. The daughter of Resident B allowed the Executive Director (ED) to view a small clip of two Certified Nursing Assistants (CNAs) providing care to Resident B on 4/30/23. One male CNA (CNA 2) entered the room and stated to Resident B "They brought me in here to set you straight, I am going to put my foot up your butt". While female CNA (CNA 4) provided care to Resident B, CNA 2 was observed on video holding Resident B's forearms. CNA 2, before leaving Resident B's room, told Resident B that he would "keep him straight if he continued to hit, kick, and spit, that he would stick his 10.5 up his butt". The follow up, dated 5/10/23, indicated skin assessments were conducted on		ED or Designee to review all allegations of abuse to ensure that incident was reported per facility guidelines. This review will occur with every allegation of abuse x 6 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	Resident B with no concerns noted. Employee education completed on Abuse and Neglect, and reporting policy. CNA 2 was terminated for violation of abuse and CNA 4 was terminated for violation of reporting abuse. An interview conducted with Director of Nursing (DON), on 5/17/23 at 1:30 p.m., indicated she reviewed video footage of CNA 2 grabbing Resident B's wrists during care and she reported such immediately to the Area Vice President. A policy titled "Abuse, Neglect and Exploitation", revised October of 2022, was provided by the Area Vice President on 5/16/23 at 9:52 a.m. The policy indicated the reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. The timeframe listed was immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or no later than 24 hours. 3.1-28(a)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or			

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	discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal			

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	rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the			

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	impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure the appropriate transfer and discharge paperwork provided to a resident upon transfer to an area hospital was included in the resident's clinical record for 2 of 5 residents reviewed for hospitalization. (Resident H and 50) Findings include: 1. Resident H's record was reviewed on 5/16/23 at 3:51 p.m. and indicated Resident H had diagnoses that included, but were not limited to, a bone infection of the vertebra, sacral and sacrococcygeal region, chronic pain syndrome, neuromuscular dysfunction of bladder, type 2 diabetes mellitus, chronic congestive heart failure, weakness on one side, anxiety, depression, pressure ulcer of sacral region, constipation, and urinary tract infection. Progress notes indicated Resident H was sent to the local hospital on the following dates: - 5/17/2023 at 1:40 p.m.: "Resident has been complaining of increased pain. New area on right side of lower butt cheek. Resident has had a bolus of morphine. Is still complaining of pain. Called wound center, wound center has advised that best interest of patient is to send to ER to evaluate.' - 4/14/23 at 8:30 a.m.:	F 0623	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident H and Resident 50: Clinical Staff were educated regarding guidelines for Transfer and Discharge to include but not limited to ensuring resident or responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that reside at the facility have the potential to be affected by the alleged deficient practice related to notification of discharge and timely completion of a discharge summary. The facility completed a seven day look back of all discharges to	06/05/2023

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	"Resident has c/o (complained of) abdominal pain and scrotum pain, urine leakage noted around catheter in brief, clear frothy emesis noted in basin...resident requested to be sent to ER, verbal order received to transport to ER, wife notified and informed, 911 called for transport, report called to (local hospital ER), DON and admin notified." - 4/4/2023 at 8:25 p.m.: "writer and another nurse walked by residents' room and noticed resident was not wearing his 02 @ the time, 2L of 02 via N.C. (nasal cannula) was applied and residents 02 was taken and was 87% at this time. NP (Nurse Practitioner) was called to the bedside and ordered for resident to be sent to ER to be evaluated and treated, and 02 to be increased to 4L. Residents' vitals obtained at this time and are as follows; BP- 120/82, P-80 regular, 02-92% on 4L of 02 via N.C., RR- 20, Temp.- 98.6, resident has a cough and is expiring mucous at this time. Resident is A&O (alert and oriented) x1 @ this time and roommate stated that resident had choked on fluids while trying to drink. Resident's wife was contacted and stated that she will go out to the hospital to be with him, 911 called for transportation, (local) Emergency Department called to give report to nurse, (local) Fire Department arrived at 8:39 AM to transport resident to hospital." - 3/25/2023 at 8:49 p.m.: "Res[ident] adm[itted] to (local) Hosp. Dx. (diagnoses) UTI, (urinary tract infection) Encephalopathy (brain disease) and Hyponatremia (low blood sodium)." Notification in writing to the resident's representative could not be located in the resident's clinical record.		ensure the clinical record include notification of transfer and discharge and discharge summary completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (RN/LPN) were educated on the guideline for Transfer and Discharge to include but not limited to ensuring resident or responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record. On-going monitoring : DNS or designee will review all discharges and transfers to ensure the clinical record includes copy of Notice of Discharge and Transfer and Bed Hold form and completion of discharge summary. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be	

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	155157	A. BUILDING 00 B. WING	05/22/2023

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	On 5/19/23 at 10:50 a.m., the Area Vice President indicated Resident H did not have a transfer and discharge notification in his record for the times he was sent to the hospital. 2. Resident 50's record was reviewed on 5/16/23 at 4:06 p.m. and indicated Resident 50 had diagnoses that included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, schizophrenia, difficulty swallowing, difficulty walking, heart disease, chronic pain syndrome and chronic respiratory failure with low blood oxygen. Progress notes indicated Resident 50 was sent to the hospital on the following days: - 5/10/2023 at 4:47 a.m.: "Resident states he fell in his bathroom and helped himself up off the floor then told the nurse he fell, vitals immediately after the fall was 117/54 94 64 97.6 18 and 15 mins later vitals were 119/45 97 66 97.7 18, on call placed to [Nurse Pratitioner] to state the events in which she stated she would be rounding on him this morning but resident then fell to the ground again in the common area complaining of pain to chest, abdomen and head at 10/10, call placed to 911 and [Nurse Pratitioner] to send to ER for further Evaluation. DON and family aware." - A progress note, dated 5/13/2023 at 11:25 p.m., indicated: Emergency services were in the facility to transport resident to the hospital to be evaluated and treated for chest pain, coughing, and wheezing. He was assisted to the cart and report was called to the emergency room. Resident 50 was also sent to the hospital on 4/27/23, 5/2/23, and 5/13/23.		brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	Notification in writing, of the reason for transfer to the hospital that was provided to the resident's representative could not be located in his clinical record. On 5/19/23 at 10:50 a.m., the Area Vice President indicated Resident 50 did not have a notification in his record for the reason he was sent to the hospital each time. A policy for "Bed Hold Prior to Transfer" was provided, by the Area Vice President, on 5/22/23 at 11:30 a.m. The policy included, but was not limited to, "It is the policy of this facility to provide written information to the resident and /or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. 3.1-12(a)(6)(A)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding			

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	bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide written bed hold information when a resident was sent to the hospital. This affected 2 of 5 residents reviewed for hospitalization. (Residents H and 50) Findings include: 1. Resident H's record was reviewed on 5/16/23 at 3:51 p.m. and indicated Resident H had diagnoses that included, but were not limited to, a bone infection of the vertebra, sacral and sacrococcygeal region, chronic pain syndrome, neuromuscular dysfunction of bladder, type 2 diabetes mellitus, chronic congestive heart failure, weakness on one side, anxiety, depression, pressure ulcer of sacral region, constipation, and urinary tract infection. Progress notes indicated Resident H was sent to the local hospital on the following dates: - 5/17/2023 at 1:40 p.m.: "Resident has been complaining of increased pain. New area on right side of lower butt cheek. Resident has had a bolus of morphine. Is still	F 0625	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident H and Resident 50: Clinical Staff were educated regarding guidelines for Transfer and Discharge to include but not limited to ensuring resident or responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that reside at the facility have the potential to be affected by the alleged deficient practice related to notification of	06/05/2023

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	complaining of pain. Called wound center, wound center has advised that best interest of patient is to send to ER to evaluate.' - 4/14/23 at 8:30 a.m.: "Resident has c/o (complained of) abdominal pain and scrotum pain, urine leakage noted around catheter in brief, clear frothy emesis noted in basin...resident requested to be sent to ER, verbal order received to transport to ER, wife notified and informed, 911 called for transport, report called to (local hospital ER), DON and admin notified." - 4/4/2023 at 8:25 p.m.: "writer and another nurse walked by residents' room and noticed resident was not wearing his 02 @ the time, 2L of 02 via N.C. (nasal cannula) was applied and residents 02 was taken and was 87% at this time. NP (Nurse Practitioner) was called to the bedside and ordered for resident to be sent to ER to be evaluated and treated, and 02 to be increased to 4L. Residents' vitals obtained at this time and are as follows; BP- 120/82, P-80 regular, 02-92% on 4L of 02 via N.C., RR- 20, Temp.- 98.6, resident has a cough and is expiring mucous at this time. Resident is A&O (alert and oriented) x1 @ this time and roommate stated that resident had choked on fluids while trying to drink. Resident's wife was contacted and stated that she will go out to the hospital to be with him, 911 called for transportation, (local) Emergency Department called to give report to nurse, (local) Fire Department arrived at 8:39AM to transport resident to hospital." - 3/25/2023 at 8:49 p.m.: "Res[ident] adm[itted] to (local) Hosp. Dx. (diagnoses) UTI, (urinary tract infection) Encephalopathy (brain disease) and Hyponatremia (low blood sodium)."		discharge and timely completion of a discharge summary. The facility completed a seven day look back of all discharges to ensure the clinical record include notification of transfer and discharge and discharge summary completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (RN/LPN) were educated on the guideline for Transfer and Discharge to include but not limited to ensuring resident or responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record. On-going monitoring : DNS or designee will review all discharges and transfers to ensure the clinical record includes copy of Notice of Discharge and Transfer and Bed Hold form and completion of discharge summary. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	Notification of bed hold information. in writing to the resident's representative, could not be located in the resident's clinical record. On 5/19/23 at 10:50 a.m., the Area Vice President indicated Resident H did not have the bed hold information in his clinical record for the dates he was sent to the hospital. 2. Resident 50's record was reviewed on 5/16/23 at 4:06 p.m. and indicated Resident 50 had diagnoses that included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, schizophrenia, difficulty swallowing, difficulty walking, heart disease, chronic pain syndrome and chronic respiratory failure with low blood oxygen. Progress notes indicated Resident 50 was sent to the hospital on the following days: - 5/10/2023 at 4:47 a.m.: "Resident states he fell in his bathroom and helped himself up off the floor then told the nurse he fell, vitals immediately after the fall was 117/54 94 64 97.6 18 and 15 mins later vitals were 119/45 97 66 97.7 18, on call placed to [Nurse Practitioner] to state the events in which she stated she would be rounding on him this morning but resident then fell to the ground again in the common area complaining of pain to chest, abdomen and head at 10/10, call placed to 911 and [Nurse Practitioner] to send to ER for further Evaluation. DON and family aware." - A progress note, dated 5/13/2023 at 11:25 p.m., indicated: Emergency services were in the facility to transport resident to the hospital to be evaluated and treated for chest pain, coughing, and wheezing. He was assisted to the cart and report was called to the emergency room.		**recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	Resident 50 was also sent to the hospital on 5/10/23, 5/2/23 and 4/27/23. Notification in writing of the bed hold information could not be located in his clinical record. On 5/19/23 at 10:50 a.m., the Area Vice President indicated Resident 50 did not have documentation of the bed hold information when he was sent to the hospital. A policy for "Bed Hold Prior to Transfer" was provided by the Area Vice President on 5/22/23 at 11:30 a.m. The policy included, but was not limited to, "It is the policy of this facility to provide written information to the resident and /or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave...The facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed -hold and reserve bed payment policy well in advance of being transferred to the hospital or when taking therapeutic leave of absence from the facility...The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences...." 3.1-12(a)(25)[A] 3.1-12(a)[25)(B)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 0641	**F 641 Accuracy of Assessment**	06/05/2023

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	Based on interview and record review, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessment regarding to mood and behavior for 1 of 2 residents reviewed for dementia care (Resident B), the use of corrective lenses for 1 of 2 residents reviewed for vision (Resident 26), and complete the pain assessment portion for 1 of 3 residents reviewed for pain (Resident H). Findings include: 1. The clinical record for Resident B was reviewed on 5/16/23 at 9:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, arthritis, cerebral infarction, muscle weakness, and symptoms and signs involving cognitive functions and awareness. Resident B was admitted to the facility on 2/16/23. An Admission Minimum Data Set (MDS) assessment, dated 2/23/23, noted Resident B with moderate cognitive impairment, physical behavioral symptoms directed towards others occurred 1-3 days, verbal behavioral symptoms directed towards others occurred 1-3 days, other behavioral symptoms not directed towards others occurred 1-3 days, "yes" to it interfering with resident's care, "yes" to significantly intruding on the privacy or activity of others, "yes" to significant disruption of care or living environment, and rejection of care within 1-3 days. Resident B required the need of extensive assistance with 2 staff persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. A quarterly MDS assessment, dated 4/13/23, indicated Resident B did not exhibit any physical, verbal, or other behaviors during the lookback		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B: no longer resides at the facility. Resident 26: 4/26/23 MDS assessment was corrected to reflect that resident utilizes reflective lenses. Resident H: Clinical record was reviewed and updated to reflect a completed pain assessment/interview in the clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Residents with glasses, Behaviors and pain risk have the potential to be affected by the same alleged deficient practice. Initial audit: The facility completed an initial review of residents with glasses to determine those that need assistance and ensured their plan of care was updated to reflect that need. The facility completed an initial review of residents with behaviors of disrobing, agitation and	

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	period of the MDS assessment. A behavior note, dated 4/11/23 at 5:51 a.m., indicated Resident B was being verbally and physically aggressive. Resident B was hitting, scratching, kneeing the CNAs, and cursing at them during care. The intervention attempted was the staff asking Resident B not to hit and curse along with talking through care with the CNAs. The interventions were listed as "not effective". No other interventions were documented as attempted when redirection did not appear to be successful. A behavior note, dated 4/12/23 at 5:46 a.m., indicated Resident B was yelling and cursing at CNA. Resident B attempted to knee the CNA and hit her. The intervention attempted was attempted redirection and talk Resident B through being changed. The interventions were listed as "not effective". No other interventions were documented as attempted when redirection did not appear to be successful. A behavior note, dated 4/13/23 at 5:57 a.m., indicated Resident B was hitting and cursing at CNAs, as well as attempting to bite them while they were trying to change his incontinent product and sheets that were soiled. The interventions attempted were "Resident asked very nicely not to do that and to be nice". The intervention was listed as not effective. No other interventions were documented as attempted when redirection did not appear to be successful. A behavior note, dated 4/26/23 at 5:44 a.m., indicated Resident B was hitting, biting, kicking, and cursing at staff during care. Staff attempted to talk to the resident and let him know everything they were doing. Resident B was asked if he was		wandering to ensure their plan of care included interventions for staff to utilize with behavior. The facility completed an initial review of residents triggered for pain management to ensure assessment/interview for pian was current. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff were educated on the Guidelines for Pain Management, Accommodation of needs and Dementia Care to include but not limited to accuracy of assessment. On-going monitoring : MDS or designee will review 5-10 MDS per week depending on quantity to submit for accuracy to include corrective lenses, Dementia/behaviors and pain assessment/interviews. These reviews to be conducted weekly x 4 weeks, then every other week x 4 weeks, then monthly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	in pain, and if there was anything the facility staff could do to help. The interventions were listed as not effective. No other interventions were documented as attempted when redirection did not appear to be successful. 2. The clinical record for Resident 26 was reviewed on 5/17/23 at 4:00 p.m. The diagnoses included, but were not limited to, anxiety disorder, muscle weakness, depressive episodes, and anemia. A care plan for vision, initiated on 6/13/2020, indicated Resident 26 was at risk for vision impairment and wears glasses on occasion. A progress note, dated 12/9/22 at 12:31 p.m., indicated Optometry came to the facility and delivered glasses to Resident 26. They were adjusted to fit. A quarterly MDS assessment, dated 4/26/23, indicated Resident 26 was cognitively intact, her vision was adequate, and marked "no" for corrective lenses. An interview conducted with Resident 26, on 5/16/23 at 3:29 p.m., indicated she was able to see through her glasses without any issue. An interview conducted with MDS Coordinator, on 5/22/23 at 12:04 p.m., indicated the MDS assessments for Resident 26 and Resident B were marked incorrectly in regards to vision and behavior. She did corrections for both residents. The expectations are to follow the Resident Assessment Instrument (RAI) manual. 3. Resident H's record was reviewed on 5/16/23 at 3:51 p.m. and indicated Resident H had diagnoses that included, but were not limited to, a bone infection of the vertebra, sacral and		**recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	sacrococcygeal region, chronic pain syndrome, neuromuscular dysfunction of bladder, type 2 diabetes mellitus, chronic congestive heart failure, weakness on one side, anxiety, depression, pressure ulcer of sacral region, constipation, and urinary tract infection. A Significant Change Minimum Data Set (MDS) assessment, dated 4/27/23, indicated Resident H was cognitively intact, is on a scheduled pain med regimen, received as needed pain medications, did not receive non-medication interventions for pain, and a pain assessment interview should be conducted but there were no answers in the pain assessment interview. Care plan: Last revised 1/20/23: Focus: "PAIN: Needs Pain management and monitoring related to: Chronic pain syndrome, pressure ulcer, spondylosis. Resident does have pain pump. Goals: Patient will achieve acceptable pain level goal through the next review. Interventions: Administer Pain medication as ordered. Evaluate need to provide medications prior to treatment or therapy. Observe for potential medication side effects. Utilize pain monitoring tool to evaluate effectiveness of interventions. warm compress to affected area." Physician's orders for pain management: Resident can receive Morphine 1.250 milligrams via bolus up to 6 times daily with a dose restriction of 1 bolus every 4 hours. Start date 4/28/2023 Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for pain or discomfort, maximum dose of			

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	acetaminophen is 3,000 mg from all sources in 24 hours AND Give 2 tablet by mouth every 4 hours as needed for Temp Greater than 100.4 Dated 4/24/2023 Biofreeze External Gel 4 %, Apply to bilateral legs topically every 6 hours as needed for pain and discomfort. Start date 4/19/2023 Lidocaine External Patch 4 %, Apply to back topically two times a day for pain and discomfort Don't use patch more than 8 hours and remove per schedule. 4/20/2023 During an interview, on 5/22/23, at 10:35 a.m., the Area Vice President indicated the nurses didn't complete the pain assessment for Resident H on the MDS for 4/27/23. On 5/22/23, at 11:30 a.m., the Area Vice President indicated they go by the Resident Assessment Instrument Manual for their policy on completing the MDS.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest			

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	practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to develop a care plan for Resident E's use of medication to treat her hypothyroidism and failed to develop a care plan for constipation for a resident with a diagnosis of constipation for 2 of 5	F 0656	**F656 Comprehensive Care Plan** **What corrective actions will be accomplished for those residents found to have been affected by the deficient**	06/05/2023

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	residents reviewed for unnecessary medications. (Resident E and Resident H) Findings include: 1. During an interview, on 5/15/23 at 2:55 p.m., Resident H indicated he has always had problems with constipation and said he has gone 10 days sometimes without a bowel movement. Resident H's record was reviewed on 5/16/23 at 3:51 p.m. and indicated Resident H had diagnoses that included, but were not limited to, a bone infection of the vertebra, sacral and sacrococcygeal region, chronic pain syndrome, neuromuscular dysfunction of bladder, type 2 diabetes mellitus, chronic congestive heart failure, weakness on one side, anxiety, depression, pressure ulcer of sacral region, constipation, and urinary tract infection. A Significant Change Minimum Data Set assessment, dated 4/27/23, indicated Resident H was cognitively intact, did not walk, is always incontinent of bowels, had no constipation, and is on a scheduled pain medication regimen. Resident H had a physician's order for Morphine, which has a high risk for constipation, 1.250 mg via bolus up to 6 times daily with a dose restriction of 1 bolus every 4 hours. Start date: 4/27/23. On 5/22/23, at 1:52 p.m., the Area Vice President provided a copy of a care plan for "Potential for drug related complications associated with use of psychotropic medications" and indicated that is the only care plan they have that addresses constipation. The care plan did not address goals or interventions for constipation.		**practice?** Resident: E: Care plan was reviewed and updated to reflect residents use of medication to treat hyperthyroidism Resident H: Care plan was reviewed and updated to reflect residents' diagnosis of constipation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed an audit of residents with a diagnosis for constipation and hypothyroidism to ensure the residents plan of care accurately reflected the diagnosis and interventions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical Staff (Nurses) were educated on the guideline for development of Comprehensive Care plan to include but not limited to ensuring diagnosis for constipation and hyperthyroidism is included in the plan of care. On-going monitoring: DNS or	

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	2. The clinical record for Resident E was reviewed on 5/17/2023 at 2:33 p.m. The medical diagnosis included hypothyroidism. A quarterly minimum data set assessment, dated 4/20/2023, indicated Resident E was cognitively intact. A physician order for Resident E, dated 12/15/2022, indicated the use of medication for hypothyroidism to be given daily. No care plan was located for the use of this medication or management of Resident E's hypothyroidism. An interview with the Area Vice President on 5/22/2023 at 11:45 a.m. indicated that there was no care plan for Resident E's medication or management of her hypothyroidism. A policy entitled, "Comprehensive Care Plans", was provided by the Area Vice President on 5/22/2023 at 11:30 a.m. The policy indicated, " ...The comprehensive care plan will describe, at a minimum, the following ...The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." 3.1-35(a)		designee will audit new orders and diagnosis for constipation and hyperthyroidism to ensure the plan of care is updated in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:			

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	(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure the discharge summary was completed in full for 1 of 3 closed records reviewed. (Resident 54) Findings include: The clinical record for Resident 54 was reviewed on 5/22/23 at 11:22 a.m. The diagnoses included, but were not limited to, neoplasm of prostate, muscle weakness, hypertension, anxiety disorder, and secondary malignant neoplasm of bone.	F 0661	**F 661 Discharge Summary** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident H and Resident 50: Clinical Staff were educated regarding guidelines for Transfer and Discharge to include but not limited to ensuring resident or	06/05/2023

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	A discharge summary, dated 3/17/23, was not completed in regard to summary of stay, functional mobility, continence, nutrition, activities, skin condition(s), medication information, treatments, community resource guide for any follow-up in regards to Resident 54's care. An interview conducted with Area Vice President, on 5/22/23 at 1:46 p.m., indicated Resident 54's discharge was prior to them arriving at the facility. She was not sure why the discharge summary wasn't completed in full. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(b)		responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that reside at the facility have the potential to be affected by the alleged deficient practice related to notification of discharge and timely completion of a discharge summary. The facility completed a seven day look back of all discharges to ensure the clinical record include notification of transfer and discharge and discharge summary completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (RN/LPN) were educated on the guideline for Transfer and Discharge to include but not limited to ensuring resident or responsible party received Notice of Discharge and Transfer and Bed Hold form, and discharge summary completed in clinical record.	

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			On-going monitoring : DNS or designee will review all discharges and transfers to ensure the clinical record includes copy of Notice of Discharge and Transfer and Bed Hold form and completion of discharge summary. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution			

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	was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on interview, observation, and record review, the facility failed to ensure Resident D's corrective lenses were in place for 1 of 2 residents reviewed for corrective lenses. Findings included: The clinical record for Resident D was reviewed on 5/17/2023 at 1:34 p.m. The medical diagnoses	F 0676	F 676 Activities of Daily Living **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D: Clinical record was reviewed and the Kardex was updated to indicate that resident	06/05/2023

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	included a history of a stroke affecting the left non-dominant side and weakness. A quarterly minimum data set assessment, dated 3/8/2023, indicated that Resident D was cognitively intact and needed extensive assistance from staff for dressing and transferring activities of daily living. A vision care plan, dated 6/23/2021, indicated for Resident D to receive assistance with placement and cleaning of her glasses as needed. An observation and interview on 5/16/2023 at 10:43 a.m. with Resident D indicated she was sitting in her wheelchair in the common area and did not have her eyeglasses in place. She indicated the staff had forgotten them in her room that morning and she was unable to propel herself back to get them. An observation of Resident D on 5/16/2023 at 12:03 p.m. indicated she was still in her wheelchair at this time and still did not have her glasses placed. A policy entitled, "Hearing and Vision Services", was provided by the Area Vice President on 5/22/2023 at 11:30 a.m. The policy indicated, " ...Employees will assist the resident with the use of any device or adaptive equipment needed to maintain vision and hearing ..." 3.1-38(a)(1)		requires assistance with use of glasses **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that require assistance with glasses have the potential to be affected by the alleged deficient practice. Initial audit: The facility completed an audit of all residents to identify those that need assistance with glasses to ensure services are provided per the plan of care. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (Nurses/Aides) educated on the guideline for Activities of Daily Living to include but not limited to assisting residents with doning and doffing glasses. On-going monitoring: DNS or Designee will round on 3 residents that require assistance with ADL needs to ensure residents are receiving assistance with glasses. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then	

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			weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0677 SS=E 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 interview, observation, and record review, the facility failed to ensure Resident D, F, and G had their facial hair shaved per their preference and failed to provide nail care for dependent residents (Resident J and H) for 5 of 9 residents reviewed for activities of daily living (ADL) care. Findings include: 1. The clinical record for Resident D was reviewed on 5/17/2023 at 1:34 p.m. The medical diagnoses included a history of a stroke affecting the left	F 0677	**F 677 ADL Care provided for dependent resident** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D: Clinical record was reviewed and the Kardex was updated to indicate that resident requires assistance with grooming of facial hair.	06/05/2023

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	non-dominant side and weakness. A quarterly minimum data set assessment, dated 3/8/2023, indicated that Resident D was cognitively intact and needed extensive assistance from staff with personal hygiene activities of daily living. An observation and interview on 5/16/2023 at 10:43 a.m. with Resident D indicated she was sitting in her wheelchair in the common area with white facial hair on her chin. She indicated she did not like to have facial hair and the staff would shave her, but only on shower days if she asked. An observation of Resident D on 5/17/2023 at 1:30 p.m. indicated she was still in her wheelchair at this time and still had white facial hair on her chin. 2. The clinical record for Resident F was reviewed on 5/17/2023 at 10:55 a.m. The medical diagnosis stroke and lack of coordination. A minimum data set assessment, dated 3/10/2023, indicated Resident F was cognitively intact and needed assistance with his personal hygiene activity of daily living. An interview and observation of Resident F on 5/16/2023 at 11:06 a.m. indicated he had long facial hair. He indicated he did not like to have a beard but preferred to be clean shaven. He indicated the staff do not assist him regularly with shaving and it had been "sometime" since someone last shaved him. An observation of Resident F on 5/16/2023 at 3:04 p.m. indicated he continued to have long facial hair at this time. 3. The clinical record for Resident G was reviewed on 5/17/2023 at 11:45 a.m. The medical diagnoses		Resident F: Clinical record was reviewed and the Kardex was updated to indicate that resident requires assistance with grooming of facial hair. Resident G: Clinical record was reviewed and the Kardex was updated to indicate that resident requires assistance with grooming of facial hair. Resident J: Clinical record was reviewed and the Kardex was updated to indicate that resident requires assistance with nail care Resident H: Clinical record was reviewed and the Kardex was updated to indicate that resident requires assistance with nail care **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents that require assistance with facial hair grooming and nail care have the potential to be affected by the alleged deficient practice. Initial audit: The facility completed an audit of all residents to identify those that need assistance with facial hair grooming and nail care ensure services are provided per the plan of care/Kardex. **What measures will be put into place and what systemic**	

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	included chronic pain and muscle weakness. A quarterly minimum data set assessment, dated 2/20/2023, indicated that Resident G was cognitively intact and needed assistance with her personal hygiene activity of daily living. An observation and interview on 5/15/2023 at 1:32 p.m. indicated that Resident G was in her room at this time. She had long white hair to her chin and upper lip. She indicated that staff would usually assist her with shaving on her shower days but had not today. She stated the facial hair does bother her and when she was at home, she would shave the areas daily in the morning. An observation on 5/16/2023 at 2:20 p.m. indicated Resident G in her room at this time with continued white facial hair. 4. During an interview, on 5/15/23 at 2:29 p.m., Resident H indicated his fingernails need trimmed. His fingernails were observed to long and had a brown substance under the nails. On 5/16/23 at 3:30 p.m., Resident H was in bed watching TV, his fingernails were long with a brown substance under the nail. Resident H's record was reviewed on 5/16/23 at 3:51 p.m. and indicated Resident H had diagnoses that included, but were not limited to, a bone infection of the vertebra, sacral and sacrococcygeal region, chronic pain syndrome, neuromuscular dysfunction of bladder, type 2 diabetes mellitus, chronic congestive heart failure, weakness on one side, anxiety, depression, pressure ulcer of sacral region, constipation, and urinary tract infection. A Significant Change Minimum Data Set		**changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (Nurses/Aides) educated on the guideline for Activities of Daily Living to include but not limited to assisting residents with facial hair grooming and nail care . On-going monitoring: DNS or Designee will round on 3 residents that require assistance with ADL needs to ensure residents are receiving assistance facial hair grooming and nail care . These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	assessment, dated 4/27/23, indicated Resident H was cognitively intact, required extensive to total assist of two for activities of daily living, including bathing and personal hygiene. A care plan, dated 1/5/23, indicated: "DIAGNOSIS: Resident has personal history of Stroke/TIA with dominant right sided hemiplegia. Goal: Will maintain current level of function through next review. Revised on 1/2023 Interventions: Assist in ADL's and mobility as needed...Monitor ADL's for assistance and render care as needed. (1/05/2023) He has a care plan that he prefers bed baths to showers. There was no documentation in the Kardex or point of care that resident had refused care. On 5/19/23, at 10:52 a.m. the Area Vice President indicated it should be on point of care/Kardex if they refuse care like having their fingernails trimmed. 5. On 5/16/23 at 11:07 a.m., Resident J's fingernails on both hands were observed to be long and had a light brown substance under most of the nails. Resident J shook his head "no" when asked if the nails are the length he liked, and shook his head yes when asked if he liked them shorter. On 5/16/23 at 3:35 p.m., Resident J was observed in bed, watching TV, his fingernails were long with a brown substance under the nails. Resident J's record was reviewed on 5/17/23 at 11:23 a.m. and indicated diagnoses that included, but were not limited to, weakness on one side, following cerebral infarction affecting right			

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	dominant side, type 2 diabetes mellitus with diabetic neuropathy, difficulty speaking and swallowing, right hand contracture, and heart disease. On 5/17/23 at 12:50 p.m., Resident J was in bed, eating lunch, His fingernails were observed to have a soiled brown substance under them. A Significant Change Minimum Data Set assessment, dated 4/7/23, indicated Resident J required extensive assistance of 2 for personal hygiene and was totally dependent on staff for bathing. A care plan for activities of daily living, last revised on 1/14/2022, indicated a problem for a physical functioning deficit related to muscle weakness due to right sided weakness from a stroke, type 2 diabetes with neuropathy, peripheral vascular disease, left below the knee amputation, and neurogenic bladder. Interventions included, but were not limited to: "DIABETIC: Nurse to do nail care PRN". On 5/19/23 at 10:13 a.m. resident shook his head "Yes", when asked if he likes his fingernails shorter. His nails were observed to be long with a brown substance under the nails. On 5/19/23 at 10:30 a.m., CNA 10 indicated he refuses nail care when she tries to trim them. On 5/19/23 at 10:52 a.m. the Area Vice President indicated it should be on point of care Kardex if a resident refuse care, for example, his fingernails trimmed. Review of behaviors documented in the Kardex indicated he had not refused any care in the last			

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	30 days. Res refused showers on 5/18/23, 5/17/23, 5/16/23, 5/11/23, and several other days, a bed bath was given, he prefers bed baths. A Policy for "Activities of Daily Living (ADLs)", was provided by the Area Vice President on 5/19/23 at 9:15 a.m. The policy included, but was not limited to, "The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition,, grooming, and personal and oral hygiene...: This Federal deficiency relates to Complaint IN00407646 and IN00406095. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental,			

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	and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review the facility failed to provide an ongoing activity program for 2 of 2 residents reviewed for activities (Resident 11 and Resident 3). Findings include: 1.) During an observation on 5/15/23 at 11:41 a.m., Resident 11 was laying in bed awake, with no TV or radio playing. During an observation on 5/16/23 at 3:28 p.m., Resident 11 was sitting in the common area, not engaging in any type of activity. During an observation on 5/17/23 at 3:41 p.m., Resident 11 was laying in bed awake, there was no TV or radio playing. During an observation on 5/18/23 at 10:22 a.m., Resident 11 was sitting in the common area, not engaging in any type of activity. Review of the record of Resident 11 on 5/18/23 at 3:35 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral palsy, spastic hemiplegia, diabetes, aphasia, profound intellectual disabilities, hypertension and pain. The Annual Minimum Data Set assessment (MDS) for Resident 11, dated 2/19/23, indicated it was very important for the resident to listen to music, be around animals, keep up with the news, do things with groups of people, participate in his favorite activity, go outside for fresh air and participate in religious services.	F 0679	**F 679 Activities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3 and 11 have been interviewed regarding their activity preference. Resident 3 and 11 activity care plan will be updated regarding activities of their interest. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** An audit has been completed to identify any other resident affected. All residents affected will be interviewed regarding their activity preferences. Resident activity care plan will be reviewed and updated. **What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur.**	06/05/2023

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	During an interview with the Administrator on 5/18/23 at 12:45 p.m., indicated Resident 11 had no documented activities for the past three months. 2.) During an interview with Resident 3's family member on 5/15/23 at 11:48 a.m., indicated Resident 3's TV had not been on for three weeks. The family member indicated she had reported to multiple staff that the TV was not working. The family member indicated the resident was elderly and the only thing she really enjoyed doing for activities was watch TV. Observation the resident's TV was turned on with no signal available. During an observation on 5/16/23 at 3:25 p.m., Resident 3 was laying in bed awake, the TV was not on. During an observation and interview on 5/17/23 at 12:46 p.m., Resident 3 was laying in bed awake with no TV on, interview with the Administrator indicated she was unaware of the resident's TV not working and would report it to Maintenance. During an interview with the Maintenance Director on 5/17/23 at 12:50 p.m., indicated Resident 3's TV was not broke, but had not been on the correct input and that is why is had not worked. During an interview with the Administrator on 5/18/23 at 12:50 p.m., indicated there were no documented activities for Resident 3 for the past three months. During an interview with the Administrator on 5/18/23 at 1:35 p.m., indicated activity staff were responsible to ensure residents TV or music was		Activity Director educated on proper programming and will attend an Activity Director program course within six months of employment. Activity Director will submit activity participation in PCC. ED or designee will review three residents to ensure residents have a documented activity program care planned and occurring. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How will 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).** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	playing in their rooms. Review of the record of Resident 3 on 5/17/23 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, displaced intertrochanteric fracture of the left femur, difficulty walking, lack of coordination, muscle weakness, repeated falls, intellectual disabilities, age related osteoporosis and depression. The plan of care for Resident 3, dated 2/7/23, indicated the resident preferred independent activities or spending time with my family rather than doing things in groups. The resident liked looking out the window in her room, listening to music and having the TV on. The Activity policy provided by the Administrator on 5/18/23 at 2:20 p.m., indicated the facility would provide an ongoing program to support residents in their choice of activities. The activities would be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial well-being. 3.1-33(a)			
F 0684 SS=D 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.	F 0684	F684 Quality of Care	06/05/2023

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	Based on interview and record review the facility failed to follow up and ensure a resident had proper preparation prior to a procedure resulting in the procedure not being able to be completed, failed to complete neurological assessments after a resident fell and hit his head, failed to apply a palm protector as ordered by the physician, apply a rolled towel as ordered by the physician, and failed to obtain weekly weights for congestive heart failure (CHF) for 1 of 7 residents reviewed for accidents, 1 of 4 residents reviewed for quality of care, 1 of 2 residents reviewed for positioning/mobility, and 1 of 8 residents reviewed for nutrition. (Resident 20, Resident 36, Resident J and Resident 35) Findings include: 1. During an interview with Resident 20 on 5/15/23 at 1:16 p.m., indicated she was suppose to have a scope last week and the facility did not follow the appropriate prep work prior to the scope. The resident indicated she went to the hospital to have the procedure done and they sent her back to the facility because she had received medication she was not suppose to of had prior to the procedure. During an interview with the Director Of Nursing (DON) on 5/17/23 at 1:52 p.m., indicated Resident 20 had reported to her that the nurse gave her medicine she was suppose to have on hold and that she had to reschedule her procedure. The DON indicated she had not had a chance to look into the situation. Review of the record of Resident 20 on 5/17/23 at 3:00 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, anxiety, insomnia, major depression, muscle		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 20: Residents clinical record was reviewed and updated with date for procedure and prep orders obtained and entered in the clinical record. Resident 36: Staff were educated on guideline for completing neuro assessment post fall as indicated in the guidelines. Clinical record was reviewed. Resident J: Residents clinical record was reviewed for orders for splinting and positioning. Resident 35: Clinical record was reviewed and order updated to reflect weight to be obtained per physicians orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility audited all diagnostic procedure orders to ensure any orders for pre procedure prep were entered in the clinical record. Facility completed a 7 day look back of events to ensure that neuro checks were completed if indicated. Facility audited orders for	

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	weakness and delusional disorder. The Significant Change Minimum Data Set (MDS) assessment for Resident 20, dated 4/17/23, indicated the resident was cognitively intact for daily decision making. The local hospital after visit summary for Resident 20, dated 4/13/23, indicated the resident was to have a gastrointestinal procedure on 5/11/23. The progress note for Resident 20, dated 5/9/23 at 10:02 a.m., indicated the local hospital called to give pre-procedure instructions. The resident was to have an endoscopy on 5/11/23 and to arrive at the hospital at 8:30 a.m. The surgeon wanted the resident to have no solid food after 12 noon on 5/10/23, the resident could have clear liquid until midnight the night before. The physician also did not want the resident to take any over the counter medications, vitamins or diabetic medications the day of the procedure. The Medication Administration Record (MAR) for Resident 20, dated May 2023, indicated the resident received potassium, multivitamin, clonazepam (antianxiety medication), eliquis (blood thinner), buspar (antianxiety) and protonix at 8:00 a.m., on 5/11/23. The food consumption for Resident 20, dated 5/10/23, indicated resident ate 76-100 % of lunch and supper. During an interview with the Unit Manager on 5/19/23 at 11:00 a.m., indicated Resident 20 was not able to get her procedure on 5/11/23 because she was suppose to have her eliquis (blood thinner) held for two days. The facility was unable to find the pre op orders for the procedure.		splinting, positioning, and weights to ensure physician orders were followed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff (Nurses and Aides) were educated on the guidelines for Provision of Quality Care and Provision of Physician ordered services to include but no limited to ensuring the plan of care and physician orders are followed. Clinical staff (Nurses) were educated on the guideline for Head Injury to include but not limited to completing Neurological Assessments as indicated post event. On-going monitoring DNS or Designee will review orders for diagnostic testing to ensure pre procedure orders are entered in the clinical record and followed per physician orders. DNS or Designee will audit fall events to ensure if head injury is suspected that neuro checks were initiated per guidelines. DNS or Designee will observe residents with orders for splinting to ensure splints are in place per orders. DNS or Designee will review residents with orders for routine	

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	Nursing would be responsible to follow up with the hospital to ensure the orders were in place for what was to be held or not done. The order should have been clarified. Dietary should have been notified and an order put in for the clear liquid diet. 2. Review of the resident 36 on 5/18/23 at 4:20 p.m., indicated the resident's diagnoses included, but were not limited to, pulmonary fibrosis, protein calorie malnutrition, schizoaffective disorder, profound intellectual disabilities, dysphagia, osteoporosis and polyneuropathy. The post fall evaluation for Resident 36, dated 12/21/22 at 4 a.m., indicated the resident had unwitnessed fall states he fell out of bed. The resident had bump present above left temple that was sore to touch. During an interview with the Administrator on 5/19/23 at 1:50 p.m., indicated Resident 36 did not have any neurological assessments after his fall on 12/21/22 when he hit his head. The facility neurological assessment protocol provided by the Administrator on 5/19/23 at 2:00 p.m., indicated neurological checks would be preformed every 15 minutes four times, then every thirty minutes four and times, then hourly four times, then every eight hours for 72 hours. The incidents and accidents policy provided by the Administrator on 5/19/23 at 2:10 p.m., indicated in the event of an unwitnessed fall or a blow to the head, the nurse would initiate neurological checks per protocol and document on the neurological flow sheet. Abnormal findings would be reported to the practitioner.		weights for timely completion and documentation in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	3. The clinical record for Resident 35 was reviewed on 5/16/2023 at 3:45 p.m. The medical diagnosis included congestive heart failure. A Quarterly Minimum Data Set Assessment, dated 3/2/2023, indicated Resident 35 was cognitively intact. A cardiovascular care plan, dated 8/28/2021, indicated to monitor Resident 35's weights. A physician order, dated 4/14/2023, indicated to obtain Resident 35's weight weekly on Tuesday. The administration record for Resident 35 indicated that her weight was not obtained on 5/2/2023, 5/9/2023, and 5/16/2023. An interview with the Area Vice President on 5/22/2023 at 11:30 a.m. indicated that the scale was down when she started in the building on 3/27/2023 and was repaired by the new maintenance director on 5/5/2023. She was unsure why the weights had not been obtained on 5/9/2023 or 5/16/2023. 4. On 5/16/23, at 11:06 a.m., Resident J was observed in bed, his right hand was contracted and his splint was lying on the over bed table. There was no rolled towel between his chest and his right arm. On 5/16/23 at 3:35 p.m., Resident J was observed in bed, watching TV and he had no splints on his hands. He did not have a rolled towel under his right arm. On 5/17/23 at 12:50 p.m., Resident J was observed in bed, eating lunch. He did not have his splint on.			

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	When asked if he has had his splint on today, he shook his head "No". He did not have a rolled towel between his right arm and chest. Resident J's record was reviewed on 5/17/23 at 11:23 a.m. The record indicated Resident J had diagnoses that included, but were not limited to, right dominant side paralysis after a stroke, unable to speak, type 2 diabetes mellitus with diabetic neuropathy, hypertensive heart disease, and a right hand contracture. A Significant Change Minimum Data Set assessment, dated 4/7/23, indicated he required extensive assist of 2 for personal hygiene, was completely dependent on 2 staff for bathing, he had impairment on one side of upper extremities - shoulder, elbow, wrist and hand - in functional limitations of range of motion, and did not receive restorative nursing including splints. A care plan, with a revision date of 1/20/23, indicated a focus for: "I am at risk for skin impairment r/t (related to muscle weakness, needing assistance with skin care and positioning, increase moisture (incont), episodes of dry skin, refusing adl care at times...Goal: My skin integrity will remain intact through next review period...Splinting instructions for contracture management: Pt will wear right palm protector and be positioned with rolled towel between pt's chest and right arm up to 24 hrs as tolerated. Remove twice daily for hygiene and ROM as tolerated. Check skin prior to placement daily at 0800. Date Initiated: 04/03/2023...." Physician's orders included: "Splinting instructions for contracture			

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	management: Pt (patient) will wear right palm protector and be positioned with rolled towel between pt's chest and right arm up to 24 hrs as tolerated. Remove twice daily for hygiene and ROM (range of motion) as tolerated. Check skin prior to placement daily at 0800 every day and evening shift." Start date: 4/8/2023 "Wash inside right hand once daily with soap and water and dry completely between each finger due to contractures. Dry, Clean, rolled wash cloth to be placed in hand to help maintain skin integrity every day shift." Start date: 4/6/2023 Review of behaviors and refusals, that were documented in the Kardex, indicated Resident J had not refused any care in the last 30 days. During an interview, on 5/19/23, at 10:20 a.m., LPN 21 indicated they wash his right hand with soap and water and place a rolled up wash cloth in his hand. She didn't see if he uses a splint, then checked his physician's orders and said that he did wear a splint, and said he uses a soft splint, it is off twice a day, and placed on at 8 a.m. During an interview, on 5/19/23, at 10:30 a.m., CNA 22 indicated 3rd shift took off the hand splint on their last round this morning, but he can remove it himself. She puts the splint on after his morning care, and he refused it this morning. On 5/19/23, at 10:52 a.m., the Area Vice President indicated it would be on the point of care Kardex if they refuse care like fingernails trimmed or a palm protector. On 5/19/23, at 10:58 a.m., the AM the Unit Manager said it should be in the Kardex or resident's chart if he refused his hand splint.			

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	On 5/22/23, at 2:19 p.m., the Area Vice President indicated splints are under the physician's orders, for their policy. A policy for "Consulting Physician/Practitioner Orders" was provided by the Area Vice President on 5/22/23 at 11:30 a.m. The policy included, but was not limited to, "The attending physician shall authenticate orders for the care and treatment of assigned residents...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview, observation, and record review, the facility failed to timely follow up on recommendation for the management of Resident F's stage three pressure area and failed to provide pressure relieving boots or float heels for Resident 20's unstageable pressure ulcer to the right heel for 2 of 6 residents reviewed for	F 0686	**F 686 Pressure Injury** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	06/05/2023

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	pressure ulcers. Findings included: 1. The clinical record for Resident F was reviewed on 5/17/2023 at 10:55 a.m. The medical diagnosis stroke and lack of coordination. A minimum data set assessment, dated 3/10/2023, indicated Resident F was cognitively intact, at risk for pressure areas, and had a stage three pressure area. A wound nurse practitioner note, dated 3/23/2023, included the recommendation for imaging, laboratory testing, and a wound culture for Resident F's stage three pressure area to his coccyx. This pressure area measures 1.34 x 0.87 cm (centimeters) x an unmeasurable depth. A wound nurse practitioner note, dated 3/30/2023, included the recommendation for imaging, laboratory testing, and a wound culture for Resident F's stage three pressure area. This pressure area measured 2.15 x 1.60 cm x an unmeasurable depth. An interview with the Area Vice President on 5/22/2023 at 1:45 p.m. indicated that the recommendations from Resident F's pressure area was not conveyed to the primary care providers until 3/29/2023. She stated that the previous director of nursing was responsible for reviewing the wound care notes and then informing the primary care providers of the recommendation, but these recommendations were identified and relayed on 3/29/2023 when the current acting director of nursing was completing an audit of all wounds.		Resident 20: Residents clinical record was reviewed and updated to reflect intervention for offloading pressure. Resident F: Clinical record was reviewed and updated with recommendations from consulting wound NP. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents with orders or interventions for offloading devices and that have consultation with the rounding Wound NP have the potential to be affected by the alleged deficient practice. Initial audit: the facility reviewed all residents that are followed by the wound nurse consultant to ensure that all current recommendations have been addressed and include documentation in the clinical record. The facility reviewed all resident with orders/interventions for offloading devices to ensure they were in place and utilized per the order or plan of care. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	

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	Physician orders for Resident F's imagining and laboratory test were entered into the medical record on 3/30/2023. 2. During an observation on 5/15/23 at 1:20 p.m., Resident 20 was laying in bed with both heels on the bed, the right foot had a bandage on it. There were no pressure relieving boots observed in the resident's room. During an observation on 5/16/23 at 12:46 p.m., Resident 20 was laying in bed with both heels on the bed, the right foot had a bandage on it. There were no pressure relieving boots observed in the resident's room. During an observation and interview on 5/17/23 at 3:47 p.m., Resident 20 was laying in bed with both heels on the bed, the right foot had a bandage on it. There were no pressure relieving boots observed in the resident's room. The resident indicated sometimes staff put pressure relieving boots on her and sometimes they would use pillows to keep her heels off of her bed. The resident's call light was activated. QMA 12 came into the resident's room and per request floated Resident 20's heels. Resident 20 indicated that felt much better with her heels not laying on the bed. Review of the record of Resident 20 on 5/17/23 at 3:00 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, anxiety, insomnia, major depression, muscle weakness and delusional disorder. The Significant Change Minimum Data Set (MDS) assessment for Resident 20, dated 4/17/23, indicated the resident was cognitively intact for daily decision making. The resident had no behaviors of rejection of care. The resident required extensive assistance of two people for		**practice does not recur** Education: Clinical staff (Nurses/Aides) were educated on the guidelines for Pressure Injury Prevention and Management to include but not limited to following plan of care regarding pressure reducing order/interventions and timely follow up on recommendations from the wound NP. On-going monitoring: DNS or designee will review recommendations made by wound NP weekly and ensure follow up timely and noted in the clinical record. DNS or designee will round on resident with orders/interventions for offloading devices to ensure they are in place and utilized per orders/plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on	

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	bed mobility, did not ambulate and was at risk for developing pressure ulcers. The resident had an unstageable pressure ulcer. The physician recapitulation for Resident 20, dated May 2023, indicated the resident was ordered to float heels every shift to relieve pressure and pressure relieving boots to bilateral feet while in bed as tolerated (4/23/23). The pressure wound assessment for Resident 20, dated 5/17/23, indicated the resident had a 2.0 centimeter (cm) by 2.0 cm unstageable pressure ulcer on the right heel. The wound was covered with eschar. During an interview with the Administrator on 5/18/23 at 3:58 p.m., indicated it was the nurses and CNA's to ensure Resident 20's heels were floated and ensure pressure relieving boots were in place. The pressure injury prevention and management policy provided by the Administrator on 5/19/23 at 9:15 a.m., indicated the facility was committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. Evidence based interventions for prevention would be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions included, but were not limited to, redistribute pressure such as offloading heels. 3.1-40(a)(2)		QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
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			

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	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. Based on interview, observation, and record review, the facility failed to ensure Resident 23's foot pedals were in place while she was in her wheelchair for 1 of 2 residents reviewed for assistive devices. Findings include: The medical record for Resident 23 was reviewed on 5/15/2023 at 1:20 p.m. The medical diagnoses included autistic disorder and cerebral palsy. An Admission Minimum Data Set Assessment, dated 3/21/2023, indicated that Resident 23 was cognitively impaired, utilized a wheelchair, and needed assistance with transferring. An activities of daily living care plan, dated 3/21/2023, indicated that Resident 23 utilized footrests to her wheelchair.	F 0688	F 688 Range of Motion **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 23: Clinical record was reviewed and plan of care and Kardex updated to include ensuring foot pedals are in place while up in wheelchair. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed an audit of all residents that utilize wheelchair to ensure if foot pedals are indicated it is reflected in the	06/05/2023

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	An observation on 5/15/2023 at 11:43 a.m. indicated Resident 23 was able to propel herself in her wheelchair with the use of her arms. Her feet hung down and did not contact the floor. She did not have footrests on her wheelchair at this time. An observation on 5/15/2023 at 12:22 p.m. indicated Resident 23 remained in her wheelchair and did not have her footrests in place. An observations on 5/15/2023 at 1:15 p.m. indicated Resident 23 remained in her wheelchair and did not have her footrests in place. An interview with the Restorative Aide 10 on 5/16/2023 at 11:30 a.m. indicated that Resident 23 could not use her legs to propel herself. A policy entitled, "Use of Assistive Devices", was provided by the Area Vice President. The policy indicated, " ...Facility staff will provide appropriate assistance to ensure that the resident can use the assistive device ..." 3.1-42(a)(2)		plan of care and Kardex for staff to ensure they are in place while up in the wheelchair. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff (Nurses and Aides) were educated on the guideline for Range of Motion to include but no limited to following the residents plan of care/Kardex. On-going monitoring: DNS or designee will observe residents that utilize foot rest on their wheelchair to ensure they are in place while resident is up in the chair. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits	

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			based on a prn basis.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to supervise a resident during meals as instructed by the Speech Therapist, failed to implement fall interventions, and failed to ensure adequate supervision and known whereabouts of a resident for 4 of 7 residents reviewed for accidents (Resident 3, Resident 49, Resident 36 and Resident 23). Findings include: 1. During an observation on 5/18/23 at 12:31 p.m., Resident 3 was laying in bed eating lunch. There was no staff present during this meal observation. Review of the record of Resident 3 on 5/18/23 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, hypertensive heart disease, age related osteoporosis, dysphagia, hypertension, dementia, muscle weakness and age related debility. The Speech Therapy discharge summary for Resident 3, dated 10/18/22, indicated the discharge instructions were supervision/full feed	F 0689	F 689 Accidents and hazards **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3: Clinical record was reviewed and plan of care/Kardex updated to include intervention of supervision during meals . Resident 49: Clinical record was reviewed and updated per the plan of care to ensure the Kardex included fall interventions Resident 36: Clinical record was reviewed and plan of care and Kardex currently reflect fall risk interventions. Resident 23 : Clinical record was reviewed and plan of care and Kardex currently reflect residents needs regarding clothing and wandering. **How other residents having the potential to be affected by the**	06/05/2023

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	during all meals, upright positioning in bed, small bites/sips, extended time between with slow rate. 2a. During an interview with Resident 49's family member on 5/15/23 at 2:24 p.m., indicated the resident had several falls at the facility since admission. During an observation on 5/16/23 at 3:23 p.m., Resident 49 was laying in bed. The resident did not have a low bed or fall mat beside her bed. During an observation on 5/17/23 at 3:43 p.m., Resident 49 was laying in bed, she indicated she wished someone would come change her because she was wet. When queried where her call light was she indicated she did not know. Resident 49's call light was activated. The Unit Manager came into the room and indicated the resident's call light was on the floor between her bed and the wall. The Unit Manager indicated the first shift CNA's that assisted her to bed should have ensured she had her call light. The resident did not have a low bed or fall mat beside her bed. The resident's remote to her bed was hanging on the grab bar beside the resident's head. During an observation on 5/18/23 at 10:24 a.m., Resident 49 was laying in bed. The resident did not have a low bed or fall mat beside her bed. During an observation on 5/18/23 at 12:30 p.m., Resident 49 was laying in bed. The resident did not have a low bed or fall mat beside her bed. The resident's remote to her bed was within reach. During an observation and interview on 5/18/23 at 1:12 p.m., the Unit Manager indicated the facility had put the fall mat down for Resident 49 approximately 10 minutes ago. The Unit Manager		**same deficient practice will be identified and what corrective action will be taken** Initial audit : Facility completed an audit of residents to identify those that require supervision with meals to ensure it is reflected in the plan of care and Kardex. Facility completed an audit of resident with fall risk or actual events to ensure interventions are in place and updated timely in the plan of care/Kardex. Facility audit resident with behavior of wandering and disrobing to ensure the clinical record included interventions in the plan of care/Kardex **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff and facility staff were educated on the guidelines Incidents and accidents to include but not limited to updating the plan of care with interventions following a fall event, following the plan of care for residents with behaviors of wandering and disrobing. On-going monitoring : DNS or designee will observe resident that need supervision with meals to ensure staff are supervising at	

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	verified Resident 20 did not have a low bed and the resident was holding the remote to her bed. 2b. Review of the record of Resident 49 on 5/17/23 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, displaced intertrochanteric fracture of the left femur, difficulty walking, lack of coordination, muscle weakness, repeated falls, intellectual disabilities, age related osteoporosis and depression. The Minimum Data Set (MDS) for Resident 49, dated 5/3/23, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of two people to transfer and did not ambulate. The plan of care for Resident 49, dated 2/9/23, indicated the resident was at risk for falls related to a history of falls. The interventions included, but were not limited to, call light available, do not give the resident the bed remote due to resident raises the bed to the high position, keep bed remote on the floor near the foot of the bed for safety, low bed with mat. During an interview with the Administrator on 5/18/23 at 1:37 p.m., indicated it was the responsibility of the nurses and CNA's to ensure Resident 49's fall interventions were in place. 3. Review of the resident 36 on 5/18/23 at 4:20 p.m., indicated the resident's diagnoses included, but were not limited to, pulmonary fibrosis, protein calorie malnutrition, schizoaffective disorder, profound intellectual disabilities, dysphagia, osteoporosis and polyneuropathy. The post fall evaluation for Resident 36, dated 12/21/22 at 4 a.m., indicated the resident had		meal time. DNS or designee will review the clinical record of residents follow fall events to ensure the plan of care/Kardex is updated timely with interventions. DNS or Designee will observe residents with behaviors of wandering and disrobing to ensure interventions are followed per the plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	unwitnessed fall states he fall out of bed. The resident had bump present above left temple that was sore to touch. During an interview with the Administrator on 5/19/23 at 1:50 p.m., indicated the facility did not implement any fall interventions to prevent further falls after Resident 36 fell and hit his head on 12/21/23. The fall prevention policy provided by the Administrator on 5/18/23 at 2:20 p.m., indicated each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 4. The clinical record for Resident 23 was reviewed on 5/19/23 at 9:30 a.m. The diagnoses included, but were not limited to, cerebral palsy, autistic disorder, anxiety disorder, depression, and adult failure to thrive. An admission minimum data set (MDS) assessment, dated 3/21/23, indicated a brief interview for mental status assessment was not conducted due to "resident is rarely/never understood", physical behavior symptoms directed towards others occurred 1-3 days, verbal behavioral symptoms directed towards others occurred 1-3 days, other behavior symptoms not directed towards others occurred 1-3 days, behaviors put Resident 23 at risk for physical illness or injury, behaviors significantly interfere with resident's care, and significantly intrude on the privacy of others.			

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	An activities of daily living (ADL) care plan, revised 3/21/23, indicated Resident 23 had an ADL self care deficit related to cerebral palsy, autism, and failure to thrive. The interventions included, but were not limited to, "Resident is not to go to TCU [Transitional Care Unit/Rehabilitation Unit] at all. Know residents where abouts at all times. Keep resident on ECU [extended care unit]". An observation conducted of Resident 23, on 5/15/23 at 11:30 a.m., to where she was propelling herself in her wheelchair in the main dining room. She was headed outside of the dining room while headed in the direction of the center hallway. She did not have a shirt on and her breasts were exposed. Another resident, Resident 45, was coming up the hallway from TCU and commented "she's naked", referring to Resident 45. There was no staff members in the dining room at the time of observation. An observation conducted of Resident 23, on 5/16/23 at 11:45 a.m., to where she was propelling herself in her wheelchair coming down the hallway on TCU from the dining room and continued down the TCU hallway towards the front entrance of the building. There was nursing staff present and no one attempted to redirect Resident 23 while she was observed on TCU. An interview conducted with Nursing Assistant (NA) 15, on 5/18/23 at 10:52 a.m., indicated she was familiar with the care of Resident 23. She would always try to know of Resident 23's whereabouts and ensure she didn't go anywhere besides ECU. An interview conducted with Certified Nursing Assistant (CNA) 16, on 5/18/23 at 10:58 a.m., indicated she was familiar with Resident 23's care.			

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	Resident 23 would go in and out of other resident's rooms when she first was admitted to the facility. Some residents were okay with Resident 23 going into their rooms and others would prefer for Resident 23 not to be in their rooms. CNA 16 indicated how Resident 23 was a busy person and would propel herself in her wheelchair "everywhere". The building has a circular floorplan and Resident 23 would go all around the facility, including the TCU unit. If staff were unable to locate Resident 23, they would call over to TCU and the TCU staff would mention how Resident 23 was over there and she was okay. It wasn't an uncommon circumstance for Resident 23 to make her way all around the facility. CNA 16 wasn't aware of any limitations to where Resident 23 wasn't allowed on the TCU unit. An interview conducted with CNA 17, on 5/18/23 at 2:08 p.m., indicated her main unit that she worked on was TCU. While she was working on TCU it was common to see Resident 23 propel herself in her wheelchair onto the TCU unit. Resident 23 would roam up and down the hallway, but she didn't see Resident 23 attempt to go in any resident rooms on TCU. A policy titled "Behavioral Health Services", undated, was provided by the Area Vice President on 5/19/23 at 9:15 a.m. The policy indicated the following, " ...2. The facility will consider the acuity of the resident population. This includes residents with mental disorders ...3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety ...10. All facility staff, including contracted staff			

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	and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents ...Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following ...a. Person-centered care and services that reflect the resident's goals for care ...f. Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, or other behavioral health conditions ...." 3.1-45(a)(2)			
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 0692	**F 692 Nutrition/Hydration**	06/05/2023

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	Based on interview and record review, the facility failed to ensure recommendations were initiated timely for residents with identified weight loss, failed to obtain weights as ordered, and failed to implement weekly weights for a resident identified with significant weight loss for 5 of 8 residents reviewed for nutrition. (Resident 18, 45, F, 22, and 8) Findings include: 1. The clinical record for Resident 18 was reviewed on 5/18/23 at 1:10 p.m. The diagnoses included, but were not limited to, muscle weakness, diabetes mellitus, malnutrition, vascular dementia, and visual hallucinations. A quarterly minimum data set (MDS) assessment, dated 4/13/23, indicated Resident 18 had weight loss and not on a weight loss regimen. A care plan for nutrition, revised 4/18/23, indicated Resident 18 was at risk for malnutrition and swallowing difficulty with a history of weight changes. The interventions included, but were not limited to, house shake daily added on 4/18/23, and weekly weights added on 10/7/22. Another nutrition care plan, revised 4/18/23, indicated Resident 18 had an elevated body mass index and the interventions listed were to provide diet as ordered and obtain weights per physician orders. The following weights were noted in Resident 18's clinical record: 1/24/23 at 190.2 pounds, 2/1/23 at 191.8 pounds, 3/17/23 at 198.0 pounds,		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 18: Clinical record was reviewed and updated to reflect order for most current Dietary Recommendation. Resident 45: Clinical record was reviewed and updated to reflect order for most current Dietary Recommendation. Resident F:Clinical record was reviewed and has physician order for routine weight Resident 22: Clinical record was reviewed and has physician order for routine weight Resident 8: Clinical record was reviewed and has physician order for routine weight **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit : Facility completed audit of residents with orders for routine weights to ensure weights are obtained per MD orders. Facility completed a 14 day look back of Registered Dietician recommendations to ensure the clinical record has been updated with new recommendations.	

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	4/6/23 at 188.4 pounds, 5/1/23 at 185.2 pounds, 5/2/23 at 168.8 pounds and 186.8 pounds, 5/6/23 of 168.2 and 180.4 pounds, 5/7/23 of 182.6 pounds, 5/10/23 of 170.1 pounds, 5/13/23 of 182.1 pounds, & 5/14/23 of 184.4 pounds. A nutrition at risk (NAR) progress note, dated 4/7/23, indicated a 5.1% weight loss over the past 30 days. A recommendation was noted for a house shake at breakfast to prevent further weight loss. A NAR progress note, dated 4/14/23, indicated an updated weight was requested due to the most recent weight being dated for 4/6/23. The recommendation was noted for a house shake at breakfast to prevent further weight loss. A physician order, dated 4/18/23, indicated a house shake in the morning for a supplement. There were no previous orders for a house shake for Resident 18. 2. The clinical record for Resident 45 was reviewed on 5/18/23 at 10:21 a.m. The diagnoses included, but were not limited to, breast cancer, anemia, muscle weakness, schizophrenia, and psychotic disorder with delusions. A quarterly MDS assessment, dated 3/29/23, indicated no weight loss for Resident 45. A nutrition care plan, revised 10/1/22, indicated being at risk for chewing difficulty due to being edentulous (without teeth). The interventions listed included, but were not limited to, weights as ordered and diet as ordered.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff (Nurses/Aides/Dietary staff) were educated on the guidelines for Nutrition and Wight Monitoring to include but not limited to obtaining weights timely per orders and following Dietician recommendations. On-going monitoring: DNS or designee will review routine weights to ensure they are obtained timely. DNS or designee will review RD recommendations weekly and ensure they are updated in the clinical record timely. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then	

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	The following weights were noted for Resident 45: 12/6/22 at 222 pounds, 1/3/23 at 219 pounds, 3/8/23 at 189.4 pounds, 3/14/23 at 219.9 pounds, 4/6/23 at 167.2 pounds, 4/18/23 at 169.8 pounds, 5/6/23 at 183.6 pounds, & 5/16/23 at 184 pounds. A NAR progress note, dated 3/9/23, indicated to weigh Resident 45 per physician orders. A NAR progress note, dated 3/23/23, indicated the recommendation for double protein portions at breakfast to provide additional protein for wound healing. A NAR progress note, dated 3/31/23, indicated the same recommendation for double protein portions at breakfast to provide additional protein for wound healing. A NAR progress note, dated 4/7/23, indicated the same recommendation for double protein portions at breakfast to provide additional protein for wound healing. A physician order, revised on 4/14/23, was noted for double protein portions at breakfast for Resident 45's diet. A NAR progress note, dated 5/3/23, indicated the recommendation for a house shake at lunch to promote adequate oral intake. A physician order, dated 5/17/23, was noted for a house shake one time a day, at 1:00 p.m., to promote adequate oral intake.		will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	There were no previous physician orders for a house shake for Resident 45. A physician order, dated 4/17/23, indicated weekly weights for Resident 45. The electronic treatment administration record for May of 2023, noted the weekly weights were not obtained on 5/2/23 and 5/9/23. A policy titled "Nutritional Management", undated, was provided by the Area Vice President on 5/19/23 at 9:15 a.m. The policy indicated the following, " ...The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition ...2. Identification/assessment ...a. Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy ...4. Care plan implementation ...a. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care ...b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to ...iii. Weight-related interventions ...c. Real food will be offered first before adding supplements ...." 3. The clinical record for Resident F was reviewed on 5/17/2023 at 10:55 a.m. The medical diagnosis stroke and lack of coordination.			

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	A minimum data set assessment, dated 3/10/2023, indicated Resident F was cognitively intact and at risk for pressure areas. A physician order, dated 4/18/2023, indicated for Resident F to have weekly weights every Tuesday. No weekly weights were obtained 5/2/2023, 5/9/2023, or 5/16/2023. 4. The clinical record for Resident 22 was reviewed on 5/22/2023 at 10:30 a.m. The medical diagnoses included diabetes and asthma. A Quarterly Minimum Data Set Assessment, dated 4/10/2023, indicated that Resident 22 was cognitively impaired and had weight loss that was not physician prescribed. A nutrition care plan, dated 1/20/2023, indicated for Resident 22 to have weights obtained as ordered. A physician order, dated 4/17/2023, for Resident 22 indicated to have weekly weights obtained every Tuesday related to weight loss. The administration record for Resident 22 indicated weights were not obtained on 5/2/2023 and 5/16/2023 and was left blank on 5/9/2023. 5. The clinical record for Resident 8 was reviewed on 5/22/2023 at 11:08 a.m. the medical diagnoses included depression and cachexia. A Quarterly Minimum Data Set Assessment, dated 4/25/2023, indicated that Resident 8 was cognitively intact. An observation and interview with Resident 8 on 5/15/2023 at 1:43 p.m. indicated he was laying in			

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	bed at this time. His clothing was noticeably loose. He indicated he is losing weight, but he is unsure why. He stated he was only weighed every now and again and when asked to clarify he said every 6 weeks or so. A physician order for Resident 8, dated 12/19/2022, indicated to obtain weight every month. A nutritional care plan, dated 5/6/2021, indicated Resident 8 was at risk for weight loss and to obtain weights as ordered. Weights for Resident 8 were as follows: 4/3/2023 - 121 pounds 5/1/2023 - 101.8 pounds 5/7/2023 - 118.1 pounds, this was struck out on 5/11/2023. 5/11/2023 - 94 pounds A nutrition progress note, dated 5/3/2023, questioned the accuracy of the 5/1/2023 weight and recommended a re-weight. An interview with the Area Vice President on 5/22/2023 at 11:30 a.m. indicated that Resident 8's weights were in question due to fluctuations, so his weight loss was not isolated until 5/11/2023. The nurse practitioner was in to see him on 5/17/2023 for his poor appetite and he picked up to be reviewed on Nutritional at Risk Committee on 5/19/2023. No order for weekly weight was entered or obtained per Resident 8's chart after identified significant weight change on 5/11/2023. An interview with the Area Vice President on 5/22/2023 at 11:30 a.m. indicated that the scale was			

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	down when she stated in the building on 3/27/2023 and was repaired by the new maintenance director on 5/5/2023. She was unsure why the weights had not been obtained on 5/9/2023 or 5/16/2023. A policy entitled, "Weight Monitoring", was provided by the Area Vice President on 5/22/2023 at 11:30 a.m. The policy indicated, " ...A weight monitoring schedule will be developed upon admission for all residents ...Weights should be recorded at the time obtained ...Residents with weight loss - monitor weight weekly ..." 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to monitor intake totals for a dependent resident who utilized a gastrostomy tube (a tube that is inserted into the stomach through the abdominal wall for nutrition) and failed to follow up when a resident's residual was less than 100 milliliters per MD orders. This affected 2 of 2 residents reviewed for gastrostomy tubes. (Residents 4 and 14) Findings include: 1. On 5/16/23 at 3:32 p.m., Resident 4 was observed in bed, his eyes were closed and his gastrostomy tube was infusing water at 65 milliliters/hour via a mechanical pump. Resident 4's record was reviewed on 5/17/23 at 2:04 p.m. The record indicated Resident 4 had diagnoses that included, but were not limited to, stroke with paralysis on one side, difficulty speaking, type 2 diabetes mellitus, seizures, and gastrostomy tube. A Quarterly Minimum Data Set assessment, dated 3/15/23, indicated Resident 4 was severely cognitively impaired, required extensive assistance of one for all activities of daily living, was totally dependant on staff for eating, and utilized a feeding tube. A care plan, last updated on 3/20/23, indicated a focus for: "Nutrition: I am dependent on tube feeding/at risk for inadequate fluid intake due to: Dx of CVA with aphasia (unable to speak) and dysphagia (difficulty swallowing)...I have an elevated BMI (body mass index) indicating overweight status. Goal: Maintain nutritional	F 0693	F 693 Tube feeding **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 4: Clinical record was reviewed and updated with order for obtaining total intake of enteral feeding. Resident 14: Clinical record was reviewed and updated with order for follow up if residual is greater than 100ml **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed an audit of residents that receive enteral feeding to ensure orders are present for total intake, residual check and intervention if residual is outside of the set parameter. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Clinical staff were educated on the guideline for enteral feeding to include but not limited to obtaining total intake of enteral feeding, checking residual	06/05/2023

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	status and body weight. Interventions: Head elevated at least 30 degrees every shift. 24 hour total of G-tube feeding intake every night shift...Enteral feed total every shift. Enteral formula and feedings as ordered. Enteral Feed Order two times a day Glucerna continuous with flushes as ordered. flush G-tube with 30ml water before and after medication adm. 15ml between each med every shift...NPO (nothing given by mouth): G-tube for Hydration/Nutrition...TF (tube feeding) as ordered." Physician's orders for Tube feeding included, but were not limited to: 1. "Increased H20 (water) flush to additional 90 ml (milliliters) from 0900-1200 while tube feeding is off to equal 2160 ml in a 24 hour period, four times a day for extra hydration related to gastrostomy status." Started on 5/4/2023 2. "Flush with 30ML of water: Before and after any tube feeding Before and after any medications (all medication should not be visible in the tube or extension after flushing)...At least once every 24 hours, every shift for G-tube care." Started 3/15/2023 3. "Enteral Feed every shift Glucerna 1.5 Cal or equivalent to Diabetisource via G-tube at 65 ml/hr, with H2O flush 90 ml/hr x 20 hrs/day." Started 2/17/23 4. "NPO diet, NPO texture." Started 12/19/2022 A Nutritional Assessment, dated 3/7/23, indicated Resident 4's estimated fluid needs are 1700 - 2000 milliliters per day. Review of the Medication Administration Records indicated the Enteral feeding and water flushes		and notification to MD/NP if outside of parameters. On-going monitoring : DNS or designee will monitor residents clinical record for documentation of intake of enteral feeding and intervention if residual is outside of the parameters. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	were checked that they were administered, but there were no totals in milliliters that indicated how much had been given each shift or in a 24 hour period. During an interview, on 5/22/23 at 10:34 a.m., the Area Vice President indicated the nurses have not been clearing the pump, and she does not know how many milliliters he gets every 24 hours. 2. The clinical record for Resident 14 was reviewed on 5/22/2023 at 10:35 a.m. The medical diagnosis included dysphagia. A Significant Change in Condition Minimum Data Set Assessment, dated for 3/31/2023, indicated that Resident 14 was cognitively impaired, utilized a feeding tube, and had an unexpected significant weight loss. A nutrition care plan, dated 1/5/2018, indicated that Resident 14 required a g-tube for nutrition. A physician order for Resident 14 indicated to obtain residual tube feeding measurements every shift and to hold the tube feeding for one hour if the residual was more than 100 ml then re-check. Then if the residual remained greater than 100 ml to call the physician. Review of the administration record for Resident 12 indicated that his residual tube feeding on 5/12/2023 was 240 ml. There was no documentation on the medical record to indicate that the tube feeding was held, rechecked, or the physician notified. An interview with the Area Vice President on 5/22/2023 at 1:30 p.m. indicated there was no			

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	documentation to infer the tube feeding was held, rechecked, or the physician notified. The nurse caring for the resident would be responsible for conducting orders as written. A policy entitled, "Care and Treatment of Feeding Tubes," was provided by the Area Vice President on 5/22/2023 at 11:30 a.m. The policy indicated, " ...It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible ...Feedings tubes will be utilized according to physician orders ...Direction for staff regarding how to manage and monitor ...Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders ...The facility will notify and involve the physician or designated practitioner of any complications ..." 3.1-44(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review the facility failed to provide pain management for a resident who had a fall with a fracture and failed to follow up PRN (as needed) pain medicine for a resident who had ineffective pain relief for 2 of 3 resident's reviewed for pain (Resident 36 and Resident E). Finding include:	F 0697	F 697 Pain Management **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 36: Clinical record was	06/05/2023

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	1. Review of the resident 36 on 5/18/23 at 4:20 p.m., indicated the resident's diagnoses included, but were not limited to, pulmonary fibrosis, protein calorie malnutrition, schizoaffective disorder, profound intellectual disabilities, dysphagia, osteoporosis and polyneuropathy. The progress note for Resident 36, dated 4/5/23 at 3:54 p.m., indicated the resident slipped and complained of right knee pain. A new order was obtained for an x-ray. The progress note for Resident 36, dated 4/5/23 at 6:06 p.m., Resident complained of right knee pain and an x-ray was ordered. The x-ray results indicated a fractured patella (knee). The Nurse Practitioner (NP) progress note for Resident 36, dated 4/6/23 at 12:00 a.m., indicated the resident was seen today for a fall occurring on 4/5/23. The resident had right knee swelling and pain. The progress note for Resident 36, dated 4/6/23 at 12:45 p.m., indicated the resident was complaining of pain to the right knee. The resident was rubbing the area of pain and repeatedly stating "my knee hurts" with facial grimacing noticed. The right knee had swelling and bruising. During an interview with the Administrator on 5/19/23 at 1:40 p.m., indicated the facility did not treat Resident 36 pain after his fall with fracture on 4/5/23 until 4/9/23. 2. The clinical record for Resident E was reviewed on 5/17/2023 at 2:33 p.m. The medical diagnosis included weakness. A quarterly minimum data set assessment, dated		reviewed and orders are in place for pain management. Resident E: Clinical record was reviewed and orders are in place for pain management. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** All residents with risk for pain have the potential to be affected by the same deficient practice. The facility completed a review of all residents with PRN pain medication to ensure medication is administered timely and documented. The facility completed a review of all residents at risk for pain following a fall event to ensure the clinical record includes pain management. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : licensed nursing staff have been in-serviced on the facility's Pain Management Guidelines to include but not limited to; notifying the physician of new onset of pain, completion of pain assessments,	

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	4/20/2023, indicated Resident E was cognitively intact. A physician order for Resident E, dated 2/22/2023, indicated the use of an opioid pain medications every 12 hours as needed for pain. A pain care plan for Resident E, dated 10/4/2021, indicated to utilize pain monitoring tool to evaluate effective of interventions. Review of the April and May medication administration record for Resident E indicated the effectiveness of pain medication as unknown on 4/4/2023, 4/23/2023, 4/24/2023, 4/29/2023, 5/3/2023, 5/4/2023, 5/15/2023, and as ineffective on 4/18/2023. An interview with Resident E on 5/15/2023 at 1:53 p.m. indicated she had 10/10 pain in her knee, hip, and groin area. She had requested as needed pain medication and was waiting for it. She indicated that the pain medication does not really help that "much but is better than nothing". She has been having pain on and off for a couple months, but believed it was time for her follow up to get "shots in her knee". An interview with the Area Vice President on 5/22/2023 at 1:45 p.m. indicated that the staff had not follow up or notified the physician on the aforementioned unknown/ineffective pain medication follow up. A policy entitled, "PRN Medications", was provided by the Area Vice President on 5/15/2023 at 2:30 p.m. the policy indicated, " ...Evaluate the effectiveness of the medication and document the findings ..." A policy entitled, "Pain Management", was		implementing non-pharmacological interventions and timely administration of requested PRN medication, documentation of PRN pain medication administered and effectiveness. On-going monitoring: DNS or Designee will complete audit of residents identified as being at risk for pain for proper pain management. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	provided by the Area Vice President on 5/18/2023 at 10:10 a.m. The policy indicated, " ...In order to help a resident attain and maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will ...Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated ...Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences ..." 3.1-37(a)			
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 interview and record review, the facility failed to ensure complete documentation of pre and/or post dialysis evaluations for 1 of 1 resident reviewed for dialysis. (Resident 28) Findings include: Resident 28's record was reviewed, on 5/17/23 at 3:12 p.m., and indicated Resident 28 had diagnoses that included, but were not limited to, end stage kidney disease, type 2 diabetes mellitus, high blood pressure, and depression. An Admission Minimum Data Set Assessment, dated 7/5/22, indicated Resident 28 was	F 0698	F 698 Dialysis Services **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 28: Clinical record was reviewed and updated to include per and post dialysis treatment assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	06/05/2023

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	cognitively intact, and received hemodialysis. Physician's orders for dialysis care included, but were not limited to: 1. "Post Dialysis Assessment. Assess site for s/s (signs and symptoms) of bleeding, infection, post dialysis complications. Notify MD of any abnormal changes." Every Mon, Wed, Fri, started 1/23/23 2. "Pre dialysis assessment. Assess site for any s/s of bleeding and infection. Notify MD of any abnormal changes. One time a day every Mon, Wed, Fri for dialysis." Dated: 1/23/2023 3. "Dialysis Treatment on (M/W/F) at [Name of Dialysis Center] one time a day every Mon, Wed, Fri for Dialysis." Started 11/21/2022 4. "Send Dialysis Communication Binder with Resident to Dialysis on Monday, Wednesday, and Friday every day shift every Mon, Wed, Fri for monitoring." Started 11/7/2022 Review of dialysis communication forms, in the clinical record, indicated there were no communication forms from the facility to the dialysis center on these dates: 4/3/23, 4/10/23, 4/24/23, 4/26/23, and 5/15/23. There were no communication forms from the dialysis center to the facility on these dates: 5/1/23, and 5/5/23. On 5/19/23, at 2:55 p.m., the Area Vice President indicated they could not find the dialysis communication forms for the dates requested.		**action will be taken** All residents that receive dialysis services have the potential to be affected by the alleged deficient practice. Initial audit: The facility completed a review of residents that receive dialysis services to ensure the clinical record includes completion of pre and post assessments. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Nurses (RN/LPN) were educated on the guidelines for Dialysis Services to include but not limited to completing pre and post dialysis assessments. On-going monitoring : DNS or designee will review residents that receive dialysis services for completion of pre and post assessment. These reviews to be conducted 3 times weekly x 4 weeks, then 1 time weekly x 8 weeks. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**	

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	A policy for "Hemodialysis" was provided by the Area Vice President on 5/22/23 at 11:30 a.m. The policy included, but was not limited to: "Policy: This facility will provide the necessary car and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis...5. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as dialysis communication form or other form, that will include, but limit itself to...e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site...." 3.1-37(a)		Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure adequate approach of care and implement interventions for a resident with dementia with a history of agitation, anxiety, and combativeness, for 1 of 2 residents reviewed for dementia care. (Resident B)	F 0744	**F 744 Treatment/Services for Dementia** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	06/05/2023

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	Findings include: The clinical record for Resident B was reviewed on 5/16/23 at 9:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, arthritis, cerebral infarction, muscle weakness, and symptoms and signs involving cognitive functions and awareness. Resident B was admitted to the facility on 2/16/23. An Admission Minimum Data Set (MDS) assessment, dated 2/23/23, noted Resident B with moderate cognitive impairment, physical behavioral symptoms directed towards others occurred 1-3 days, verbal behavioral symptoms directed towards others occurred 1-3 days, other behavioral symptoms not directed towards others occurred 1-3 days, "yes" to it interfering with resident's care, "yes" to significantly intruding on the privacy or activity of others, "yes" to significant disruption of care or living environment, and rejection of care within 1-3 days. Resident B required the need of extensive assistance with 2 staff person for bed mobility, transfers, dressing, toilet use, and personal hygiene. A care plan, dated 2/20/23, indicated Resident B had impaired neurological status related to Alzheimer's disease. The interventions listed were to assist in activities of daily living (ADLs), mobility as needed, and monitor ADLs for assistance and render care as needed. A care plan, dated 2/24/23, indicated Resident B felt down, depressed, or hopeless, along with difficulty falling or staying asleep, and feeling bad about oneself. The interventions listed were to encourage activity involvement, offer food and beverages to ones liking, and take the time to		Resident B: no longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed an audit of residents with diagnosis of Dementia to identify those with behaviors agitation, anxiety and combativeness to ensure the residents plan of care includes appropriate interventions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Facility staff were educated on the guideline for Dementia care to include but not limited to developing plan of care for Dementia care and interventions for behaviors. On-going monitoring : DNS or designee will observe staff interaction and interview staff on providing care for residents with Dementia and interventions for behaviors. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.	

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	discuss ones feelings when feeling sad. A care plan, dated 2/24/23, indicated impaired cognition for Resident B. The interventions listed were to help maintain dignity, help with reminders and cues as needed, allow resident to do what he was capable of doing, at his own pace in his own way, and remember that I (Resident B) am an adult and treat him accordingly. A behavioral care plan, dated 3/6/23, indicated the following, "...I [Resident B] sometimes have incidents of being uncooperative with care AEB [as evidenced by]; anxiousness, pinching, grabbing at staff, lifting my feet off ground during transfers, being verbally aggressive with staff (cursing, yelling), swinging at staff/attempting to hit...Interventions...Approach me one caregiver at a time. Multiple people talking in the room may agitate me...Attempt one task at a time with short simple instructions. Don't rush me...Explain to resident in simple terms what you are trying to do and how it will benefit him/her...Offer fluids or snack...Offer toileting/incontinent care when needed...Play some jazz music if I am combative or restless...Please explaining [sic] what you are doing and allow me time to comprehend before attempting...Provide a quiet calm area for me to unwind when agitated. Loud noises can cause me agitation...Provide care in pair when agitated...Provide me with drumsticks and an object to drum on when agitated. Place me away from others I may inadvertently injure [sic]...." A trauma care plan, dated 3/6/23, indicated the following, "...I have a hx [history] of trauma r/t [related to] Physical/Verbal abuse, physical/emotional neglect, sudden unexpected loss of family member, witness to violence. If experiencing a trigger from history of Trauma, I		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	may display signs and symptoms of Anxiety, fear, irritability, being easily startled, outburst of anger or rage, emotional swings/detachment, self-blame, and shame...." The interventions listed were to arrange for mental health services as indicated, encourage to express thoughts and feelings in a safe place, identify the items that lessen the effects of trauma and provide comfort, observe for signs and symptoms of depression, anxiety, eating disorders, sleep disturbances, and substance use disorder, and provide a quiet, non threatening environment with decreased stimulation. A care plan, dated 4/10/23, indicated Resident B refused care at times. An intervention was listed to re-approach resident when he refused care. A behavior note, dated 4/11/23 at 5:51 a.m., indicated Resident B was being verbally and physically aggressive. Resident B was hitting, scratching, kneeing the CNAs [Certified Nursing Assistants], and cursing at them during care. The intervention attempted was the staff asking Resident B not to hit and curse along with talking through care with the CNAs. The interventions were listed as "not effective". No other interventions were documented as attempted when redirection did not appear to be successful. A behavior note, dated 4/12/23 at 5:46 a.m., indicated Resident B was yelling and cursing at CNA. Resident B attempted to knee the CNA and hit her. The intervention attempted was attempted redirection and talk Resident B through being changed. The interventions were listed as "not effective". No other interventions were documented as attempted when redirection did not appear to be successful.			

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	A behavior note, dated 4/13/23 at 5:57 a.m., indicated Resident B was hitting and cursing at CNAs, as well as attempting to bite them while they were trying to change his incontinent product and sheets that were soiled. The interventions attempted were "Resident asked very nicely not to do that and to be nice". The intervention was listed as not effective. No other interventions were documented as attempted when redirection did not appear to be successful. A behavior note, dated 4/26/23 at 5:44 a.m., indicated Resident B was hitting, biting, kicking, and cursing at staff during care. Staff attempted to talk to the resident and let him know everything they were doing. Resident B was asked if he was in pain, and if there was anything the facility staff could do to help. The interventions were listed as not effective. No other interventions were documented as attempted when redirection did not appear to be successful. A wound assessment report, dated 4/26/23, indicated a cluster of small skin tears from self inflicted scratching noted measuring 9 x 2.5 centimeters. A progress note, dated 4/30/23 at 1:43 p.m., indicated the following, "...CNA brought camera from resident room that was positioned to point at his bed. Camera was hidden near TV. Camera removed from resident room, brought to nurses station and battery removed...." An interview conducted with Family Member 8 during the survey indicated Resident B requested his Alexa device to utilize while he was at the facility. He utilized the device at home and since there was no roommate there wasn't the concern for others privacy. During the last week of being			

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	at the facility prior to being hospitalized, Resident B had fallen and acting extra anxious while also picking at his arms. Resident B was having behaviors but Family Member 8 wondered why Resident B was yelling and so upset. The facility staff kept mentioning it was dementia, but it seemed like something else was wrong. Family Member 8 had the ability to review the camera footage that was located on the Alexa device in Resident B's room. Someone was holding Resident B's wrists and when the "other girl" applied a shirt on Resident B he commented "quit holding my arm" and he [male caregiver] didn't. Resident B ended up with bruises to his wrists. The male caregiver commented "I'm so high I could burn you up for supper" and admitted to "being high". He was a new CNA and worked night shift. The male CNA also mentioned "I'm going to put my 10.5 up your butt". The staff were being rough and in a hurry while caring for him. Resident B became sensitive and had distrust with others during his stay. It appeared to be a trauma response. Family Member 8 noticed Resident B was sleeping a lot more recently. Family Member 8 reported the incident when she observed it on the camera footage a couple days after it occurred on 4/30/23. An encounter note, dated 5/3/23, indicated the following, "...Spoke to daughter in lengthy period overall patient?s [sic] condition...Daughter also would like to talk to Psych/mental health provider...." A progress note, dated 5/4/23, indicated the following, "...ALZHEIMER'S DISEASE...worsening, verbally and physically combative with staff...if continues patient needs to be send out to inpatient psych...Restlessness and agitation...buspar discontinued, as daughter			

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	worries makes her dad lethargic...." There were no other psychiatry progress notes since the previous one on 4/11/23. A behavior note, dated 5/4/23 at 12:51 a.m., indicated Resident B was hitting, spitting on staff, cursing and threatening staff. They attempted to redirect resident and that was not effective. No other interventions were documented as attempted when redirection did not appear to be successful. A progress note, dated 5/4/23 at 6:28 a.m., indicated Resident B was swinging and trying to hit and bite staff during obtaining vital signs. No interventions were documented as attempted when behaviors were present. A behavior note, dated 5/5/23, indicated the following, "...Screaming "shut up, get in line were in line to get to tomorrow", pointing to resident talking saying he is going to make them shut up, telling them to go out in the yard with him and "see what he will do to the resident."...Interventions attempted: asked resident if he would like to be moved to a quieter area, where there is less noise. Resident says 'don't you move me im [sic] where I am supposed to be". Asked resident if he would like to get cleaned up ready for bed and have some snacks and warm coffee in bed he agrees, resident states "that will be nice"...effective, resident resting in bed quietly at this time...." A progress note, dated 5/6/23 at 5:14 a.m., indicated while attempting to obtain vital signs Resident B was swinging arms and cursing at staff. No interventions were documented as attempted when behaviors were present.			

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BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

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	A progress note, dated 5/7/23 at 4:59 p.m., indicated Resident B was yelling out for daughter. They explained to resident she wasn't there currently. Resident B said "okay" but as soon at the staff left the room, Resident B began yelling again. No interventions were documented as attempted when Resident B continued to yell out. A progress note, dated 5/10/23 at 5:32 a.m., indicated Resident B was being combative with care that shift. Resident B was hitting, cursing, and screaming. Resident not easily redirected. No other interventions were documented as attempted when redirection did not appear to be successful. A progress note, dated 5/11/23 at 9:04 p.m., indicated Resident B was admitted to the hospital with weakness, altered mental status, and acute encephalopathy related to hypotension. An interview conducted with CNA 6, on 5/17/23 at 1:05 p.m., indicated on a few occasions he attempted to hold Resident B's wrists during personal care. He was not aware that it was considered a restraint or abuse. The facility had CNA 6 retake a class on abuse and now he knows what to do the next time this were to happen. The CNA class he participated in did not go over behaviors or how to deal with residents with dementia. He has worked at the facility for approximately 3 years and there was a lot of agency staff and they would discuss their history of working at the State hospital in regards to restraining residents. The staff would try to hold Resident B's hands but he continued to focus on the CNA providing care but sometimes we would hold his wrists in attempt to calm him.			

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	An interview conducted with Director of Nursing (DON), on 5/17/23 at 1:30 p.m., indicated she reviewed video footage of CNA 2 grabbing Resident B's wrists during care as well as making comments that were inappropriate and not acceptable at the facility. An interview conducted with CNA 2, on 5/17/23 at 3:00 p.m., indicated Resident B was physical during care with hitting and kicking at the staff members. He cared for Resident B on 2 occasions. At the beginning of Resident B's care he would attempt to bribe him with ice cream. As soon as the other female CNA (CNA 4) started to care for Resident B, he starting flailing his arms. CNA 2 stated he previously worked at a behavioral unit in the long-term care facility and they conducted procedures like manual methods. The other staff members at the facility are the ones that told CNA 2 they usually handle Resident B with manual methods like holding his hands and wrists. He had only worked at the facility for a couple of weeks and only received 1 day of orientation and then he was working by himself. A policy titled "Dementia Care", revised 2/2023, was provided by the Regional Vice President on 5/17/23 at 3:20 p.m. The policy indicated the following, "...It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being...Policy Explanation and Compliance Guidelines...1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible...3. The care plan interventions will be related to each			

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	resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses...4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety...7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary...8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e., physician, mental health provider, licensed counselor, pharmacist, social worker)...9. All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure residents' safety and help resident's attain or maintain the highest practicable physical, mental, and psychosocial well-being...." 3.1-37(a)			
F 0756 SS=E Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician			

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	and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure a system was in place to review pharmacy reviews and potential recommendations for 4 of 5 residents reviewed for unnecessary medications. (Resident 18, Resident E, Resident 25, and Resident 50)	F 0756	F 756 Drug Regime Review **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 18: recommendations were reviewed by the provider and	06/05/2023

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	Findings include: 1. The clinical record for Resident 18 was reviewed on 5/18/23 at 1:10 p.m. The diagnoses included, but were not limited to, muscle weakness, diabetes mellitus, malnutrition, vascular dementia, and visual hallucinations. A quarterly minimum data set (MDS) assessment, dated 4/13/23, indicated the use of a antipsychotic and antidepressant for the previous 7 day look behind period of the MDS assessment. A physician order, dated 12/14/22, noted the use of Seroquel (antipsychotic medication) 50 milligrams in the morning and 100 milligrams at bedtime for visual hallucinations. A pharmacy review, dated 9/29/22, indicated the clarification for the appropriate use for the medication Seroquel. There was no documentation to show that the recommendation was followed up with. A monthly pharmacy review was documented as conducted on the following date(s): 9/1/22, 9/21/22, 10/23/22, 11/18/22, 12/23/22, 1/17/23, 2/20/23, 3/28/23, & 4/22/23. 2. The clinical record for Resident E was reviewed on 5/22/23 at 10:50 a.m. The diagnoses included, but were not limited to, diabetes mellitus, bipolar		clinical record updated accordingly Resident E: recommendations were reviewed by the provider and clinical record updated accordingly Resident 25: recommendations were reviewed by the provider and clinical record updated accordingly Resident 50: recommendations were reviewed by the provider and clinical record updated accordingly **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: Facility completed a 30 day look back of pharmacy recommendations to ensure all recommendations were reviewed by the provider and clinical record updated accordingly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical Staff (Nurses) were educated on the guideline for Pharmacy Services to include but not limited to follow up on pharmacist recommendations. On-going monitoring: DNS or designee will review pharmacy recommendations upon receiving them and ensure the MD/NP completes review and response	

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	disorder, anxiety disorder, and depressive episodes. Resident E was admitted to the facility on 10/2/21. A physician order, dated 12/2/22, was noted for aripiprazole 30 milligrams (antipsychotic); give 1 tablet daily for bipolar disorder. A physician order, dated 4/5/23, was noted for citalopram 20 milligrams (antidepressant); give 1.5 tablets by mouth daily for depressive episodes. A monthly pharmacy review was documented as conducted on the following date(s): 4/22/23, 3/28/23, 2/20/23, 1/17/23, 12/23/22, & 12/2/22. There was no documentation in the clinical record about any possible recommendations for the following pharmacy reviews. 3. The clinical record for Resident 50 was reviewed on 5/16/23 at 4:06 p.m. The diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, schizophrenia, and depression. A physician order, dated 4/5/23, was noted for escitalopram 5 milligrams (antidepressant) daily for depression. A physician order, dated 2/3/23, was noted for risperidone 4 milligrams (antipsychotic) daily at bedtime for "moods". A monthly pharmacy review was conducted on the following date(s):		timely and documented in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	2/7/23, 2/20/23, 3/28/23, 4/22/23, 4/29/23, 5/4/23, 5/13/23, & 5/18/23. There was no documentation in the clinical record about any possible recommendations for the following pharmacy reviews. 4. The clinical record for Resident 25 was reviewed on 5/16/23 at 3:51 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, diabetes mellitus, anxiety disorder, depression, and encephalopathy. A physician order, dated 5/22/23, was noted for escitalopram 20 milligrams, half tablet, daily for depression. A physician order, dated 4/25/23, was noted for aripiprazole 5 milligrams daily for depression. A monthly pharmacy review was conducted on the following date(s): 1/3/23, 1/14/23, 2/20/23, 3/28/23, 4/3/23, 4/10/23, 4/14/23, 4/22/23, & 5/20/23.			

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	There was no documentation in the clinical record about any possible recommendations for the following pharmacy reviews. An interview conducted with Area Vice President, on 5/19/23 at 10:50 a.m., indicated she could not locate pharmacy reviews or recommendations for Resident 18. A policy titled "Pharmacy Services", undated, was provided by the Area Vice President on 5/22/23 at 9:37 a.m. The policy indicated the following, " ...Compliance Guidelines ...4. The licensed pharmacist will collaborate with facility leadership and staff to coordinate pharmaceutical services within the facility, guide development and evaluation of pharmaceutical services procedures, and help the facility identify, evaluate, and resolve pharmaceutical concerns which affect resident care, medical care, or quality of life such as the ...a. Provision of consultative services by a licensed pharmacist as necessary ...8. The pharmacist, in collaboration with the facility and medical director, should include within its services to ...a. Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmaceutical services, including procedures to support resident quality of life such as those that support safe, individualized medication administration programs ...9. The pharmacist, in collaboration with the facility and medical director, may include other aspects of pharmaceutical services such as ...a. Development of procedures and guidance in relation to medication issues and/or adverse effects ...." 3.1-25(i)			
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview and record review, the facility failed to ensure an infection control program that consisted of mapping and tracking infections for 11 of 12 months reviewed. Findings include: The infection control binder was provided by the Area Vice President on 5/22/23 at 2:50 p.m. She	F 0880	**F880 Infection Control** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No specific residents were identified	06/05/2023

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	indicated the facility found the binder in the Clinical Education Coordinator's office. The binder included the following: June of 2022- blank, July of 2022- blank, August of 2022- blank, September of 2022- blank, October of 2022 - blank, November of 2022- blank, December of 2022- blank, January of 2023- blank, February of 2023- Facility mapping with a list of cultures obtained in November and December of 2022, March of 2023- facility mapping with a list of cultures obtained but none referring to "lung" as marked on the facility map, & April of 2023- facility mapping with a list of cultures obtained. The binder did not reflect the number of infections, where they were acquired, and/or the rate of infection. A document titled "Infection Surveillance Monthly Report", dated May of 2023, was provided by the Area Vice President on 5/19/23 at 12:11 p.m. The document noted the total number of infections, if they were community acquired, if they were acquired in the facility, the infection category, and the rate of facility acquired infections. An interview conducted with the Area Vice President, on 5/19/23 at 12:11 p.m., indicated the only infection surveillance log she could locate was for May of 2023. She was unsure if it was being conducted prior to the Assistance Director of Nursing (ADON's) arrival to the facility.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: The facility completed a 30 day look back of infections to track and map infections. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education : Director of Clinical Education was educated on the guideline for Infection Prevention and Control Program to include but not limited to mapping and tracking infections for trends and cause and rate of infection. On-going monitoring: DNS or designee will monitor new orders for antibiotic therapy to ensure they are added to the facility mapping, followed by the IPC for tracking, trends and rate of infection. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	A policy titled "Infection Prevention and Control Program", undated, was provided by the Area Vice President on 5/22/23 at 9:37 a.m. The policy indicated the following, " ...1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases ...3. Surveillance ...a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment, and accepted national standards ...b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee ...." 3.1-18(b)(1)(A)		**into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's			

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	155157	A. BUILDING 00 B. WING	05/22/2023

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	representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure influenza and pneumococcal immunizations were offered and/or administered for 3 of 5 residents reviewed for immunizations. (Residents H, 29, and 49) Findings include: 1. The clinical record for Resident H was reviewed on 5/19/23 at 9:10 a.m. Resident H was admitted to the facility in December of 2022. No influenza vaccine was documented since admission. The immunizations documentation indicated Resident H received a previous pneumococcal vaccine in 2012. There were no further pneumococcal vaccinations documented since the previous vaccine was administered prior to Resident H turning 65 years of age. 2. The clinical record for Resident 29 was reviewed on 5/19/23 at 9:25 a.m. There was no influenza or pneumococcal vaccine documented in Resident 29's clinical record. 3 The clinical record for Resident 49 was reviewed on 5/19/23 at 9:11 a.m. Resident 49 was admitted to the facility on 1/6/23 with documentation of a pneumococcal vaccine given on 10/1/2013 but no influenza vaccine documented since admission. There were no further pneumococcal vaccinations documented since the previous vaccine was administered prior to Resident 49 turning 65 years	F 0883	F 883 Influenza and pneumococcal immunization **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident H: Clinical record has been reviewed and updated with consent and administration or declination of vaccine Resident 29: Clinical record has been reviewed and updated with consent and administration or declination of vaccine Resident 49: Clinical record has been reviewed and updated with consent and administration or declination of vaccine **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Initial audit: The facility completed an audit of all residents of Influenza/Pneumococcal vaccine status to ensure there is documentation in the clinical record of receiving or declining	06/05/2023

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	of age. An interview conducted with Area Vice President on 5/19/23 at 12:11 p.m., indicated the facility staff were unable to find indication of the influenza vaccine and/or pneumococcal vaccines being administered to Resident's H, 29, and 49. A policy titled "Pneumococcal Vaccine (Series)", undated, was provided by the Area Vice President (AVP) on 5/22/23 at 9:37 a.m. The policy indicated the following, " ...1. Each resident will be assessed for pneumococcal immunization upon admission ...Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received ...2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized ...5. The type of pneumococcal vaccine ...offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations ...." A policy titled "Influenza Vaccination", undated, was provided by the AVP on 5/22/23 at 9:37 a.m. The policy indicated the following, " ...It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza...." 3.1-13(a)(1)		vaccine. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Education: Clinical staff (Nurses) were educated on the guideline for Influenza/Pneumococcal vaccine to include but not limited to the resident is offered the vaccine, and documentation is present in the clinical record for consent, administration or declination. On-going monitoring : DNS or designee will review new admissions for Influenza/Pneumococcal vaccine to ensure the resident is offered the vaccine, and documentation is present in the clinical record for consent, administration or declination. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6	

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			months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 9999 Bldg. 00		F 9999	**F9999 Final Observations**	06/05/2023
	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No Residents identified as affected **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** No residents identified **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** On-going monitoring : ED or designee will review new hire employee files for timely completion of required items per state regulation. These reviews to be conducted weekly x 4 weeks, then 2 times a	

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	residents and to gain understanding of the current standards of care for residents with dementia. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or		month x 5months . **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to ensure that employee files contained 2 references, tuberculosis testing, a physical exam, and/or training for resident rights, abuse, and/or dementia for 8 of 10 employee files reviewed. ((Dietary Aide 9, Restorative Aide 10, Certified Nursing Assistant (CNA) 2, Qualified Medication Aide (QMA) 18, Assistant Director of Nursing (ADON), CNA 19, Licensed Practical Nurse (LPN) 20, and CNA 4)). Findings include: Employee files were reviewed on 5/19/23 at 10:30 a.m. The following items were not noted in the personnel files for the following employee(s): Dietary Aide 9 did not have 2 references in the personnel file, Restorative Aide 10 did not have a 1st and 2nd step for tuberculosis testing, QMA 18 did not have 1st and 2nd step for tuberculosis testing, ADON did not have 2 references in the personnel file, CNA 2 did not have 2 completed references and completed dementia training, CNA 19 did not have 2 references and completed dementia training, LPN 20 did not have a criminal background check, 2 references, a physical exam, and 1st and 2nd step for tuberculosis testing, & CNA 4 did not have current, annual resident rights, abuse, and/or dementia training.			

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	An interview conducted with Area Vice President, on 5/22/23 at 10:39 a.m., indicated she was not able to locate any further documentation from the employee files.			