DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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 IN00408748, IN00407225 & IN00410341. Complaint IN00408748 - No defiencies related to the allegations are cited. Complaint IN00407225 - Federal/state deficiencies related to the allegations are cited at F600 and F684. Complaint IN00410341 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: June 12, 13, 14, 15, 16 & 19, 2023 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 0 Medicaid: 55 Other: 9 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/26/2023.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after July 14, 2023.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory Schiavone	RVPO	07/10/2023

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 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation			

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	to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on observation, interview and record review, the facility failed to ensure the signed advance directive was updated in the plan of care and physician order for 1 of 25 residents reviewed for advanced directives. (Resident 20) Finding includes: A record review was completed on 6/14/2023 at 2:40 P.M. Diagnoses included, but were not limited to: cerebral infarction and hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side. A Physician Orders For Scope of Treatment (POST), dated 5/12/2023, indicated do not attempt resuscitation. A Physician Order, dated 4/5/2022, indicated full code. A Care Plan, dated 2/19/2020, indicated resident/legal representative prefers a full code status. During an interview on 6/14/2023 at 10:30 A.M., the Director of Nursing indicated they obtain a code status upon admission, readmission, and revisit during a quarterly care conference. The resient was a do not resuscitate and the order and care plan should have been updated when it was changed. On 6/14/2023 at 10:47 A.M., the Director of Nursing provided a policy titled, "Advanced Directives", revised 2/2023, and indicated the	F 0578	**F578 Request, refuse, discontinue treatment, formulate advanced directives** It is the practice of this facility to ensure that residents have the right to request, refuse, and/or discontinue treatment, to formulate an advanced directive and that this is provided to residents consistent with professional standards of practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20's physician order and care plan were updated to reflect resident/POA's advanced directive wishes. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. An audit of all residents advanced directives, code status orders and care plans will be completed. Any findings will be reviewed with resident/POA, MD, and orders/care plans will be updated as needed. **What measures will be put into**	07/14/2023

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	policy was the one currently used by the facility. The policy indicated "...if a resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive, in accordance with state law...Information about any Advanced Directives already in place will be gathered as part of the admission process. Executed Advanced Directives will be documented in the medical record. Advanced Directives which reflect medical care and treatment will be documented in a physician's order...Advanced Directives will be reviewed quarterly during care plan conference and as needed upon change in condition....The POST (physician's orders for scope of treatment) is a physician's order based on resident's individual goals and treatments for medical treatment...the POST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference, anytime there is a significant change in the resident's condition and at anytime the resident or legally recognized health care decision maker requests it...at any time, a resident or legally recognized health care decision making can revoke the POST form or change his/her mind about treatment preferences by verbalizing or given a written advance directive, or after consultation with physician or advanced practice nurse, a new POST form...All discussions about revising or revoking the POST form should be documented in the resident's medical record...." 3.1-4(5)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses and social services will be reeducated on reviewing and updating advanced directives per resident and/or POA wishes. Advanced directives will be reviewed and updated including orders and care plans upon admission, quarterly, and as needed per resident/POA request and with changes in condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “advanced directives” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must--			

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	(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already			

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	paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.			
	Based on record review and interview, the facility failed to ensure a notification of change in Medicare covered services was provided for 1 of 3 residents reviewed for Medicare services. (Resident 64) Finding includes: The clinical record for Resident 64 was reviewed on 6/14/2023 at 11:00 A.M. Resident 64 was admitted to the facility on 11/29/2022 and was receiving Medicare Part A Services. Review of the record indicated the resident's last covered Medicare Part A services day was 2/16/2023. The clinical record for Resident 64, reviewed on 6/13/2023 at 1:17 P.M., indicated the resident was admitted to the facility on 11/29/2022 with diagnoses included, but not limited to: hemiparesis and hemiplegia related to subarachnoid hemorrhage, diabetes mellitus, depression, and dysphagia. The resident was receiving Medicare Part A skilled services when she was admitted, and her last covered Medicare day was 2/16/2023. The facility Business office provided	F 0582	**F582 Medicaid, Medicare, coverage liability notice** It is the practice of the facility to ensure the appropriate financial liability notification forms are provided. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Business Office, Therapy, and social service staff in-service will be completed on or before 7/14/23 on issuing a notice of Medicare non-coverage letters. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. An audit of all Advanced Beneficiary Notices and Notice of Medicare Non-Coverage letters were reviewed and corrected by	07/14/2023

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	documentation that a skilled care ABN (Advanced Beneficiary Notice of Non-Coverage form and a NOMNC (Notice of Medicare Non-Coverage) form were not issued to Resident 64. Resident 64 chose to remain a resident of the facility after 2/16/2023. During an interview with the Business Office Manager (BOM), on 6/13/2023 at 10:30 A.M., she indicated she could not locate the forms for Resident 64 and both forms should have been provided to the resident. The BOM indicated the facility policy was to follow the requirements of both forms per CMS (Centers for Medicare and Medicaid Services). The form instructions for the NOMNC form indicated a completed copy was to be delivered to the resident and/or their representative 2 calendar days prior to Medicare covered services ending. The form instructions for the ABN indicated it was to be issued in advance of a shift from Medicare covered items and/or services to expected non-coverage of items or services. 3.1-4(f)(2)		7/14/23 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Business Office, Therapy, and social service staff in-service will be completed on or before 7/14/23 on issuing notice of all advanced beneficiary notices and notice of Medicare non-coverage letters. Business office log will be reviewed by home office business office monthly to ensure the NOMNOC was issued timely. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Notice of Medicare Non-Coverage Letters” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on record review and interview, the facility failed to protect a residents right to be free from verbal abuse for 1 of 1 resident reviewed for abuse. (Resident C) Finding includes: Review of a facility reported incident, on 6/11/2023 indicated Resident C reported a staff person to be verbally abusive to her. The report indicated the identified employee was suspended pending an investigation, alert and oriented residents were interviewed to determine any concerns with staff they might have, the identified employee received Customer service education and the progressive discipline policy was followed. Resident C was to be monitored for any psychosocial concerns regarding the event. There was no specific information regarding the event on the facility reported incident. However, review of the incident investigation, provided	F 0600	**F600 Free from abuse and neglect** It is the practice of this facility to ensure that residents have the right to be free from abuse, neglect, and exploitation consistent with professional standards of practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C was assessed for psychosocial distress with no abnormal findings. MD and POA were updated. Employee 16 was immediately suspended pending investigation and was ultimately terminated. **How other residents having the potential to be affected by the**	07/14/2023

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	upon request on 6/14/2023 indicated the following: On 6/8/2023, two activity aides (Employee 15 and 16) had transported Resident C on the facility bus to an outside physician's office for an appointment. During the bus ride to the appointment, Employee 16 had been driving the bus and Employee 15 was sitting with the resident on the bus. Resident C had been complaining about the bumpy road during the trip. Once the bus arrived at the medical office building, Employee 15 assisted Resident C to the building and discovered they were at the wrong entrance/address. According to Employee 15, Resident C and Employee 16 started speaking to each other, in a raised voice and arguing. Employee 16 then stated to Resident C "I brought your a-- to the right place. I'm tired of your f------ yelling at me." Employee 16 also called Resident C a "b----." During an interview with Employee 15, on 6/14/2023 at 3:57 P.M. she confirmed the other Act Aide called Resident C a "b----" and said also told Resident C that she had "brought her a-- to the right place" and told the resident she was "tired of her f------ yelling at her." Employee 15 indicated she did not do anything immediately as she did not want to get in the "middle of it" but she did consider it "mental abuse" and she reported the incident to the Administrator immediately when she returned from the outing. Resident 15 indicated she pushed Resident C into the doctor's office immediately after arriving at the correct entrance and she and Employee 16 drove back to the facility. Employee 15 indicated she had been in-serviced regarding the facility's abuse policy and was able to verbalize the resident was to be removed from any abusive situation and any		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Other residents were interviewed with no additional findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on abuse on or before 7/14/23, upon hire, annually, and as needed. Residents will be interviewed weekly by SS/designee to ensure residents are not verbally abused. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Abuse prohibition and investigation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee	

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	abuse was to be reported to the Administrator immediately. Review of an Employee Communication Form and interview with the Director of Nursing, on 6/14/2023 at 3:15 P.M. she indicated Employee 16 was terminated for "Disruptive Behavior" on 6/8/2023. The form indicated the employee used "Inappropriate Verbage" and her "workplace conduct was no in accordance with customer service expectations" and she was "argumentative with resident." The form was completed on 6/13/2023. The Director of Nursing indicated the employee had some previous disciplinary reports and she was terminated after this incident. The facility's Abuse, Prohibition, Reporting and Investigation policy, provided by the Administrator upon entrance to the facility on 6/12/2023, included the following: "...It is the policy of [name of company]to provide each resident with an environment that is free from abuse...[name of company] will not permit residents to be subjected to abuse by anyone, including employees...Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance...This includes any episode of staff to resident...Resident Abuse - Staff member, volunteer, or visitor: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately. 2. Any individual who witnesses abuse, or has suspicion of abuse, shall immediately notify the chart nurse of the unit, which the resident resides and to the Executive Director (Administrator)...." This Federal tag relates to complaint IN00407225.		for review and follow up.	

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	3.1-27(b)			
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 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,			

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	(ii) Language, (iii) Other functional communication systems. Based on interview and record review, the facility failed to ensure showers were provided for 1 out of 3 Residents reviewed for activities of daily living. (Resident 50) Finding includes: During an interview on 6/13/2023 at 9:11 A.M., Resident 50 indicated he preferred to take a shower but does not get one. During an interview on 6/14/2023 at 1:28 P.M., Resident 50 indicated he did not have a shower this week. During an interview on 6/16/2023 at 1:41 P.M., the resident indicated he had not received a shower this week. A record review was completed on 6/15/2023 at 2:00 P.M. Diagnoses included, but were not limited to: neoplasm of the brain, Diabetes Mellitus, anxiety and depression. A Quarterly Minimum Data Set (MDS) Assessment, dated 5/22/2023, indicated physical help in part of bathing activity. A Preference for Customary Routine and Activities, dated 4/11/2023, indicated he would like twice a week shower in the P.M. and that it was very important to him to choose between tub bath, shower, and bed/sponge bath. A Care Plan, dated 4/9/2023, indicated resident required assistance with activities of daily living (ADL's) with an intervention to assist with bathing as needed per residents' preference. Offer	F 0676	**F 676 – Activities of daily living/maintain abilities** It is the practice of the facility to ensure all residents receive care and services to ensure resident's ability with Activities of Daily Living do not diminish consistent with professional standards of practice. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 50 has been provided showers per preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and accuracy of shower schedule will be completed on or before 7/14/23. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will ensure Shower schedules are established. The DNS/Designee will review Shower Sheets daily to ensure showers are provided per resident preference.	07/14/2023

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	155115	A. BUILDING 00 B. WING	06/19/2023

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	showers two times a week and partial bath in between. During an interview on 6/15/2023 at 3:53 P.M., the Director of Nursing indicated they have a shower schedule posted at the nurse's station, it is the only location where the resident showers are posted. The staff document the showers on the shower sheet and chart in the progress notes of any refusals. She indicated that he was not on the shower schedule, and she could not find any documentation indicating he got a shower or of any refusals. No shower sheets were located for month of May and June. He should have been getting two showers a week per his preference. On 6/16/2023 at 12:00 P.M., the Director of Nursing indicated that they have no policy on showers. 3.1-38(2)(A)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interviews, the facility failed to ensure Activities of daily living assistance was provided for 2 of 4 residents reviewed. (Resident 20 and 53) Findings include: 1. Resident 53 was observed on 6/12/2023, 6/13/2023 and 6/14/2023 dressed in the common areas and/or at an activity. Her hair was observed	F 0677	**F 677 – ADL Care Provided for Dependent Residents** It is the practice of the facility to ensure all residents receive assistance with Activities of Daily Living in accordance with professional standards. **What Corrective action(s) will be accomplished for those**	07/14/2023

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	to be unkept in appearance and greasy. The clinical record for Resident 53, reviewed on 6/19/23 at 9:16 A.M., indicated the resident had diagnoses included but not limited to: hypertension, chronic kidney disease hyperlipidemia, obesity, insomnia, adjustment disorder with depressed mood, dementia, and major depressive disorder, recurrent, The most recent MDS (Minimum Data Set) assessment for Resident 53, completed on 5/11/2023 for a quarterly review, indicated the resident was severely cognitively impaired and required extensive assist of one for toileting, bathing, dressing, and limited assist of one for personal hygiene. The annual MDS assessment, completed on 4/12/2023, indicated it was very important for the resident to choose between a bath/shower/bed bath on the preferences section of the assessment. The current care plan regarding preferences indicated the resident was to be showered twice a week in the mornings. The documentation in the resident's clinical record regarding showering and/or bathing from 5/19/2023 - 6/19/2023, indicated the resident was only documented to have received a shower on 5/31/2023 at 8:37 A.M. The Point of care documentation for bathing from 4/19/2023 - 5/18/2023 indicated the resident only received 3 showers and 1 complete bed bath. Finally, the charting form 4/1/2023 - 4/19/2023 indicated there were no showers documented. Copies of additional "Shower Report" forms for		**residents found to have been affected by the deficient practice:** Resident 53 has been provided assistance with washing her hair and shower assistance per preference. Resident 20 was provided assistance with nail care per preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. An audit of shower preferences and nail care will be completed on or before 7/14/23. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will ensure Shower schedules are established. The DNS/Designee will review Shower Sheets daily to ensure showers are provided per resident preference. Care companions will monitor resident's nails daily and report any findings to DNS for any needed follow-up. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this	

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	Resident 53 were provided on 6/14/2023 at 2:00 P.M. by the Administrator. The forms indicated the resident had received a shower on the following dates: 4/3/2023, 4/6/2023, 4/10/2023, 4/13/2023, 4/17/2023, 4/20/2023, 4/27/2023, 5/1/2023, 5/4/2023, 5/8/2023, 5/15/2023, 5/18/2023, 5/25/2023, 5/29/2023, 6/1/2023, and 6/8/2023. The shower form on 4/3/2023 and 4/6/2023 were not signed by the aide or the nurse and did not indicate the time the shower was given and if a shampoo, nail care, was given. The form on 4/10/23, 4/27/2023, 5/4/2023, 5/8/2023, 5/15/2023, 5/18/2023, 5/25/2023, 5/29/2023, 6/1/2023 and 6/8/2023 were all signed by the same nurse, LPN 1, not signed by the aide completing the showering and only indicated "shower" given, not shampoo. Review of the April 2023 schedule and interview with the Director of Nursing, on 6/19/2023 at 11:40 A.M., indicated on several of the days Employee 1, an LPN, had signed an incomplete shower report, she was not on the working schedule for the day. The Director of Nursing indicated she did know why LPN 1 was not on the schedule on the days she had signed the shower report forms but she was going to "look into" the discrepancy. She indicated the aides were not good about documenting correctly in the Point of Care electronic record. No further information regarding the showers and/or shower forms was provided during the survey.2. A record review was completed on 6/14/2023 at 2:40 P.M., for Resident 20. Diagnoses included, but were not limited to: cerebral infarction and hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side. During an observation, on 6/13/2023 at 10:17 A.M., Resident 20 was in bed and had long, jagged fingernails with a dark substance under		corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool "Accommodation of Needs" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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them.

During an observation, on 6/14/2023 at 9:04 A.M., the resident was in bed fingernails long, jagged with brown substance under the nails.

During an observation, on 6/16/2023 at 2:34 P.M., the resident was in bed and had long, jagged fingernails with brown substance under them.

A Quarterly Minimum Data Set (MDS) assessment, dated 5/24/2023, indicated that he is total dependent for bathing with one assist.

A Care Plan, dated 2/9/2020, indicated resident requires assistance with activities of daily living (ADL's), assist with dressing, grooming, and hygiene as needed.

During an interview, on 6/14/2023 at 3:21 P.M., certified nurse aide (CNA) 5 indicated when she gives a shower she washes the entire body, wash hair, brush residents' teeth, and inspects the skin for redness.

During an interview, on 6/15/2023 at 10:17 A.M., CNA 7 indicated when she gives a shower, she will assist with washing the body and their hair, brush the teeth and shave them if needed.

During an interview, on 6/15/2023 at 10:21 A.M., CNA 6 indicated when she gives a shower she washes the whole body, hair, shaves them and clips toe and fingernails, dries them off and assist with dressing.

On 6/16/2023 at 12:00 P.M. the Director of Nursing indicated she does not have a policy on nail care or showers.

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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.			
	Based on observation, record review and interviews, the facility failed to ensure antibiotic medications were administered as directed by the physician's orders and anti- coagulant medication was resumed timely for 1 of 3 residents reviewed. (Resident C) Findings include: The record for Resident C, reviewed on 6/14/2023 at 11:01 A.M., indicated Resident C was admitted with diagnoses included, but not limited to: acute embolism and thrombosis of right lower extremity, thrombocytopenia, repeated falls, muscle weakness, unsteadiness on feet and osteomyelitis of vertebra -cervical and thoracic region. The resident was hospitalized 3/28/2023 - 4/11/2023 for a septic arthritic left hip joint and on 6/8/2023 for an acute deep vein thrombosis. Review of the hospital discharge records for Resident C, completed on 4/11/2023 indicated the resident was to receive enoxaparin (an anticoagulant) .3 ml (mililiter) via subcutaneous injections every 12 hours for 21 days. In addition, the resident was to receive the antibiotic, Vancomycin 1 gram via intravenous route every	F 0684	**F684 Quality of care** It is the practice of the facility to ensure all residents receive treatment and care in accordance with professional standards. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C was evaluated by the MD and a medication review was completed with new orders received. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will conduct an audit of all residents who received anticoagulant medications and have been transferred to the hospital to ensure current order is per physician orders. An audit of	07/14/2023

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	12 hours for 6 weeks. Review of the medication administration record (MAR) for April and May 2023 for Resident C indicated she received the enoxaparin injections from 4/11/2023 through 5/2/2023. The resident had received the Vancomycin infusions but missed one dose on 4/18/2023, 4/19/2023, 4/21/2023, 4/25/2023 and 4/29/2023. The resident missed both doses on 4/20/2023. After 5/2/2023 the resident had no physician's orders for any type of blood thinning medication. During an interview with the Director of Nursing, on 6/19/2023 at 1:46 P.M., she indicated on 4/20/2023 the vancomycin was put on hold due to staff waiting on dosing from the pharmacy based on laboratory results and on 4/25/2023 the resident had been out of building with her family for the morning dose and was given the evening dose when she returned. The Director of Nursing indicated she could not account for the other 4 missing doses. Review of acute care records for Resident C, dated 6/8/2023 indicated the resident presented to the emergency room with "overt nonpitting edema to the right lower extremity with associated tenderness below the knee." The resident was diagnosed with an acute DVT (deep vein thrombosis of the deep femoral vein on the right side. The hospital notes emphasized the resident had not been on anticoagulant for several weeks. The resident had reported to the acute care physician she thought the anticoagulation medication had been stopped the first week in May 2023. Review of physician progress notes, dated 5/26/2023 and 6/5/2023, indicated the resident's		residents with current anticoagulant orders will be audited to ensure order is per physician's orders. All antibiotic orders will be audited for the past 30 days to ensure medication was given per physician's order. A medication review will be completed with MD as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS or Designee will in-service all nursing staff regarding the timely assessment of new or worsening edema to include MD notification. DNS or Designee will in-service all nursing staff regarding administering antibiotic and anticoagulant medications as ordered. DNS/designee will in-service the medical director regarding appropriateness of resident's current medical regimen. DNS/designee will monitor administration compliance via the EMAR administration report and any changes in conditions via the facility activity report daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each**	

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	current medication list included enoxaparin injections, even though the order was discontinued on 5/2/2023. The note also listed "Assessment" issues including "Acute embolism and thrombosis of left femoral vein: continue Xarelto, monitor extremities for changes in color, temperature and peripheral pulse." and "Muscle weakness (generalized) Pt (patient) is immobile. Continue Lovenox (brand name for enoxaparin) ...." During an interview with the physician on 6/19/23 at 11:56 A.M., he indicated he used a "Scribe" system for writing his notes which accounted for the way certain "things" were typed on the notes. He indicated acute orders from the hospital orthopedic team and/or hospitalists take presidence over routine orders and often resident's blood thinners were held prior to surgical procedures. He indicated while the resident would not be prescribed Lovenox injections at the same time as oral Xarelto medications, she should have been on a blood thinner. He indicated Resident C did have an IVF (intravenous filter) due to her history of blood clots, but she should also have been on Xarelto indefinitely. He indicated the whole clinical team was responsible for reviewing the resident's chart and ensuring her medication regimen was complete and accurate. He indicated no one from the facility had notified him of the need to reorder Xarelto. The facility policy and procedure, titled, "Resident Change of Condition" provided by the Regional Nurse Consultant on 6/19/2023 at 2:29 P.M., included instructions for reporting " Non-urgent Medical Change". The facility policy and procedure, titled,		**deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool. The DNS/designee will be responsible for completing the QAPI Audit tool “change in condition”, “antibiotic therapy” and “physician services” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	"Physician Services" provided by the Regional Nurse Consultant on 6/19/2023 at 2:29 P.M., included the following: "...The Physician must document a review of the resident's total program of care, including the resident's current condition, progress and problems in maintaining or improving their physical, mental, and psychosocial well-being and decisions about the continues (sic) appropriateness of the resident's current medical regimen...." This Federal tag relates to complaint IN00407225 and IN00410341. 3.1-37			
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 observation and record review, the facility failed to ensure physicians orders to prevent the development of pressure ulcers was implemented for 1 of 3 residents reviewed. (Resident 33)	F 0686	**F 686 Prevent/heal pressure ulcers** It is the practice of this facility to ensure residents receive care consistent with professional standards of practice to prevent	07/14/2023

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	Finding includes: A record review was completed on 6/14/2023 at 11:55 A.M. for Resident 33. Diagnoses included, but were not limited to: acute and chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease. During an observation, on 6/12/2023 at 12:41 P.M., resident was lying in bed supine with her legs crosses at the ankles, heels not floated, no prevalon boots on or ear protectors on the oxygen tubing. During an observation, on 6/13/2023 at 10:03 A.M., resident was lying supine in bed, heels not floated, no prevalon boots on and no ear protectors on the oxygen tubing. During an observation, on 6/14/2023 resident was lying supine in bed, heels not floated, no prevalon boots on and no ear protectors on the oxygen tubing. A Physician Order, dated 2/24/2023, indicated prevlon [sic] boots to be worn at all times except during patient care. A Physician Order, dated 2/24/2023, indicated to encourage to float heel when in bed. A Physician Order, dated 4/7/2023, indicated ear protectors to oxygen tubing and check placement every shift. A Care Plan, dated 11/11/2022, indicated at risk for skin breakdown with interventions to encourage to float heel and prevlon [sic]boots to be worn at all times except during patient care.		pressure ulcers. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Prevalon boots, ear protectors and heels floated interventions were put into place per physician orders for resident 33. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. An audit of resident's skin preventative measures will be completed to ensure items are in place per physician's orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing will be re-educated related to pressure ulcer prevention. Care companions will round daily using the resident's CP profile to ensure ordered skin interventions are in place, DNS/designee will be notified of any findings for follow-up as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	During an interview, on 6/14/2023 at 11:16 A.M., the Director of Nursing indicated she is not wearing prevalon boots or ear protectors on the oxygen tubing or floating her heels. She does have orders for them and should have been wearing them. She was unable to find documentation of refusals in the progress notes or the treatment record. She would expect her staff to document refusals and inform management or doctor of refusals and discontinue them. On 6/16/2023 at 12:00 P.M., the Director of Nursing indicated she does not have a policy on physician orders. 3.1-40		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “wounds and skin management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interviews, the facility failed to ensure respiratory equipment was maintained per professional standards for 3 of 3 residents reviewed for respiratory care. (Resident 44, 33 and 1) Findings include: 1. Resident 44 was observed on 6/12/2023 during	F 0695	**F695 Respiratory/Tracheostomy Care** It is the practice of this facility to ensure residents receive respiratory care in accordance with professional standards, comprehensive plan of care, and residents’ preferences. **What corrective action(s) will**	07/14/2023

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	the initial tour of the facility, lying in bed, holding his oxygen tubing and nasal cannula in his hands. The resident's oxygen tubing, which was connected to a concentrator was not dated and there was no plastic storage bag observed in the room. On 6/13/23 at 10:07 A.M., Resident 44 was observed seated in his wheelchair with oxygen per a nasal cannula connected to a portable oxygen tank. The tubing was not dated. On 6/16/23 at 9:30 A.M., Resident 44 was observed lying in bed. The resident was not wearing oxygen at the time. The oxygen tubing was hanging off the back of his wheelchair, connected to a portable oxygen tank. There was no storage bag noted and the oxygen tubing was not dated. A record review was completed on 6/16/23 for Resident 44. Diagnoses included, but not limited to: dementia, Wernicke's encephalopathy, severe protein-calorie malnutrition, chronic obstructive pulmonary disease, lack of coordination, repeated falls, constipation, chronic pain, generalized anxiety disorder, major depressive disorder, hyperkalemia, dysphagia, cognitive communication and alcohol dependence with delirium withdrawal, nicotine dependence, osteoarthritis. During an observation and interview of resident 44, with the DON, on 6/16/2023 at 10:58 A.M., she indicated oxygen tubing and/or a storage bag should have date on it and tubing was to be changed every week. She indicated the nurses usually wrote the date with a permanent marker when they changed the oxygen tubing. 2. During an observation on 6/12/2023 at 12:40		**be accomplished for those residents found to have been affected by the deficient practice:** Resident 44 had oxygen administered per physician order, new tubing was applied that was dated and bagged when not in use. Resident 33's oxygen concentrator filter was cleaned per policy. Resident 1 received new tubing and humidification bottle that were dated, and no smoking signage was applied to resident's door. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving oxygen has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit will be reviewed and ensure administration of oxygen per physician order, all tubing and humidification bottles are dated and bagged when not in use, concentrator filters are cleaned, and all residents receiving oxygen therapy have no smoking signage on their doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	P.M., Resident 33's oxygen concentrator filter was covered with white/gray colored lint. During an observation on 6/13/2023 at 10:04 A.M., the concentrator was covered with white/gray colored lint. During an observation on 6/14/2023 at 8:53 A.M., lint continued to be covering the filter. A record review was completed on 6/14/2023 at 11:55 A.M. Diagnoses included, but were not limited to: acute chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. A Physician Order, dated 4/7/2023, indicated to change the oxygen tubing and humidity, clean concentrator and filter once a day on Monday. During an interview on 6/14/2023 at 1:08 P.M., the Director of Nursing indicated that there was lint on the filter but needed to contact filter company on the maintenance of the filter. On 6/16/2023 at 1:20 P.M., the Regional Vice President of Operation (RVPO) provided maintenance on the filter for the concentrator titled, "Provider Maintenance", undated. The routine maintenance indicated "...The external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly...." On 6/16/2023 at 1:22 P.M. the Regional Vice President of Operation (RVPO) indicated that the filter should have been cleaned weekly. On 6/16/2023 at 1:20 P.M. the Regional Vice President of Operations provided a policy titled,		The DNS/designee will in-service nurses on oxygen administration, dating tubing/humidification bottles, bagging if not in use, concentrator filter cleaning per schedule, and no smoking signage on doors on or before 7/14/23. Any resident requiring oxygen will be reviewed daily by the DNS/designee to ensure administration of oxygen per physician order, equipment is dated and bagged when not in use, and no smoking signs are present on doors. Any residents with an oxygen concentrator will be audited weekly to ensure filters are cleaned per schedule. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Oxygen Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	"Oxygen Therapy Devices" , undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Oxygen Safety 1) No smoking signs need to be affixed to front and back of doors (OSHA regulations), Oxygen Devices 1) Nasal cannula e. Change out weekly and PRN, f. place in a labeled bag when not in use...." 3. A record review was completed for Resident 1 on 6/14/2023 at 10:00 A.M. The most recent MDS (mimimum data set), assessment, dated 4/4/2023, indicated severe cognitive impairment. Diagnoses included, but not limited to: chronic obstructive pulmonary disease, schizophrenia, palliative care for respiratory failure. Medications included but not limited to: Oxygen at 3 liters per nasal cannula as needed. During an observation on 6/14/2023 at 10:00 A.M., resident was dressed in bed with the head of the bed elevated. Oxygen was on at 3 liters/via nasal cannula. Tubing was not dated; humidification bottle not dated. During an observation on 6/15/2023 at 9:41 A.M., resident was in bed with oxygen on at 3 liter via nasal cannula. The tubing and humidification bottle were not dated. During an interview on 6/15/2023 at 9:57, Employee 1 indicated the resident should have an order to change all oxygen equipment on Sundays. A order for oxygen supply changes was not found in the clinical record. During an observation on 6/16/2023 at 9:18 A.M.,			

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	Resident was resting in bed with oxygen on at 3 liters via nasal cannula. No oxygen signage was on the door. During a 2nd interview, on 6/16/2023 at 9:18 A.M., with Employee 1 he indicated that tubing and humidification bottles should be dated, and that staff is responsible for chaning oxygen tubing and bottles on Sundays. Hospice managed oxygen therapy for this resident but that staff in the facility should change out oxygen supplies on Sundays as the ordered. She indicated if not directed in the physician order the oxygen supply changes should default to Sundays and there should be signage on the door. On 6/16/2023 at 1:20 P.M., Employee 16 presented a copy of the " Oxygen Therapy and Devices policy. The policy indicated ".....for some people with certain health conditions whose lung function is impaired, the amount of oxygen that is obtained through normal breathing is not enough. Therefore, they require supplemental amounts to maintain normal body function......oxygen must be ordered by physician, No smoking signs need to be affixed to front and back of doors per OSHA, practice standard precautions, gather equipment (liquid, cylinder, concentrator and humidity if applicable, apply device at appropriate flow, place oxygen signs and document in patient file.....Oxygen nasal cannula to be changed out weekly and as needed and place in labeled bag when not in use...." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observations and interviews, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents by 1 of 2 medication carts, 1 of 3 treatment carts. Findings include: 1. During a medication observation, on 6/14/2023, at 8:20 A.M., Qualified Medication Aide (QMA) 8 left the medication cart unlocked while she was in a resident's room. The medication cart was not in view of the QMA. QMA 8 indicated she should have locked the cart before entering the resident's room.	F 0761	**F761 Label/Storage Drugs and Biologicals** It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1 medication cart and 1 treatment cart were found to be unlocked; all medication carts were locked	07/14/2023

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	2. During a medication observation, on 6/14/2023 at 2:45 P.M., Licensed Practical Nurse (LPN) 9 walked away from the medication cart without locking it. It was not in view of the LPN. LPN 9 indicated he should have locked the medication cart before walking away. 3. On 6/15/2023 at 8:08 A.M., during an observation and interview with QMA 17, the treatment cart was unlocked in the unit's resident lounge with treatment medications and supplies. QMA 17 indicated the cart should be locked. 4. During a medication observation, on 6/15/2023 at 11:56 A.M., Registered Nurse (RN) 11 pre-poured metoclopramide 10 mg 1 tab oral every 6 hours, a medication for Resident 10, and left it in the resident's room on the nightstand while she went back to the nurse's desk. The resident was sitting in his wheelchair in the room at the time. During an interview at the time RN 10 indicated she should not have left the medication in the resident's room unattended. During an interview, on 6/15/2023 at 1:23 P.M., the Director of Nursing indicated medication and treatment carts should be locked when unattended and medications should not be left in a resident's room unattended. A current policy titled, "Storage and Expiration Dating of Medication, Biologicals" and revised on 7/21/2022, provided by the corporate nurse consultant, on 6/19/2023 at 10:13 A.M. The policy indicated, " ...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors ...."		immediately. QMA 8, LPN 9, and QMA 17 were immediately reeducated on locking medication and/or treatment carts. Resident 10 was not affected by this deficient practice; RN 10 was immediately reeducated related to not leaving medications unattended. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The DNS/designee will complete an audit of medication carts and treatment carts to ensure that all are locked appropriately when not in the presence of licensed nurse or pharmacy personnel. DNS/designee will complete an audit of resident rooms to ensure medications are not being left in rooms. In addition, the DNS/designee will be responsible for a facility wide weekly medication cart inspection. This will ensure that all medication storage areas are locked appropriately per facility policy and procedure. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Storage on	

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	A current policy titled, "General Dose Preparation and Medication Administration" and revised on 1/1/2022, was provided by the corporate nurse consultant, on 6/19/2023 at 11:04 A.M. The policy indicated, " ...Facility staff should not leave medications or chemicals unattended ...." 3.1-25(m)		or before 7/14/23. The in-service will be conducted by the DNS/designee and will review the facility policy related to Storage of medications and biologicals. Nursing staff will be re-educated regarding proper locking of medication carts and treatment carts. In addition, the DNS/designee will be responsible for a facility wide weekly medication cart inspection. This will ensure that all medication storage areas are locked appropriately per facility policy and procedure. The DNS/designee will round daily to ensure medication carts are locked timely and appropriately and medications are not being left in resident rooms. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” daily for 4 weeks, weekly for 1 month, monthly for 6 months. and skills checklist “medication pass procedure” will be completed for all nurses and QMAs. If threshold of 90% is not met, an	

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			action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation and interview, the facility failed to ensure food items in the freezer were dated/labeled and sealed securely after opening and failed to ensure used by dates on foods. This deficient practice had the potential to affect 62 of 64 residents who received meals out of the kitchen. Findings include:	F 0812	**F812 Food Procurement, Storage/Prepare/Serve-Sanitar y** It is the practice of this facility to ensure food is stored in compliance with currently accepted professional standards. **What corrective action(s) will be accomplished for those residents found to have been**	07/14/2023

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	On 6/12/23 at 9:28 A.M., during on observation and kitchen tour with the dietary manager, the following was oberserved: - In the pantry of the main kitchen, graham cracker crumbs were in an open bag with no date on the bag indicating when opened. - In the cooler, an open half gallon of milk and a carton of Half and Half had no open date. - In the freezer, two open tubs of ice cream had no open dates. Italian sausage, pork loin chops, beef cubed patties were found to be undated and unsealed. On 6/15/23 at 12:30 P.M., the Regional Nurse Consultant provided a policy titled, "Food Storage", revised 5/23 and indicated the policy was the one currently used by the facility. The policy indicated " ...frozen foods, should be covered or wrapped tightly, labeled and dated with the date the item is being placed in the freezer. Frozen food items should be used within 1 year of this date to maintain quality ....dry storage, all foods should be covered or wrapped tightly, labeled and dated ....refrigerated, ready-to-eat, potentially hazardous foods purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded ...." 3.1-21 (3)		**affected by the deficient practice:** Graham cracker crumbs, milk and half and half, ice cream, Italian sausage, pork chops, and beef cubed patties were discarded. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A kitchen audit will be completed by RD/designee related to proper storage and dating opened food items and any findings will be immediately corrected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The CDM/designee will in-service culinary staff on food storage and labeling opened items on or before 7/14/23. CDM/designee will conduct daily am check list to ensure proper food storage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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			Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Food Storage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	