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	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	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 Complaint IN00356736 and Complaint IN00358454. Complaint IN00356736 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-725. Complaint IN00358454 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-677. Survey dates: July 18, 19, 20, 21, 22, & 23 2021 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 7 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 3, 2021	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.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

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

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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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview and record review, the facility failed to promote a dignified environment for a resident by not providing a covering for a urinary catheter bag for 1 of 1 resident reviewed for dignity. (Resident 40) Findings include: An observation was conducted of Resident 40, on 7/19/21 at 10:47 a.m., sitting up in her wheelchair with a urinary catheter bag that was uncovered with the ability to see the contents of the catheter bag. Another observation conducted, on 7/19/21 at 3:19 p.m., of Resident 40's urinary catheter bag that was lying on the floor with the catheter bag covering mostly off the urinary catheter bag. There was the ability to see the contents of the catheter bag. Another observation conducted, on 7/20/21 at 9:25 a.m., of Resident 40's urinary catheter bag that was uncovered with the ability to see the contents of the catheter bag. On 7/20/21 at 10:45 a.m., Resident 40 was seated in a wheelchair with the urinary catheter bag covered with a privacy bag. The clinical record for Resident 40 was reviewed on 7/22/21 at 3:44 p.m. The diagnoses included, but were not limited to, intellectual disabilities and obstructive uropathy. A care plan for the use of an indwelling catheter, dated 3/26/21, indicated to check catheter tubing for proper drainage and positioning as well as always keeping the catheter bag below the level of	F 0550	**F 550 Resident Rights/Exercise of Rights** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #40: medical record has been reviewed and a urinary catheter bag covering is in place to ensure privacy. **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 foley catheters/drain bags have the potential to be affected by the alleged deficient practice. All residents with foley catheters have been audited to ensure a urinary catheter bag covering is in place and in use to provide for residents privacy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Clinical staff educated on the guidelines for catheter care to include proper use of urinary catheter bag covering. DNS or Designee will audit residents with foley catheters for proper placement of tubing off the floor and drain bag maintained in a urinary catheter bag covering or use of a drain bag with attached	08/22/2021

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	the bladder and off the floor. An interview was conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated urinary catheter bags should be covered with a privacy bag. A policy titled "Catheter Care", undated, was provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m. The policy indicated the following, " ...It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use ...." A policy titled "Promoting/Maintaining Resident Dignity", undated, was provided by Corporate Nurse 18 on 7/23/21 at 11:08 a.m. The policy indicated the following, " ...It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality ...12. Maintain resident privacy ...." 3.1-3(t)		privacy flap. Audit is to be reviewed five times a week for four weeks, then three times a week times four weeks, then weekly for four 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. **By what date the systemic changes be completed: August 22, 2021**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of			

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	this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to provide showers, as preferred, and failed to provide dining in the dining room, for 2 of 2 residents reviewed for choices (Resident D and T). Findings include: 1. During an interview, on 7/19/21 at 10:44 a.m., Resident D indicated he gets bed baths and hasn't been offered a shower in over a week. He hasn't had a choice to get a shower or bed bath, he just gets a bed bath and would like 2 showers a week. His hair was observed to be greasy.	F 0561	**F 561 Self Determination** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Facility is unable to identify Resident D and Resident T **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Facility audit was completed on 8/10/21 with a look back of 7 days to determine showers/bathing	08/22/2021

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	Resident D's record was reviewed on 7/20/21 at 2:40 PM. The record indicated Resident D had diagnoses that included, but were not limited to, stroke, depression, chronic pain, generalized muscle weakness, and dementia with behavioral disturbance. A Significant Change Minimum Data Set assessment (MDS), dated 5/21/21, indicated Resident D was cognitively intact, required extensive assist of one for most activities of daily living, and it was very important for him to choose between a tub bath, shower, bed bath or sponge bath. A care plan, dated as last reviewed on 2/26/21, indicated a problem for: "PREFERENCE: Resident D prefers 3 showers a week on day shift Monday, Wednesday, Friday. Goal: Residents preferences will be honored. Interventions: Honor residents preferences. Provide and assist with 3 showers a week on day shift." Review of the tasks for Bathing, provided by Corporate Nurse 18 on 7/23/21 at 9:00 a.m., indicated his prefers showers 3 times a week, on Monday, Wednesday, and Friday. The documentation indicated he had no showers in the past 30 days, from 6/22/21 to 7/21/21, he had a full bed bath on 6/29/21, 7/6/21, and 7/14/21, and a partial bed bath 26 times. Corporate Nurse 18 indicated this is where CNA's document showers. 2. During an interview on 7/19/21 at 2:14 p.m., Resident T indicated staff keep you from going to the dining room on the weekends, but through the week you can go to the dining room. They tell her the dining room is not open on the weekends and		provided per residents preference. Preferences were updated in the resident's medical record. Facility audit was completed to identify those resident that have a preference to eat in the dining room and or those needing assistance with dining. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Clinical staff educated on the facility guideline for providing showers/bathing per resident preference. Facility staff educated on the guideline for self-determination which includes the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice with focus on residents receiving showers/bathing and attending meals in the dining room and assistance with dining per their preference. DNS or Designee with review shower/bathing schedule for completion of showers/bathing per the resident's preference. Audit is to be reviewed five times a week for four weeks, then three times a week times four weeks, then weekly for four months. Dietary Manager or Designee will review meals services to ensure the dining room is open and	

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	no one eats in the dining room on the weekends. Resident T's record was reviewed on 7/21/21 at 3:07 p.m. The record indicated Resident T had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, acute and chronic respiratory failure with low blood oxygen, type 2 diabetes with complications, breast cancer, congestive heart failure, atrial fibrillation, heart disease, and hypertensive heart disease with heart failure. A Significant Change MDS, dated 5/6/21, indicated Resident T was cognitively intact. During an interview, on 7/23/21 at 12:30 p.m., the Assistant Director of Nursing indicated they tell them to get everyone up to the dining room, but logistically they cannot get them down with lack of staff. On the weekends, the dining room isn't open, there isn't enough staff with management to help with dining on the weekends. A policy for "Resident Rights" was provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m. The policy included, but was not limited to: "The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or having rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing...Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a.		serving meals per facility guidelines. Audit is to be reviewed five times a week for four weeks to include weekend observations, then three times a week times four weeks, then weekly for four 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. **By what date the systemic changes be completed:** August 22, 2021	

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	The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident...." 3.1-(u)(1)			
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 observation, interview and record review the facility failed to prevent verbal abuse for 1 of 1 resident reviewed for abuse (Resident F). Finding include: During an interview with Resident F on 7/18/21 at 12:40 p.m., indicated Temporary Nurse Aide (TNA) 19 verbally abused him over the weekend. Resident F requested something to drink with his	F 0600	**F 600 Free from Abuse and Neglect** **F 607 Develop/implement Abuse/Neglect Policies** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident F no longer reside at the facility	08/22/2021

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	supper meal and TNA 19 cussed at him and told him to get his own drink. The resident indicated he called the Executive Director E.D. and reported the verbal abuse via voicemail. The Resident indicated TNA 19 was currently working on the other side of the building. LPN 3 indicated at this time that she had reported the verbal abuse to the E.D. and DON via text message with her phone. During an interview with the Director Of Nursing (DON) on 7/18/21 at 12:46 p.m., indicated verbal abuse of Resident F by TNA 19 had not been reported to him. The DON indicated he would report it to the E.D. at this time and find out if TNA 19 was currently working. During an interview with the DON on 7/18/21 at 12:59 p.m., indicated TNA 19 was working and he suspended her at this time pending an investigation. During an interview with E.D. on 7/18/21 at 1:52 p.m., indicated verbal abuse by TNA 19 had not been reported to him until approximately 45 minutes ago when the DON reported it to him. The E.D. indicated Resident F had called him and left a voicemail, but he was unable to understand the voicemail. The E.D. indicated he attempted to call the number back and the resident did not answer and he was unable to leave a message on the resident's voicemail. During an interview with Resident F on 7/19/21 at 11:08 a.m., indicated the E.D. had talked with him about TNA 19 being verbally abusive to him. The resident indicated LPN 3 heard TNA 19 being verbally abusive to him. The resident indicated he did not want anyone to be fired, but he would not put up with someone being verbally abusive to him.		TNA # 19 was suspended pending outcome of the investigation and was terminated upon conclusion of the investigation Interim Executive Director's contact information has been posted for staff , resident or family member to contact. Director of Nursing Services received education on guideline for abuse prevention and timely reporting. LPN 5 received education on guideline for abuse prevention and timely reporting **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 have the potential to be affected by the same deficient practice. An audit was completed of all reportable in the past 30 days to ensure timely reporting and investigation. **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 educated on the guidelines for Abuse prevention and timely reporting. Interim E.D. or Designee will interview residents to include questions regarding treated with respect, dignity and free of abuse. Interview is to be five times a	

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	During an interview with the E.D. on 7/20/21 at 3:15 p.m., indicated the facility was going to terminate TNA 19 due to too many people have collaborated what Resident F reported. The E.D. indicated he would provide the full abuse investigation when it was completed. During an interview with LPN 3 on 7/21/21 at 4:03 p.m., indicated she was the nurse on duty on 7/17/21 when she heard TNA 19 being verbally abusive to Resident F. LPN 3 indicated the resident asked TNA 19 for something to drink with his dinner on and TNA 19 told the resident "you can get it your own f------- self". LPN 3 indicated she attempted to call the E.D. and the DON and no one returned her phone call. LPN 3 indicated she did not leave a voicemail about the verbal abuse. LPN 3 showed a text message, dated 7/17/21 at 5:03 p.m., that was sent to the E.D., DON, Assistant Director Of Nursing (ADON), LPN 5 reporting the verbal abuse by TNA 19 to Resident F. LPN 3 indicated she did not suspend TNA 19 when the verbal abuse occurred because she did not have the authority to, the facility required you to talk with management first before sending anyone home. The facility had not interviewed LPN 3 about TNA 19 being verbally abusive to Resident F since the abuse investigation began on 7/18/21. Review of the record of Resident F on 7/22/21 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, chronic obstructive pulmonary disease, asthma, epilepsy, diabetes, arthritis, depression, weakness and post traumatic stress disorder. The Admission Minimum Data (MDS) for Resident F, dated 7/7/21, the resident was		week for four weeks (10 residents per week) , then three times a week times four weeks, then weekly for four months. Interim E.D. or Designee will interview staff which to include questions about types of abuse, timely reporting of abuse, and abuse prevention. Interview is to be reviewed five times a week for four weeks (10 staff per week) , then three times a week times four weeks, then weekly for four 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 Interviews 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 interviews based on a prn basis.	

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cognitively intact, decisions were consistent and reasonable.

The plan of care for Resident F, dated 7/12/21, indicated the resident was cognitively intact. The intervention included, but were not limited to, help the resident maintain his dignity.

During an interview with the E.D. on 7/22/21 at 4:30 p.m., indicated he was not able to substantiate that TNA 19 was verbally abusive to Resident F because he was unable to find anyone to collaborate the resident's story. The E.D. indicated he had not interviewed LPN 3 about the verbal abuse.

During an interview with E.D. on 7/23/21 at 12:10 p.m., indicated it appeared the allegation of verbal abuse would be substantiated. The E.D. had 140 text messages on his phone on 7/17/21 and did not see the text from LPN 3 about the verbal abuse. The E.D. indicated the DON and the ADON was also on the text that LPN 3 sent about TNA 19 being verbally abusive to Resident F. The E.D. indicated LPN 3 should have called his phone or his spouses phone and reported the verbal abuse.

The abuse policy provided by Corporate Nurse 18 on 7/18/21 at 2:45 p.m., indicated the facility would have policy and procedures in place to prohibit and prevent abuse. The definition of abuse included, but were not limited to, verbal abuse meant the use of oral communication that willfully included disparaging and derogatory terms to residents.

3.1-27(a)(b)

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F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) 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, §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, Based on interview and record review the facility failed to implement their abuse policy of protecting residents of abuse by allowing a staff member to continue working after witnessed verbal abuse of a resident, and failed to report the witnessed verbal abuse immediately to the Administrator for 1 of 1 residents reviewed for abuse (Resident F). Finding include: During an interview with Temporary Nurse Aide (TNA) 19 on 7/18/21 at 12:18 p.m., indicated she had started her shift on this day around 5:50 a.m. During an interview with Resident F on 7/18/21 at 12:40 p.m., indicated Temporary Nurse Aide (TNA) 19 verbally abused him over the weekend. Resident F requested something to drink with his supper meal and TNA 19 cussed at him and told him to get his own drink. The resident indicated he called the Executive Director E.D. and reported the verbal abuse via voicemail. The Resident	F 0607	**F 600 Free from Abuse and Neglect** **F 607 Develop/implement Abuse/Neglect Policies** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident F no longer reside at the facility TNA # 19 was suspended pending outcome of the investigation and was terminated upon conclusion of the investigation Interim Executive Director's contact information has been posted for staff , resident or family member to contact. Director of Nursing Services received education on guideline for abuse prevention and timely reporting. LPN 5 received education on	08/22/2021

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	155157	A. BUILDING 00 B. WING	07/23/2021

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	indicated TNA 19 was currently working on the other side of the building. LPN 3 indicated at this time that she had reported the verbal abuse to the E.D. and DON via text message with her phone. During an interview with the Director Of Nursing (DON) on 7/18/21 at 12:46 p.m., indicated verbal abuse of Resident F by TNA 19 had not been reported to him. The DON indicated he would report it to the E.D. at this time and find out if TNA 19 was currently working. During an interview with the DON on 7/18/21 at 12:59 p.m., indicated TNA 19 was working and he suspended her at this time pending an investigation. During an interview with E.D. on 7/18/21 at 1:52 p.m., indicated verbal abuse by TNA 19 had not been reported to him until approximately 45 minutes ago when the DON reported it to him. The E.D. indicated Resident F had called him and left a voicemail, but he was unable to understand the voicemail. The E.D. indicated he attempted to call the number back and the resident did not answer and he was unable to leave a message on the resident's voicemail. During an interview with Resident F on 7/19/21 at 11:08 a.m., indicated LPN 3 heard TNA 19 being verbally abusive to him. The resident indicated he did not want anyone to be f During an interview with LPN 3 on 7/21/21 at 4:03 p.m., indicated she was the nurse on duty on 7/17/21 when she heard TNA 19 being verbally abusive to Resident F. LPN 3 indicated the resident asked TNA 19 for something to drink with his dinner on and TNA 19 told the resident "you can get it your own f------- self". LPN 3		guideline for abuse prevention and timely reporting **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 have the potential to be affected by the same deficient practice. An audit was completed of all reportable in the past 30 days to ensure timely reporting and investigation. **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 educated on the guidelines for Abuse prevention and timely reporting. Interim E.D. or Designee will interview residents to include questions regarding treated with respect, dignity and free of abuse. Interview is to be five times a week for four weeks (10 residents per week) , then three times a week times four weeks, then weekly for four months. Interim E.D. or Designee will interview staff which to include questions about types of abuse, timely reporting of abuse, and abuse prevention. Interview is to be reviewed five times a week for four weeks (10 staff per week) , then three times a week times four weeks, then weekly for four	

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	indicated she attempted to call the E.D. and the DON and no one returned her phone call. LPN 3 indicated she did not leave a voicemail about the verbal abuse. LPN 3 showed a text message, dated 7/17/21 at 5:03 p.m., that was sent to the E.D., DON, Assistant Director Of Nursing (ADON), LPN 5 reporting the verbal abuse by TNA 19 to Resident F. LPN 3 indicated she did not suspend TNA 19 when the verbal abuse occurred because she did not have the authority to, the facility required you to talk with management first before sending anyone home. Review of the record of Resident F on 7/22/21 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, chronic obstructive pulmonary disease, asthma, epilepsy, diabetes, arthritis, depression, weakness and post traumatic stress disorder. The Admission Minimum Data (MDS) for Resident F, dated 7/7/21, the resident was cognitively intact, decisions were consistent and reasonable. The time card detail record for TNA 19 provided by Corporate Nurse 18 on 7/22/21 at 10:00 a.m., indicated TNA 19 worked at the facility on 7/17/21 from 5:55 a.m., until 6:10 p.m., TNA 19 worked on 7/18/21 from 6:00 a.m., until 12:57 p.m. During an interview with E.D. on 7/23/21 at 12:10 p.m., indicated it appeared the allegation of verbal abuse would be substantiated. The E.D. had 140 text messages on his phone on 7/17/21 and did not see the text from LPN 3 about the verbal abuse. The E.D. indicated the DON and the ADON was also on the text that LPN 3 sent about TNA 19 being verbally abusive to Resident F. The E.D. indicated LPN 3 should have called his phone		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 Interviews 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 interviews based on a prn basis.	

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	or his spouses phone and reported the verbal abuse. The abuse policy provided by Corporate Nurse 18 on 7/18/21 at 2:45 p.m., indicated the facility would prevent abuse by identifying, correcting and intervening in situation in which abuse occurred. Protection of resident included, but were not limited to, staffing changes to protect the resident(s) from alleged perpetrator. Reporting abuse immediately to the Administrator, but no later than 2 hours after the allegation was made. 3.1-28(a)			
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. Based on interview and record review, the facility failed to accurately reflect the resident's dental status on an MDS (Minimum Data Set) assessment for 1 of 25 residents reviewed. (Resident D) Findings include: During an interview, on 7/19/21 at 10:50 a.m., Resident D indicated he has talked to staff about getting the rest of his teeth pulled and hasn't heard anything else and it has been awhile. He said he figured they forgot about it. He was observed to have no upper teeth and had a few lower teeth with some that were broken and blackened. He said he has 12 lower teeth in the front, the back teeth are gone, and he has to "gum" his food.	F 0641	**F 641 Accuracy of Assessment** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D medical record was reviewed and updated to reflect accurate assessment of the resident's status related to dental needs. **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 have the potential to be affected by the same deficient practice. The MDS Coordinator will	08/22/2021

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	Resident D's record was reviewed on 7/20/21 at 2:40 PM. The record indicated Resident D had diagnoses that included, but were not limited to, stroke, depression, chronic pain, protein-calorie malnutrition, generalized muscle weakness, and dementia with behavioral disturbance. A Significant Change Minimum Data Set assessment (MDS), dated 5/21/21, indicated Resident D was cognitively intact, required extensive assist of one for most activities of daily living, and he had no obvious or likely cavity or broken natural teeth. A care plan, dated as last reviewed on 12/11/20, indicated: "DENTAL: At risk for dental problems related to: Some or all natural teeth loss. 10/20 recent resident had routine removal of tooth # 6,7,8,9,10,11 & surgical ext. of #15. Resident is Edentulous. Goal: Will be free of complications related to dental/oral issues through next review period. Interventions: Assess pain and admin[ister] pain meds as ordered. Assistance with Oral care as needed. Educate resident on risk/benefits of refusal of oral care and/or dentures. F/U (follow up) appoint per recommendations. Inspect oral cavity for bleeding of gums or other issues. Observe bleeding and swelling. Oral surgical care per order/instructions as indicated. Refer for Dental services as needed. ST (Speech Therapy) to eval and tx (treat) as indicated." Documentation from a dental appointment, on 6/2/21, indicated he denied pain or issues, had no abnormal tissue, has several root tips that he would like to have extracted to fabricate dentures, he sees his own dentist in town and wants to have an appointment for work set up with his outside dentist.		complete a visual observation of resident's dental status, if resident allows, with quarterly/significant change and comprehensive MDS. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** MDS Coordinator educated on the facility guideline to ensure accuracy of assessment to reflect the resident's status with focus on MDS accuracy related to dental status. DNS or Designee with audit ten MDS per week for accuracy of section L on the MDS for four weeks, then five MDS a week times four weeks, then two MDS per week for four 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. **By what date the systemic changes be completed:** August 22, 2021	

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	During an interview, on 7/23/21 at 10:55 a.m., the MDS Coordinator indicated she would have to look to see if anything was charted in the 7 day lookback, if there is charting on that, it would be incorrect, if there is no charting. On 7/23/21 at 11:28 a.m., the MDS Coordinator indicated she called her RAI (Resident Assessment Instrument) specialist and there was no supportive documentation to say he had any problems with anything related to his teeth during the look back period. She said there was also nothing written in the progress notes.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to create an accurate care plan related to a resident's dental status for 1 of 25 resident's reviewed for care plans. (Resident D) Findings include: During an interview, on 7/19/21 at 10:50 a.m., Resident D indicated he has talked to staff about getting the rest of his teeth pulled and hasn't heard anything else and it has been awhile. He said he figured they forgot about it. He was observed to have no upper teeth and had a few lower teeth with some that were broken and blackened. He said he has no upper teeth, he has 12 lower teeth in the front, the back teeth are gone, and he has to "gum" his food. Resident D's record was reviewed on 7/20/21 at	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D: Medical Record was reviewed and Care plan updated to reflect residents current dental status and dental care needs. **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 have the potential to be affected by the same deficient practice. A initial audit was done to	08/22/2021

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	2:40 PM. The record indicated Resident D had diagnoses that included, but were not limited to, stroke, depression, chronic pain, protein-calorie malnutrition, generalized muscle weakness, and dementia with behavioral disturbance. A Significant Change Minimum Data Set assessment (MDS), dated 5/21/21, indicated Resident D was cognitively intact, required extensive assist of one for most activities of daily living, and he had no obvious or likely cavity or broken natural teeth. A care plan, dated as last reviewed on 12/11/20, indicated: "DENTAL: At risk for dental problems related to: Some or all natural teeth loss. 10/20 recent resident had routine removal of tooth # 6,7,8,9,10,11 & surgical ext. of #15. Resident is Edentulous. Goal: Will be free of complications related to dental/oral issues through next review period. Interventions: Assess pain and admin[ister] pain meds as ordered. Assistance with Oral care as needed. Educate resident on risk/benefits of refusal of oral care and/or dentures. F/U (follow up) appoint per recommendations. Inspect oral cavity for bleeding of gums or other issues. Observe bleeding and swelling. Oral surgical care per order/instructions as indicated. Refer for Dental services as needed. ST (Speech Therapy) to eval and tx (treat) as indicated." The care plan did not accurately reflect the resident's dental status as he is not edentulous. On 7/23/21 at 10:58 a.m., the MDS Coordinator indicated the care plan should be corrected to show what he has, related to his dental status. 3.1-35		determine the dental status of residents and care plans were updated as indicated. Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All Interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's guideline for developing Comprehensive Care Plans. DNS or Designee will complete random audits of care plans for accuracy. Audit is to be reviewed five times a week for four weeks, then three times a week times four weeks, then weekly for four 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. **By what date the systemic changes be completed:** August 22, 2021	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure routine care plan conferences were held with the resident and/or resident	F 0657	**F 657 Care plan timing and revision** **What corrective actions will be accomplished for those**	08/22/2021

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	representative for 1 of 25 residents reviewed for care plan conferences. (Resident 34) Findings include: The clinical record of Resident 34 was reviewed on 7-21-21 at 3:48 p.m. His diagnoses included, but were not limited to multiple sclerosis, cerebral infarction and anxiety. His most recent Minimum Data Set assessment, dated 6-26-21, indicated he is able to understand and be understood and is moderately cognitively impaired. In an interview with Resident 34 on 7-19-21 at 11:00 a.m., he indicated he was not familiar with care plan meetings, when asked if he is included in care plan meetings where his care, medications and treatments would be discussed. Review of his progress notes indicated on 2-7-20, an initial care plan meeting was conducted with the resident, the Social Services Designee (SSD) and therapy staff. No further care plan meetings were documented until 7-22-21, which indicated, "Care plan meeting took place in residents room at resident request. DON, SS, Dietary were present for meeting..." In an interview on 7-22-21 at 5:05 p.m., with the SSD, he indicated, "I have been in this job for about nine months now. I can't really find any care plan meeting notes, except for the one I put in today. I will look for more notes and get it to you in the morning." In an interview on 7-23-21 at 10:25 a.m., the SSD indicated, "I am looking for more care plan meeting notes right now. Our goal is to have the meetings quarterly for each resident." In another interview on 7-23-21 at 10:35 a.m., with the SSD, he indicated he was unable to locate any other notes for care plan meetings for		**residents found to have been affected by the deficient practice?** Resident # 34 clinical record was reviewed and documentation is current for care plan meeting taking place on 7/22/21, the next care plan meeting will be due in October or as needed before then. **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 have the potential to be affected by the deficient practice. An audit was completed, with a 30 day look back review to identify residents that were due for care plan conference. Resident that did not have a documented conference were offered to have one scheduled noted in the medical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** All Interdisciplinary care plan team members responsible for coordinating care plan conference will be educated on the facility guideline for care planning-resident participation. Social Service Director or Designee will conduct a weekly audit of ten residents to ensure	

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	Resident 34. On 7-23-21 at 11:08 a.m., Corporate Nurse 18 provided an undated copy of a policy entitled, "Care Planning - Resident Participation." This policy indicated, "This facility supports the resident's right to be informed of, and participate in, his or care planning and treatment (implementation of care)...The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes...If the participation of the resident and/or representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record.", 3.1-35(c)(2)		that the resident/resident representative has been invited to a care conference on a regular basis (initial, quarterly etc.) Audit is to be reviewed ten residents weekly for four weeks, then five residents weekly for four weeks, 10 residents a month for four 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. **By what date the systemic changes be completed:** August 22, 2021	
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 observation, interview and record review the facility failed to assist dependent residents with showers and bathing for 8 of 8 residents reviewed for Activities of Daily Living (ADL) assistance (Resident F, Resident J,	F 0677	**F 677 ADL Care Provided for Dependent Residents** **What corrective actions will be accomplished for those residents found to have been**	08/22/2021

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

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	Resident D, Resident C, Resident L, Resident N, Resident S, and Resident P). Findings include: 1.) During an interview with Resident F on 7/19/21 at 11:26 a.m., indicated he had not had a shower since his admission to the facility. The resident indicated he washes up in the sink but wanted a shower. The resident indicated he would prefer two showers a week. Review of the record of Resident F on 7/22/21 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis, chronic obstructive pulmonary disease (COPD), asthma, epilepsy, diabetes, arthritis, depression, weakness and post traumatic stress disorder. The Admission Minimum Data (MDS) for Resident F, dated 7/7/21, the resident was admitted to the facility on 6/27/21. The resident was cognitively intact, decisions consistent and reasonable. The resident had no rejection of care and it was very important for the resident to choose between a bath or shower. The resident required physical help in part of bathing activity of one person. The plan of care for Resident F, dated 6/30/2021, indicated he physical functioning deficit related to: Mobility impairment, Knee Arthritis/Pain, COPD and Hemiplegia. The resident's preference was to have two showers a week on second shift. The shower documentation for Resident F indicated the resident had not received a shower from 6/27/21 to 7/22/21. 2.) During an interview and observation with		**affected by the deficient practice?** The facility was not able to identify Residents F, J, N, S, P Resident D medical record was reviewed and updated to reflect resident's preference for bathing/showers. Resident C medical record was reviewed and updated to reflect resident's preference for bathing/showers. Resident L medical record was reviewed and update to reflect resident's preference for bathing/showers **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 have the potential to be affected by the same deficient practice. An audit with a 7 day look back was completed to ensure residents were being offered showers/bathing per their preference. Any residents identified not receiving a shower/bath per their preference were offered a shower/bath and results documented. All residents preference were reviewed with the resident or responsible party to ensure preferences were honored and updates made to their medical record as needed. **What measures will be put into**	

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	Resident J on 7/19/21 at 10:42 a.m., indicated the facility had not been provided a shower or had her hair washed since admitted to the facility. The resident indicated her hair stunk from not being washed. The resident would prefer to have two showers a week. Resident J's hair was observed to be dirty and disheveled. Review of the record of Resident J on 7/22/21 at 4:40 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes mellitus, depression, muscle weakness, hypertension, difficulty walking and anxiety. The resident was admitted to the facility on 7/7/2021. The Shower documentation for Resident J indicated the resident had not received a shower from 7/7/21 to 7/22/21. 3.) On 7/19/21 at 10:44 a.m., Resident D indicated he gets bed baths and hasn't been offered a shower in over a week. He said he hasn't had a choice to get a shower or bed bath, he just gets a bed bath and would like 2 showers a week. His hair had a greasy appearance. On 7/22/21 at 2:29 p.m., Resident D said he doesn't remember having a shower but said he wouldn't be surprised if it has been awhile. Resident D's record was reviewed on 7/20/21 at 2:40 PM. The record indicated Resident D had diagnoses that included, but were not limited to, stroke, depression, chronic pain, generalized muscle weakness, and dementia with behavioral disturbance. A Significant Change Minimum Data Set assessment (MDS), dated 5/21/21, indicated Resident D was cognitively intact, required extensive assist of one for most activities of daily		**place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses and Aides were educated on the facilities guideline for Providing ADL to include bathing and showers provided per preference and assistance with ADL needs (example: bathing, showers, shaving, hygiene etc.) and documentation of completed tasks. DNS or Designee will audit the shower/bathing schedule for completion and documentation five times a week for four weeks then three times a week for four weeks then weekly for four weeks. The DNS or Designee will interview and observe residents for ADL needs being met. Audit is to be completed five times a week for four weeks, then three times a week times four weeks, then weekly for four 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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	living, and it was very important for him to choose between a tub bath, shower, bed bath or sponge bath. A care plan, dated as last reviewed on 2/26/21, indicated a problem for: "PREFERENCE: Resident D prefers 3 showers a week on day shift Monday, Wednesday, Friday. Goal: Residents preferences will be honored. Interventions: Honor residents preferences. Provide and assist with 3 showers a week on day shift." Review of the tasks for Bathing, provided by Corporate Nurse 18 on 7/23/21 at 9:00 a.m., indicated his prefers showers 3 times a week, on Monday, Wednesday, and Friday. The documentation indicated he had no showers in the past 30 days, from 6/22/21 to 7/21/21, he had a full bed bath on 6/29/21, 7/6/21, and 7/14/21, and a partial bed bath 26 times. Corporate Nurse 18 indicated this is where CNA's document showers. 4.) In an interview on 7-20-21 at 9:47 a.m., Resident C indicated he thought the facility was "severely understaffed." He indicated he has been receiving only one shower about every two weeks and yesterday received the first shower in the last 13 days. He indicated he had been promised by the facility that he would receive two showers weekly and this has not happened since admission. Resident C indicated, "The facility explains this is because they do not have enough staff." "I need help with setting up my meals, like opening condiments, cutting up meat due to only be able to use his right arm...The staff don't always do those things; they are quick to drop off my tray in my room and leave." Signage on the wall of Resident C's room indicates, "Please set up to brush teeth after breakfast and before bed." Resident C indicated he usually has to do this		based on a prn basis. **By what date the systemic changes be completed:** August 22, 2021	

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	himself. Resident C indicated for daily hygiene services, he needs assistance with set up and actual washing, but does not feel staff are doing this either. In an interview with a family member of Resident C on 7-21-21 at 11:00 a.m., she indicated Resident C has gone several times since his admission without receiving showers for 2 weeks at a time. She indicated when lack of showers has been addressed to the facility, "They tell me he refuses. They tell me it's part of his brain injury. I don't know much about brain injuries, but that is not like him. He used to take at least 1 or 2 showers a day...On the weekends, they tell me they are very short-handed and they do not have enough help [nursing staff] to get extra things like showers done...He usually can feed himself, but only [can] use the right hand. [He] needs help cutting up his food and setting up his plate." The clinical record of Resident C was reviewed on 7-21-21 at 11:00 a.m. His diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage in thebrain stem, left-sided hemiplegia, aphasia, dysphagia, cognitive communication deficit, hypertension and. psoriasis. His most recent Minimum Data Set (MDS) assessment, dated 4-21-21, indicated he is cognitively intact, requires extensive assistance of 2 persons for bed mobility and transfers, is able to walk with extensive assistance of 1 person, requires extensive assistance of 2 persons for dressing and toileting, requires extensive assistance of 1 person for hygiene care, is dependent of 1 person for bathing, is frequently incontinent of urine and always incontinent of stool. Review of his current care plans indicate his bathing preference is to receive "2 showers a week on first shift before noon," with the initiation			

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	date of 4-19-2021. An associated care plan, dated 5-18-21, indicated Resident C has occasional behaviors of care rejection, specific to refusal of showers, declining staff to change his clothing and provision of incontinence care when needed. Grievances were documented on 6-1-21 and 6-16-21 from family members with concerns related to Resident C not receiving his showers. A progress note, dated 7-21-21 indicated a family member was concerned with the resident not receiving showers. Review of the facility's electronic "Kiosk" documentation of bathing care provided indicated for June, 2021 (30 days): 6 showers documented on 6-1-21, 6-5-21, 6-8-21, 6-15-21, 6-16-21 and 6-29-21; documented 12 full bed baths on 9 separate days. Documented resident refusals for bathing/showers on Friday 6-18-21. Progress note refusal of hygiene and/or bathing documented on 6-1-21, 6-9-21, 6-15-21, 6-16-21 and 6-17-21. For July, 2021 (21 days), electronic "Kiosk" documentation of bathing care provided identified 3 showers documented on 7-7-21, 7-9-21 and 7-19-21; documented 5 full bed baths with 2 days reflecting a shower and full bed bath were given on the same date. Resident refusals were documented for bathing/showers on 7-6-21 and 7-7-21, but later documentation reflected a shower was given on 7-7-21. Progress notes indicated refusal of hygiene and/or bathing was documented on 7-7-21 and 7-20-21. Please note there were several dates, specifically on 6-1-21, 6-15-21, 6-16-21 and 7-7-21 that documentation of the electronic Kiosk documentation and the progress notes reflected both refusals and showers were provided. 5.) In an interview with Resident L on 7-19-21 at			

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	2:44 p.m., he indicated he had not received a shower "for a long time" and he prefers to be clean shaven. In an observation at this time, Resident L had a full beard and the nails of his left hand had brown debris under nails. In an observation and interview with Resident L on 7-21-21 at 10:00 a.m., he was clean shaven of his beard, but his mustache remained and his nails were clean. In an interview with Resident L at this time, he indicated he received a shower yesterday, was shaved and the facility trimmed his mustache to accommodate his request for this. The clinical record of Resident L was reviewed on 7-20-21 at 3:26 p.m. His diagnoses included, but were not limited to, cerebral infarction, right-sided hemiplegia, traumatic brain injury, cognitive communication deficit and general muscle weakness. Review of his most recent Minimum Data Set assessment, dated 7-10-21, indicated he is severely cognitively impaired, is able to understand and be understood, requires extensive assistance of 1 person with dressing and toileting, requires limited assistance of 1 person with hygiene, requires extensive assistance of 2 persons with toileting and is dependent of 1 person for hygiene services. Review of Resident L's care plans indicated on 9-7-20 and revised on 7-10-21, he "prefers showers before breakfast 2 days a week with no specific shift." A progress note, dated 7-10-2021, indicated, "He has carious teeth and staff provides assistance with oral care. He needs assistance with hair combing and shaving. He is not able to do his own adl's [activities of daily living]: personal hygiene, bathing, skin care, dressing, bed mobility, and transfers d/t [due to] his R Hemiplegia/CVA [stroke] and staff assist with completion of his adl's."			

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	Review of the electronic/Kiosk shower/bathing documentation for June, 2021, (30 days) indicated no showers were provided, 7 full baths were documented on 6 days, with no showering or bathing refusals documented. Review of the electronic/Kiosk shower/bathing documentation for July, 2021 (21 days) indicated no showers were provided, 4 full baths were documented on 4 days, with no refusals of showers or baths documented. Progress notes reflected the resident refused a shower on 6-9-21. 6.) In an interview with Resident N on 07-19-21 10:33 a.m., she indicated, "There seems to be no schedule for showers and [I] cannot recall receiving one in over a month." She recalled she previously received showers on Mondays and Thursdays. She currently receives daily "wash ups" in which she receives set up assistance only. In an interview with Resident N on 7-21-21 at 3:08 p.m., she indicated the Director of Nursing (DON) spoke with her on 7-20-21, about her preferences for bathing and showering. "I told him that I want to get at least two showers a week, it don't have to be on Mondays and Thursdays like before, but I haven't been getting any showers for a long time and I want to get back to getting showers again." Resident N indicated she has been having to wash herself up at the sink and is able to do so with limited assistance from staff. A progress note, dated 7/21/2021 at 8:48 a.m., written by the DON indicated, "Writer met with resident to discuss care preferences. Resident reported that she prefers to clean herself in her bathroom and that she is being cleaned adequately with assistance from staff. Will review and update care plan with preferences if indicated.			

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	Last EVE, resident received nail care and shave." In an interview on 7-21-21 at 3:25 p.m., with the DON, he indicated he recently spoke with Resident N in regards to her bathing and showering preferences. "I didn't intend for the [progress] note to sound like she was okay with not getting showers, just that we would discuss her preferences more in depth and review and update her care plan according to her preferences." The DON indicated the staff are to be doing the showers and he feels their staffing is adequate to meet those needs. Review of the facility's electronic "Kiosk" documentation of bathing care provided for Resident N indicated for June, 2021 (30 days), it indicated no showers were documented as received, 11 full baths were documented on 11 days, with no showering or bathing refusals documented. The July, 2021 (21 days) electronic "Kiosk" documentation of bathing care provided for Resident N indicated no showers were documented as received, 6 full baths were documented on 6 days, with no refusals of showers or baths documented. Resident N's care plans, which were initiated on 9-5-20, and revised on 9-13-20, indicated, "prefers to have showers 2 times a week on Monday and Thursday after dinner." 7.) In an interview with Resident S on 7-20-21 at 10:26 a.m., he indicated he is to receive a shower twice weekly. However, he reported in the recent past, he has been receiving showers only on Sunday. He indicated, "This past Sunday they [the facility staff] said they didn't have enough help and [I] didn't get one then."			

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	The clinical record of Resident S was reviewed on 7-21-21 9:33 a.m. His diagnoses include, but are not limited to, diabetes, chronic venous hypertension, peripheral vascular disease, an unspecified intracranial injury, general muscle weakness and cellulitis of the right lower extremity. His most recent Minimum Data Set assessment, dated, 5-19-21, indicated he is cognitively intact, is understood and can understand; does not walk, requires extensive assistance of 2 persons for dressing and toileting, requires extensive assistance of 1 person for hygiene, is dependent of 1 person for bathing and is occasionally incontinent of urine and is always incontinent of stool. Review of his care plans indicated, he has a physical functioning deficit with a self care impairment related to requiring bathing assistance with his upper and lower tasks and dressing assistance for upper and lower body tasks and nail care as needed. His preference for bathing is to receive two showers weekly on the day shift and wash up in his room on the other days. This care plan was revised on 6-25-2021. Review of the facility's electronic "Kiosk" documentation of bathing care provided for Resident S indicated for June, 2021 (30 days), it indicated no showers were documented as received, 7 full baths were documented on 7 days, with no showering or bathing refusals documented. The July, 2021 (21 days) electronic "Kiosk" documentation of bathing care provided for Resident S indicated 1 shower was documented as received on Sunday, 7-4-21, 2 full baths were documented on 2 days, with no refusals of showers or baths documented. 8.) An interview conducted with Resident P, on 7/20/21 at 10:15 a.m., indicated she prefers to have a complete bed bath given instead of a shower, but she has not received a bed bath twice weekly.			

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	The clinical record for Resident P was reviewed on 7/23/21 at 10:52 a.m. The diagnoses included, but were not limited to, osteoarthritis, fibromyalgia, muscle weakness and dependence on supplemental oxygen. A Quarterly Minimum Data Set (MDS) assessment, dated 6/17/21, indicated extensive assistance with 1 staff person for personal hygiene and total assistance of 1 staff person for bathing. An ADL care plan, initiated on 7/19/21, indicated the following, " ...Interventions ...Assist with self care ...Bed mobility assistance of 1-2 ...Personal Hygiene: set up and assist of 1 with combing hair ...." A document regarding ADL documentation, dated June of 2021, indicated Resident P prefers a bed bath twice weekly in the morning. The following date(s) noted a full bed bath and/or shower being signed off, as given, to Resident P: 6/1/21- full bed bath, 6/15/21- full bed bath, & 6/29/21- shower. A document regarding ADL documentation, dated July of 2021, indicated Resident P received a full bed bath on 7/13/21. There were no other full bed baths and/or showers documented for July of 2021. An interview conducted with Executive Director (ED), on 7/23/21 at 3:50 p.m., indicated the facility staff have been discussing resident preferences with bathing to ensure they are honored.			

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	The ADL policy provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m., indicated the facility would ensure a resident who were unable to carry out ADL's would receive the necessary services and maintaint good groomaing nd personal hygiene. This Federal tag relates to Complaint IN00358454. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2)			
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, interview and record review, the facility failed to ensure an intravenous (IV) antibiotic was administered per physician orders and ensure boots were applied per the plan of care for 1 of 2 residents reviewed for hospitalization and failed to provide dressing changes as ordered by the physician for 2 of 2 residents reviewed for skin conditions (Resident 38, Resident H, Resident G). Findings include: 1.) The clinical record for Resident 38 was reviewed on 7/21/21 at 11:39 a.m. The diagnoses	F 0684	**F 684 Quality of Care** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 38 medical record has been reviewed and resident is not currently ordered receiving antibiotic therapy. Care plan was reviewed and reflects current interventions to promote skin integrity. Resident H Facility is not able to identify resident	08/22/2021

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	included, but were not limited to, hemiplegia (paralysis on one side of the body) following cerebral infarction, contracture, muscle weakness, and gastrostomy (feeding tube) status. Resident 38 was admitted to the hospital on 4/12/21 related to a change in condition regarding altered mental status. A hospital discharge summary, dated 4/20/21, indicated the following physician order, " ...piperacillin-tazobactam [intravenous antibiotic] 3.375 g [grams] in sodium chloride ...Infuse 3.375 g intravenously every 8 (eight) hours for 7 doses ...." A physician order, dated 4/20/21, indicated the following, " ...Piperacillin Sod [sodium] -Tazobactam So [sodium] Solution Reconstituted ...Use 3.375 gram intravenously three times a day for ATB [antibiotic] until 4/27/21 ...Give 3.375g [grams] via IV in 100ml [milliliters] q [every] 8hrs [hours] for 7 days ...." The physician order did not match the hospital discharge summary for the IV antibiotic being administered for 7 days instead of 7 does, per the hospital records of 7 doses. The electronic medication administration record (EMAR), dated April of 2021, indicated the IV antibiotic was administered for 16 doses and not signed off as administered on 4 administration times at 8:00 a.m. on 4/22/21, 4/23/21, 4/27/21 and 4/28/21. A care plan for skin, initiated on 9/1/2016, indicated the following, " ...I am at risk for skin impairment due to: needing assistance with positioning, and skin care d/t [due to] R [right] Hemiplegia with contractures R ankle/R hand		Resident G Facility is not able to identify resident **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 receiving antibiotic therapy have the potential to be affected by the same deficient practice. An initial audit of residents currently on antibiotic therapy was completed to ensure residents are receiving medication as ordered by the physician. Residents that have pressure reducing interventions in place have the potential to be affected by the same deficient practice. An initial audit of residents with pressure reducing interventions was completed to ensure interventions were in place per orders and plan of care. Resident with orders for dressing change treatments have the potential to be affected by the same deficient practice. An initial audit of residents with orders for dressing change treatments was completed per physician orders. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** RN/LPN Staff were educated on the facility guideline for following physician orders. Nurses and Nurse Aides were	

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	155157	A. BUILDING 00 B. WING	07/23/2021

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	...Interventions ...pressure relieving boots to feet ...." A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/21, noted extensive assistance with 2 staff persons for bed mobility, transfers, and dressing. Resident 38 was at risk for developing pressure ulcers/injuries. Observations were conducted on the following date(s)/time(s) where Resident 38 did not have pressure relieving boots in place: 7/22/21 at 12:19 p.m. while lying in bed, 7/22/21 at 2:03 p.m. while lying in bed, 7/22/21 at 3:45 p.m. up in wheelchair with shoes on, 7/22/21 at 4:32 p.m. up in wheelchair with shoes on, & 7/23/21 at 9:05 a.m. while lying in bed. An interview conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated the expectations are for nursing staff to follow physician orders as written. A policy titled "Pressure Injury Prevention and Management", undated, was provided by Corporate Nurse 18 on 7/23/21 at 12:58 p.m. The policy indicated the following, "...c. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to...i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)...." 2.) During an interview and observation on 7/18/21 at 12:32 p.m., LPN 3 indicated dressing changes were not being completed as ordered by the physician. LPN 3		educated on the facility guideline for following interventions per the plan of care. (pressure reducing interventions) DNS or Designee will audit the administration record for residents that receive antibiotic therapy for timely administration. Audit is to be reviewed 5 times weekly x 1 month, then 3 times weekly times 1 month, then weekly x 4 months. DNS or Designee will audit the treatment administration record for timely completion of dressing changes and will do a visual observation that dressing changes were completed as ordered and pressure reducing interventions are in place per plan of care. Audit will be 4 times weekly x 1 month, then 3 times weekly times 1 month 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. **By what date the systemic changes be completed: August 22, 2021**	

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	indicated Resident H was suppose to have her surgical wound dressing changed two times a day and it was only getting completed once a day. Observation at this time revealed Resident G's dressings located on her right axilla, left anterior chest wall and left lateral chest wall were dated 7/17/21 at 5:10 p.m., with LPN 3's initials. LPN 3 indicated the dressing should have been changed on 7/17/21 by the nightshift nurse. Resident H indicated her dressing changes were not being completed as ordered by the physician. Review of the record of Resident H on 7/22/21 at 5:12 p.m., indicated the resident's diagnoses included, but were not limited to, cutaneaous abscess of left axilla, cutaneous abscess of other sites, cutaneous abscess of right axilla and methicillin resistant staphylococcus aureus infection (MRSA), disruption of wound and infection following a surgical procedure. The physician order for Resident H, dated 7/3/21, indicated daily dressing changes to right axilla, left anterior chest wall and left lateral chest wall, gently pack with lightly moistened kerlix, cover with a dry 4/4 ABD pad and tape into place two times a day. .The Admission Minimum Data Set (MDS) for Resident H, dated 7/7/721, indicated the resident's daily decision making were consistent and reasonable. 3.) During an interview and observation on 7/18/21 at 12:36 p.m., LPN 3 indicated Resident G also had not been receiving a dressing changed twice a day as ordered by the physician. Observation at this time Resident G had an abdominal dressing dated 7/17/21 at 3:33 p.m., with LPN 3's initials. LPN 3 indicated no one had			

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	been changing the resident's dressing but herself. Resident G indicated her dressing changes had not been being completed twice a day. Review of the record of Resident G on 7/22/21 at 5:00 p.m., indicated the resident's diagnoses included, but were not limited to, postprocedural retroperitoneal abscess, infection following a procedure and MRSA. The physician order for Resident G, dated 7/1/21, indicated the resident was ordered an abdominal dressing with wet to dry kerlix with normal saline two times a day. The wound treatment policy provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m., indicated the policy was to promote wound healing of various types of wounds and it was the facilities policy to provide evidence based treatments in accordance with current standards of practice and physician orders. "Wound treatments will be provided in accordance with physician orders". A policy titled "Provision of Physician Ordered Services", undated, was provided by Corporate Nurse 18 on 7/23/21 at 12:58 p.m. The policy indicated the following, "...The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality...." 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			

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	§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, interview and record review the facility failed to identify, treat and implement appropriate interventions for a stage three pressure ulcer (full thickness skin loss) for 1 of 2 residents reviewed for pressure ulcers (Resident 248). Finding include: During an interview and observation on 7/19/21 at 2:24 p.m., Resident 248 was laying in bed with slipper socks on, the resident's right lateral ankle bone was laying flat on the bed. Resident 248 indicated he was a diabetic and had a "bedsore". Resident 248's wife took the resident's sock off his right foot and a dressing was observed on the right ankle bone dated 7/16/21 at 8:45 a.m., The resident indicated the dressing was done at the local hospital and it had not been changed since. The resident did not have on pressure relieving boots and no pressure relieving boots were observed in his room. During an interview and observation with LPN 1 on 7/19/21 at 3:20 p.m., LPN 1 verified Resident	F 0686	**F 686 Treatments/Services to Prevent/Heal Pressure Ulcer** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 248 discharged from the facility on 8/1/2021 **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 admitted to the facility have the potential to be affected by the same deficient practice. The facility audited all admissions to the facility in the past 7 days to ensure a documented head to toe assessment was completed and the DNS or Designee completed a secondary head to toe assessment to ensure accuracy. **What measures will be put into**	08/22/2021

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	248 had a dressing on his right ankle dated 7/16/21 at 8:45 a.m., LPN 1 took the dressing off and the resident had an pink open area and dark black area on his right ankle bone. The resident's ankle was directly on the bed and the resident indicated to LPN 1 that the reason he had a sore on his ankle was from the pressure of his ankle laying on the bed. During an interview with LPN on 7/19/21 at 3:25 p.m., verified Resident 248 did not have an assessment of the pressure ulcer or a treatment ordered for the pressure ulcer. LPN 1 indicated the resident was admitted on 7/16/21 in the evening and the admitting nurse did the skin assessment and "must have missed" the pressure ulcer on his right ankle. During an interview with the Director Of Nursing (DON) on 7/19/21 at 3:35 p.m., reported Resident 248's pressure ulcer, the DON indicated he would assess the pressure ulcer and provide the assessment. The DON indicated the Admitting nurse would have been responsible to complete the skin assessment and identify the pressure ulcer and get a physician order treatment for the pressure ulcer. Review of the record of Resident 248 on 7/22/21 at 2:40 p.m., indicated the resident's diagnoses included, but were not limited to, cerebrovascular disease with right side hemiplegia and hemiparesis, type two diabetes mellitus, dysphagia, muscle weakness and chronic kidney disease. The resident was admitted to the facility on 7/16/21. The Admission skin assessment documenting for Resident 248 dated, 7/16/2021 10:12 p.m., did not have an assessment of the pressure ulcer on the		**place and what systemic changes will be made to ensure that the deficient practice does not recur** Licensed staff educated on the facility's guideline for the admission process to include completion of a head to toe skin assessment to identify, treat and implement appropriate interventions. DNS or Designee will complete a secondary assessment and audit of all admissions daily x 2 weeks, then 5 times a week x 2 weeks, then 3 times weekly times 1 month, then weekly x 4 months. To ensure the facility has identified, initiated treatment and appropriate interventions. **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. **By what date the systemic changes be completed: August 22, 2021**	

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	right ankle. The wound assessment for Resident 248, dated 7/19/21 at 4:05 p.m., indicated the resident had a stage three pressure ulcer on the right lateral ankle that measured 1 centimeter (cm) by 0.6 cm by 0.1 cm. The pressure ulcer policy provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m., indicated the facility was committed to the promotion of healing existing pressure injuries. The Licensed Nurse would conduct a full body skin assessment on all residents upon admission and document the findings in the medical record. "In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care, and will notify physician to obtain orders." 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review the facility failed to provide timely incontinent care for a dependent resident for 1 of 1 resident reviewed for 1 of 1 resident reviewed for incontinent care (Resident P). Finding include: During an interview and observation on 7/18/21 at 1:25 p.m., Resident P had her call light on. Upon entering the resident's room the resident was crying and indicated she had been laying in urine for over an hour and waiting for someone to come change her. The resident indicated there were not enough staff at the facility and she felt like she suffered due to not having enough staff. Temporary Nurse Aide (TNA) 4 came into the resident's room and apologized to the resident for having to wait so long for incontinent care. TNA 4 indicated she was the only staff on the unit. TNA 4 provided incontinent care to Resident P and the	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident P: facility is unable to identify resident P **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 incontinence care by staff have the potential to be affected by the same deficient practice. The facility completed an audit to identify residents that require	08/22/2021

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	resident brief was soaked with yellow urine. The resident continued to cry during incontinence care and stated "remember what I told you something has to be done." Review of the record of Resident P on 7/22/21 at 4:17 p.m., indicated the resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure, anxiety, depression, osteoarthritis and muscle weakness. The Quarterly Minimum Data Set (MDS) for Resident P, dated 3/26/21, indicated the resident was cognitively intact for daily decision making. Decisions were consistent and reasonable. The resident was always incontinent of her bowels and bladder and required extensive assistance of one person for toileting needs. The plan of care for Resident P, dated 7/19/21, indicated the resident had alteration of the bowels and bladder and required assistance with perineal care. The interventions included, but were not limited to, prompt assistance with perineal care. The Activities of Daily Living policy provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m., indicated when a resident was unable to carry out activities of daily living they would receive the necessary services to maintain good personal hygiene. 3.1-41(a)(2)		assistance with incontinence care and reviewed their medical record to ensure their plan of care and kardex reflected the services needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses and Aides were educated on the facility guidelines for providing timely care to meet residents incontinence needs. The DNS or Designee will complete an audit to include observation of incontinence care being completed and interviewing residents to ensure incontinence care is provided timely. Audit is to be 5 times weekly x 1 month, then 3 times weekly times 1 month, 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. **By what date the systemic changes be completed: August**	

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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 nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to ensure feeding tube settings for feeding per physician orders and ensure water flushes were initiated to the feeding tube to avoid dehydration for 1 of 1 resident reviewed for feeding tubes. (Resident 38) Findings include: 1a. The clinical record for Resident 38 was reviewed on 7/21/21 at 11:39 a.m. The diagnoses included, but were not limited to, hemiplegia	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 38: Medical record was reviewed and reflects physician orders for enteral feeding and water flushes. **How other residents having the potential to be affected by the same deficient practice will be**	08/22/2021

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	(paralysis on one side of the body) following cerebral infarction, contracture, muscle weakness, and gastrostomy (feeding tube) status. A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/21, noted extensive assistance with 1 staff person for eating and a feeding tube was present. A care plan for nutrition, revised 3/18/20, indicated the following, " ...Receives total 100% of nutrition and hydration via G [gastrostomy] tube due to dysphagia due to CVA [cerebrovascular accident], at risk for fluid/electrolyte imbalance/complications ...Interventions ...G tube care as ordered ...Provide g tube flushes as ordered ...." A physician order, dated 4/20/21, indicated Resident 38's diet was NPO status (nothing by mouth). A physician order, dated 5/14/21, indicated feeding was to be administered, through Resident 38's feeding tube, at 60 milliliters an hour from 12:00 p.m. until 8:00 a.m. the next day for a total of 20 hours a day. Observations were conducted to where Resident 38's feeding tube was connected to feeding at 70 milliliters an hour instead of 60 milliliters an hour as ordered on 7/22/21 at 12:19 p.m. and 7/22/21 at 2:03 p.m. The following observations were conducted to where Resident 38 was up in his wheelchair and not connected to his feeding as ordered by the physician: 7/22/21 at 3:45 p.m.,		**identified and what corrective action will be taken** All resident receiving enteral feeding have the potential to be affected by the same deficient practice. A facility audit was completed on all resident with enteral orders to ensure they included water flushes. An initial visual audit was completed to ensure all resident that receive enteral feeding and hydration via pump are at correct settings per physician orders. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Licensed staff educated on the facilities guideline for following physician orders. The DNS or Designee will complete an audit to ensure enteral orders include water flushes and a visual observation to ensure that pumps are set at accurate rates per physician orders. Audit is to be completed 5 times weekly x 1 month, then 3 times weekly times 1 month, 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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	7/22/21 at 4:32 p.m., & 7/22/21 at 5:48 p.m. Interview conducted with the Director of Nursing (DON), on 7/22/21 at 5:50 p.m., indicated Resident 38 is on and off the feeding through his feeding tube at certain time periods. Interview conducted with Certified Nursing Assistant (CNA) 12, on 7/22/21 at 5:52 p.m., indicated Resident 38 usually gets up in his wheelchair on day shift. A progress note, dated 7/22/21 at 6:15 p.m., indicated the following, " ...Resident transferred into bed. Head to toe assessment completed. No skin issues. RD [Registered Dietitian] notified of delayed enteral feed start time ...." 1b. The following physician orders were noted for water flushes through Resident 38's feeding tube for hydration: Dated 1/28/21 to 2/15/21- flush feeding tube with 400 milliliters of water four times daily, Dated 2/15/21 to 2/18/21- flush feeding tube with 500 milliliters of water four times daily, Dated 2/18/21 to 2/20/21- flush feeding tube with 80 milliliters of water hourly for 20 hours, & Dated 2/20/21 to 2/21/21- flush feeding tube with 120 milliliters of water hourly for 24 hours and then return water flushes to 80 milliliters an hour after the 24-hour period. There were no physician orders for hourly water flushes of 80 milliliters on or after, 2/21/21. The following progress notes titled "weight note" indicated Resident 38 was on an NPO diet and receiving tube feeding at 60 milliliters an hour with		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. **By what date the systemic changes be completed: August 22, 2021**	

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	155157	A. BUILDING 00 B. WING	07/23/2021

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	water flushes of 80 milliliters an hour over 20 hours on the following date(s): 3/5/21, 3/12/21, 3/19/21, 3/24/21, 3/31/21, & 4/9/21. A progress note, dated 4/12/21 at 7:10 a.m., indicated Resident 38 was experiencing altered mental status and was being transferred to the hospital for evaluation and treatment. A hospital history and physical note, dated 4/12/21, indicated the following, " ...Nursing staff reported that patient is nonverbal however he is able to communicate with his left hand which he has not been responding since Saturday. They reported when his sodium goes up [sic] he becomes lethargic and does not act his usual ...Lab workup indicated sodium of 183 [normal levels were 135 to 145] ...Patient with h/o [history of] hyperaldosteronism needing high dose water flushes however unable to tolerate, probable reason for hypernatremia [elevated sodium] ...His water deficit is 15 l [liters] ...." An interview conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated the expectations are for staff to follow physician orders as written. A policy titled "Care and Treatment of Feeding Tubes", undated, was provided by Corporate Nurse 18 on 7/23/21 at 11:08 a.m. The policy indicated the following, " ...1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of			

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	administration, and frequency of flush ...3. The resident's plan of care will address the use of feeding tube, including strategies to prevent complications ...4. The facility will utilize the Registered Dietician in estimating and calculating a resident's daily nutritional and hydration needs ...9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided ...e. Ensure that the administration of enteral nutrition is consistent with and follows the practitioner's orders ...." 3.1-44(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.			

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	§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to have sufficient nursing staff available to ensure residents were served meals in the dining room for 12 residents observed occupying the dining room, ensure residents received showers according to their plan of care for 8 residents who needed assistance with bathing, ensure incontinence care was provided timely for 1 of 1 resident observed for the need of incontinence care, and ensure dressing changes were conducted for 2 residents with surgical wounds. (Residents F, J, D, C, L, N, S, T, G, H and P) Findings include: 1. Residents F, J, D, C, L, N, S, and P were not provided adequate assistance with Activities of Daily Living (ADLs), related to bathing and showers. Cross reference F677. 2. Resident D and T not being provided showers as preferred and providing dining services in the dining room as preferred. Cross reference F561. 3. Residents G and H were not provided dressing changes to a surgical wound as ordered by the physician. Cross reference F684. 4. Resident P not being provided incontinent care	F 0725	F725 Sufficient Nursing Staff **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents F, J, D, C, L, N, S, T, G, H, P**:** Facility is unable to identify the residents **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 have the potential to be affected by the same deficient practice. The ED and DNS completed an initial audit of the Clinical Schedule to ensure there is a sufficient amount of staff scheduled to meet the care needs of the residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Clinical scheduler and Clinical staff were in-serviced on ensuring schedule is reviewed and scheduled staff are on duty and what the process is in the event there is a call off and the need to	08/22/2021

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	timely and dependent of staff for incontinence care that resulted in a long waiting period for assistance. Cross reference F690. 5. An observation was conducted of Resident T, on 7/18/21 at 11:58 a.m. They were observed in the hallway asking if the dining room was going to be open towards Hospitality Aide. The Hospitality Aide responded about the dining room not being open and the resident was to eat in their room. Hospitality Aide indicated on the weekends the residents do not eat in the dining room related to lack of staff. The dining room was observed empty at the time of interview. An interview conducted with Licensed Practical Nurse (LPN) 3, on 7/18/21 at 12:25 p.m., indicated there were 2 nurses and 2 Certified Nursing Assistants (CNAs) working for the entire facility. They reported the potential staffing shortage to management this past Friday with no response from them. The Director of Nursing would not answer the phone and the Assistant Director of Nursing had their phone turned off. The residents are not getting their showers. They had 15 residents on the rehab unit with 1 CNA and that's why skin treatments were not being completed. The residents don't eat in the dining room on the weekends. Observations were conducted to where the dining room was open with residents on the following date(s)/time(s): 7/19/21 at 12:10 p.m., with 12 residents observed & 7/20/21 at 12:05 p.m., with 11 residents observed. 6. An interview conducted with Resident F, on		seek a replacement arises. The ED or Designee will review the clinical schedule daily 5 x a week to include weekend schedules for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 weeks for 4 months. The ED or Designee will audit for sufficient staff to meet needs through interviews with residents to include questions regarding care needs met and meal service in dining room. This will occur daily 5 x a week to include weekend schedules for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 weeks for 4 months. Refer to POC 561, 677, 690, 684 for observation of services provided **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. **By what date the systemic changes be completed: August**	

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	7/19/21 at 11:19 a.m., indicated at times there are only 1 "aide" for each side of the facility and only one nurse sometimes. They were not getting showers and they "begged" for a shower the day before and the staff still didn't give one. An interview conducted with Resident G, on 7/18/21 at 12:36 p.m., indicated there was inadequate nursing staff and the dressing changes were not being completed to their surgical site. An interview conducted with Resident Q, on 7/19/21 at 2:14 p.m., indicated the facility is "very short staffed". They would have to wait an hour or longer, at times, for care. This occurred on all hours of the day. An interview conducted with Resident R, on 7/19/21 at 10:58 a.m., indicated yesterday (Sunday) there were only 2 "aides" for the entire building. They were supposed to receive a shower on Tuesdays and Saturdays, but she did not receive one. They prefer to go down to the dining room for meals, but they only receive lunch in the dining room Monday through Friday and no dining occurs in the dining room on the weekends. An interview conducted with Resident P, on 7/20/21 at 10:15 a.m., indicated they were not receiving adequate care due to not having enough staff. Their "pull up" would be soiled and they would sit for 3-4 hours waiting to be given perineal care. This occurred frequently and at different times of the day. They would rather have a bed bath twice a week but that hasn't occurred. They receive one bed bath every 2-3 weeks. An interview conducted with Resident C, on		**22, 2021**	

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	7/20/21 at 9:47 a.m., indicated the facility was "severely understaffed". They would only receive a shower about once every two weeks. They were told they would receive two showers in a week period but that hasn't happened. The staff don't have the time to assist me in preparation for my meals such as opening condiments and cutting up meat. The staff were quick to drop off the tray and leave my room. An interview conducted with Resident H, on 7/18/21 at 12:32 p.m., indicated the facility did not have sufficient staff. Their treatments were not being completed to their surgical wound nor being giving showers. An interview conducted with Resident S, on 7/20/21 at 10:21 a.m., indicated there was a delay in call light response times, especially during the weekends. It could take up to 15 to 30 minutes for a response and even longer on the weekends. There have been issues of having a bowel movement while waiting for assistance and "that's uncomfortable for me". An interview conducted with Resident T, on 7/19/21 at 2:23 p.m., indicated there was not enough "aides", especially on the weekends. It can take 30 minutes, or longer, for staff to respond to the call light. An interview conducted with Resident J, on 7/19/21 at 10:42 a.m., indicated there was not enough staff and there would be only one "aide" for the entire building sometimes. This would result in long call light response time of 30 minutes, or greater. There has also been a lack of receiving showers due to insufficient staff as well. An interview conducted with Resident N, on			

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	7/19/21 at 10:33 a.m., indicated "there seems to be no schedule for showers and [I] cannot recall receiving one in over a month." They previously received showers on Mondays and Thursdays. 7. An interview conducted with CNA 20, on 7/18/21 at 3:25 p.m., indicated she was the only CNA on the long-term care unit and had 36-37 residents by herself. Residents don't receive showers, charting doesn't get done, and residents who need assistance with eating don't get fed until late. An interview conducted with LPN 5, on 7/18/21 at 12:16 p.m., indicated on the weekends when staffing was low, we do not conduct dining in the dining room. The residents eat in their rooms. The dining room was observed empty during the interview. An interview conducted with CNA 14 on 7/19/21 at 2:45 p.m., indicated there was usually 3 CNAs on the long-term care unit and 1 CNA on the rehab unit. When it's short staffed with only 2 CNAs on the long-term care unit showers may not get done and we cannot meet the residents needs timely. An interview conducted with LPN 3, on 7/21/21 at 5:00 p.m., indicated there isn't enough staff to ensure the adequate care can be given to the residents on the rehab unit and the residents the facility continues to admit on top of that. An interview conducted with CNA 2, on 7/21/21 at 5:20 p.m., indicated when there are only 2 CNAs on the long-term care unit it's short staffed. The staff cannot get residents to bed and/or fed timely. They attempt to give partial bed baths because we are unable to give the residents			

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	showers or full bed baths. There have been occasions to where I was the only CNA that showed up for the entire building and I would have to wait to assist the residents who needed 2 staff assistance until another CNA came in. That could take about 1-2 hours. An interview conducted with Temporary Nurse Aide (TNA) 4, on 7/22/21 at 11:30 a.m., indicated she works over her hours on a routine basis. TNA 4 stated "to be honest, there are several of us that are thinking of quitting because we are just getting burned out". She voiced concerns regarding her status as a TNA and the expectations to conduct tasks that she is unqualified to perform, specifically feeding residents and use the Hoyer lift for transfers without assistance. TNAs are on units by themselves on a frequent basis. Due to being short-handed of aides, the residents are not getting their showers. There are 4-5 residents that need assistance with eating, and they usually get fed last. A confidential interview was conducted. They indicated the staffing goal would be to have 3 nurses and 5 CNAs on day and evening shift. They were told that TNAs and Personal Care Assistants (PCAs) can work as CNAs due to the emergency mandate. There are agency staff present to cover but it's still not sufficient. One nurse on night shift at times. If that occurs dressing changes may not be completed, and the attempt will be made to pass on to day shift. Scheduled and PRN (as needed) medications may be delayed in administration as well. There was a big issue with showers and if we are short staffed, they will give bed baths instead, if there's time for that. The administrative staff tell the staff to get residents up for meals in the dining room but			

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	logistically they cannot get them down with the lack of staff. We try to get the residents to the dining room for lunch service during the week. The weekends don't have enough staff with management to help with dining. The dining room is basically closed on the weekends. An interview conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated she wasn't aware of the residents not having the ability to consume all meals in the dining room, including the weekends. The Executive Director (ED) was present and indicated they have been discussing resident preferences with bathing and to ensure they are honored. They have noticed a pattern with bathing. There was a battle with having enough staff at meals. About 3 months ago they opened the dining room for lunch and the goal would be to open for dinner and then breakfast soon. 8. The "Resident Council Notes", dated from March of 2021 through July of 2021, was reviewed, and noted the following concerns: - March 23, 2021- wanting to open the dining room for dinner, - April 27, 2021- wanting to open the dining room for breakfast and dinner, - May 18, 2021- "sometimes the aids [sic] are pretty slow to helping you" and "long time to answer call lights", - June 15, 2021- "not knowing shower days, or receiving enough showers" and "to long of a wait for medications", & - July 20, 2021- "get food out before it gets cold" and "work on showers". 9. Grievance forms were reviewed from March of 2021 through July of 2021, and indicated the			

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	following: - March of 2021- 12 grievances in total with 5 pertaining to delay in care and/or lack of ADL care, - April of 2021- 4 grievances in total with 3 pertaining to lack of ADL care, - May of 2021- 4 grievances in total with 3 pertaining to lack of ADL care and/or delay in medication administration, - June of 2021- 6 grievances in total with 1 pertaining to lack of ADL care with showers, & - July of 2021- 7 grievances in total with 2 pertaining to lack of ADL care with transfers and feeding. 10. The daily staffing schedules were reviewed and noted 3 or less, CNAs, TNAs, and/or PCAs scheduled for the entire facility on the following days/shifts: - 7/10/21 on day shift, - 7/11/21 on day shift, - 7/12/21 on day shift, - 7/16/21 on day and evening shift, - 7/17/21 on day and evening shift, - 7/18/21 on day and evening shift, & - 7/19/21 on evening shift. 11. Review of the facility's Facility Assessment, revised 4/16/21, indicated 60 residents were listed as dependent for bathing needs. The document indicated the following, " ...1.7 At our Living Center we consider other pertinent facts or descriptions of our resident population that we take into account when determining staffing and resource needs (e.g., residents' preferences with regard to daily schedules, waking, bathing, activities, naps, food, going to bed, etc.) ...."			

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	Review of the Resident Census and Condition form, dated 7/20/21, indicated the total census was 46 residents. 31 residents needed assistance with 1-2 staff for bathing, 35 residents needed assistance with 1-2 staff for dressing, 29 residents needed assistance with 1-2 staff for transferring, 28 residents needed assistance with 1-2 staff for toilet use, and 6 residents needed assistance with 1-2 staff for eating. 31 residents were incontinent. The number of residents listed for the need of total dependence indicated the following: - 12 residents for bathing, - 8 residents for dressing, - 14 residents for transferring, - 15 residents for toilet use, & - 5 residents for eating. A policy titled "Nursing Services and Sufficient Staff", undated, was provided by Corporate Nurse 18 on 7/23/21 at 12:58 p.m. The policy indicated the following, "...It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment...4. Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs...5. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care...." This Federal tag relates to Complaint IN00356736.			

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	3.1-17(a) 3.1-17(b)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure the medication storage refrigerators didn't contain expired pneumococcal vaccine and purified protein derivative for 1 of 2 medication storage rooms observed.	F 0761	**F 761 Label/Storage or drugs and biologicals** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	08/22/2021

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GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

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	Findings include: An observation was conducted of the medication storage room located on the long-term care side of the facility on 7/23/21 at 10:05 a.m., with Qualified Medication Aide (QMA) 15. A bottle containing a vial of pneumococcal vaccine was noted with an expiration date of 2/10/21. There was Tuberculin solution that was opened and dated for 6/8/21. An interview with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated the pharmacy comes out monthly for auditing purposes. A policy titled "Medication Storage", undated, was provided by Corporate Nurse 18 on 7/23/21 at 12:58 p.m. The policy indicated the following, " ...Policy ...It is the policy of this facility to ensure all medication housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations ...8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels ...." 3.1-25(o)		No residents identified for correction Items were removed at the time of discovery during survey. **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 receive medications that require dating for expiration are at risk for the same deficient practice. The DNS or Designee completed an initial audit of all multidose medications that required monitoring for expiration to ensure no medications were kept past the date open expiration date. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nurses were educated on the facility guideline for Labeling and Storing medications. The DNS or Designee will audit medication storage areas for expired medication. Audit is to be 3 times weekly x 1 month, then 2 times weekly times 1 month, 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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			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. **By what date the systemic changes be completed: August 22, 2021**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the			

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	resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on interview and record review, the facility failed to provide routine dental services for 1 of 1 resident reviewed for dental services. (Resident R) Findings include: The clinical record for Resident R was reviewed on 7/21/21 at 2:24 p.m. The diagnoses included, but were not limited to, dysphagia, abnormal weight loss, and pain. A Quarterly Minimum Data Set (MDS) assessment, dated 4/14/21, indicated Resident R was cognitively intact. An interview conducted with Resident R, on 7/19/21 at 11:05 a.m., indicated she lost a cap on one of her teeth. She hasn't seen a dentist since last year and does have difficulty chewing at times. A care plan for activities of daily living, dated	F 0791	**F 791 Routine and Emergency Dental Services** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident R: Medical Record was reviewed and referral was made to dental services. Appointment date pending at this time **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 dental services are assisted with obtaining a routine or emergent dental exam have the potential to be affected by the same deficient practice.	08/22/2021

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	10/11/19, indicated to conduct dental exams as necessary. A form for authorization of ancillary services, undated, was signed by Resident R to receive ancillary services that included dental care. A dental visit form, dated 1/8/20, indicated Resident R was to be seen for an assessment but she was ill and not seen on 1/8/20. There were no other dental visit forms in Resident R's clinical record. An interview conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated Social Services are responsible for following up with ancillary visits for whether it's an acute concern or a routine visit. A policy titled "Dental Services", undated, was provided by Corporate Nurse 18, on 7/23/21 at 11:08 a.m. The policy indicated the following, " ...Routine dental services ...means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs) ...3. The Social Services Director maintains contact information for providers of dental services that are available to facility residents at a nominal cost ...4. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location ...." 3.1-24(a)(1)		SSD or Designee completed an initial audit of residents to ensure dental needs were addressed timely. Any resident identified needing services had a referral made and noted in their clinical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Social Service Director and Nursing Staff were educated on the facility guideline for Dental Services. SSD or Designee will follow up with residents identified needing dental services. Audit is to be 5 times weekly x 1 month, then 3 times weekly times 1 month, 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. **By what date the systemic changes be completed: August 22, 2021**	

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F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure unit refrigerators didn't contain expired food for 2 of 2 unit refrigerators observed. Findings include: An observation was conducted of the rehab unit medication storage room on 7/23/21 at 9:23 a.m. There were 2 refrigerators stacked on each other with a black refrigerator located on the floor with a red one stacked on top of the black refrigerator. The black refrigerator was opened and noted a temperature of 72 degrees and a pitcher that was	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No residents identified for correction. ECU and TCU refrigerator: Items were removed at the time of discovery. **How other residents having the potential to be affected by the same deficient practice will be**	08/22/2021

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	dated for 7/13/21 and "use by" date of 7/16/21. Licensed Practical Nurse (LPN) 5 was present and opened the pitcher. There was a blue/green fuzzy substance floating at the top of the liquid. LPN 5 commented "that's yucky" and proceeded to pour the liquid in the sink. LPN 5 indicated the black refrigerator was broken and shouldn't contain anything. An observation was conducted of the long-term care unit medication storage room on 7/23/21 at 10:05 a.m. A refrigerator noted a container of vanilla ice cream with a "best by" date of 5/27/21. Qualified Medication Aide (QMA) 15 proceeded to remove the container of ice cream from the refrigerator and place it in the sink in the medication room. A policy titled "Food Safety Requirements", undated, was provided by Corporate Nurse 18 on 7/23/21 at 12:58 p.m. The policy indicated the following, " ...It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared and served in accordance with professional standards for food service safety ...1. Food safety practices shall be followed throughout the facility's entire food handling process ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms ...3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage ...c. Refrigerated storage ...iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded ...."		**identified and what corrective action will be taken** All residents have the potential to be affected by the same deficient practice. All food storage refrigerators were visually inspected and confirmed to not contain expired food and that temperatures were within acceptable range. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Nursing and Dietary staff educated on the facility guidelines for Food Storage with focus on expired items and refrigerator temperatures. Dietary Manager or Designee will Audit food storage refrigerators for expired items and to monitor that refrigerator temperatures are within appropriate range. Audit will be conducted 5x week x 2 weeks, 3 x a week x 2 weeks, then 2 x weekly x 1 month, 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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	3.1-21(i)(3)		will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis. **By what date the systemic changes be completed: August 22, 2021**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, 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			

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	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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.			

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	Based on observation, interview and record review, the facility failed to prevent and/or contain the spread of COVID-19 by failure to ensure staff donned personal protective equipment (PPE) prior to entering a room on transmission-based precautions (TBP), don PPE and initiate TBP during and after an aerosol-generating procedure (AGP) for observations, perform hand hygiene upon entering and/or exiting resident rooms after serving hall trays, ensure urinary catheter bags and tubing remained off of the floor and ensure face mask worn appropriately for 14 of 14 infection control observations (Resident 248, Resident C, Resident 247, Resident 30, Resident R, Resident 40, Resident 38, Resident 37 and Resident S). Findings include: 1.) An observation was conducted of the passing of hallway trays on the rehab unit for dinner, on 7/21/21 at 4:55 p.m. Certified Nursing Assistant (CNA) 12 went into Resident 248's room that was identified as "yellow" and on TBP. She only wore a surgical mask and did not don any other PPE prior to entering Resident 248's room. No hand hygiene was performed after leaving the room. CNA 12 proceeded to go into Resident 43's room and drop off the meal tray with no hand hygiene performed after leaving the room. CNA 12 then went into Resident C's room that was identified as "yellow" and on TBP. She only wore a surgical mask and did not don any other PPE prior to entering Resident C's room. No hand hygiene was performed after she exited Resident C's room. CNA 12 then went back into Resident 248's room with only a surgical mask and no other PPE donned prior to entering the room. No hand hygiene was performed before or after going into Resident 248's room.	F 0880	**F 880 Infection Prevention and Control** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 248 no longer resides at the facility Resident 247 no longer resides at the facility Resident 30 no longer resides at the facility Resident 43 medical record was reviewed and no negative trend noted from alleged event Resident 40 medical record was reviewed and no negative trend noted from alleged event Resident 38 medical record was reviewed and no negative trend noted from alleged event Resident 37 medical record was reviewed and no negative trend noted from alleged event Resident C , R, S: Facility is unable to identify **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 foley catheters/drain bags have the potential to be affected by the alleged deficient practice. Residents with foley catheters have been audited to ensure a dignity/privacy bag is in place and	08/22/2021

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	A random observation was conducted of the rehab unit on 7/21/21 at 5:10 p.m. Therapy Staff 11 went into Resident 247's room that had signage indicative of being on TBP related to a "yellow" room. Therapy Staff 11 donned a gown and gloves but only had a surgical mask on with no eye protection in place prior to entry. A random observation was conducted of the rehab unit on 7/22/21 at 11:45 a.m. Medical Records Staff 10 was observed entering Resident 247's room while only wearing a surgical mask. No other PPE was donned prior to entering the room. Temporary Nurse Aide (TNA) 4 then went into Resident 247's room after donning a gown and gloves but only was wearing a surgical mask and no eye protection. LPN 3 then went into Resident 247's room after donning a gown and gloves while only wearing a surgical mask and no eye protection. There was signage posted about the use of N95 and/or approved KN95 masks, gown, gloves, and eye protection prior to entering Resident 247's room. Gowns and N95 masks were noted in a 3-compartment bin located outside of Resident 247's room. The "COVID-19 LTC [long-term care] Facility Infection Control Guidance Standard Operating Procedure", revised 7/1/21, indicated the following, " ...Unknown COVID-19 status (Yellow): All residents in this category warrant TBP (droplet and contact.) HCP [healthcare personnel] will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed ...Fully vaccinated HCP may choose to not wear eye protection in green zones and in yellow zones when residents are being		in use to provide for residents privacy. Residents in transmission based precautions or that receive AGP have the potential to be affected by the same deficient practice. An audit of residents in transmission based precautions or that receive AGP to ensure appropriate signage was posted for proper PPE usage. Resident that required dressing changes have the potential to be affected by the same deficient practice. An initial audit of resident that receive dressing changes was completed to ensure proper hand hygiene during treatment. **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 (to include all departments) were educated on the facility guidelines for infection control and prevention with focus on proper PPE use for Transmission Based Precautions (including AGP), maintaining catheter bag and tubing up and off the floor, hand hygiene, and meal delivery. Licensed staff were educated on infection control during dressing change procedure. DNS or Designee will complete observations of staff through rounding and competency check offs for proper PPE use, following	

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	monitored for new admission quarantine irrespective of county positivity rates. HCP must keep on eye protection for any symptomatic or positive COVID-19 resident in TBP ...." 2.) An observation was conducted of medication administration of Resident 30 on 7/22/21 at 11:10 a.m., with Licensed Practical Nurse (LPN) 3. LPN 3 proceeded to prepare Ipratropium/Albuterol nebulizer treatment for administration to Resident 30. LPN 3 administered the nebulizer treatment while leaving the door open to Resident 30's room and did not don any PPE before, during, or after administration of the nebulizer treatment. A random observation was conducted of the rehab unit on 7/23/21 at 9:20 a.m. LPN 8 was observed in Resident 30's room with the door open while a nebulizer treatment was being administered. LPN 8 proceeded to turn off the machine and remove the face mask from Resident 30's face. No initiation of TBP was conducted during and/or after the nebulizer treatment. LPN 8 was only wearing a surgical mask at the time of observation. LPN 8 left Resident 30's room and walked towards the nurses' station while leaving Resident 30's room door open. The clinical record for Resident 30 was reviewed on 7/23/21 at 5:04 p.m. A physician order, dated 6/21/21, noted the following, " ...Ipratropium-Albuterol Solution ...1 vial inhale orally every 4 hours for SOB [shortness of breath] ...." The "COVID-19 LTC [long-term care] Facility Infection Control Guidance Standard Operating Procedure", revised 7/1/21, indicated the following, " ...AGPs [aerosol-generating procedures] in Green zones ...Staff providing		TBP and AGP, and hand hygiene. Audit is to be reviewed 5 times weekly (to include weekends) x 1 month, then 3 times weekly times 1 month, then weekly x 4 months. DNS/Designee to observe licensed staff completing a dressing change. These observations to be completed 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, then weekly x 5 months. DNS or Designee will audit residents with foley catheters for proper placement of tubing off the floor and drain bag maintained in a dignity bag or use of a drain bag with attached privacy flap. Audit is to be reviewed five times a week for four weeks, then three times a week times four weeks, then weekly for four 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. **By what date the systemic changes be completed: August 22, 2021**	

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	direct care within six feet of the resident while AGP is in progress should wear full PPE including N-95 mask and eye protection for all types of scenarios ...." 3.) An observation conducted on 7/19/21 at 11:13 a.m., noted Resident R sitting up in her wheelchair with her urinary catheter bag contacting the floor. An observation conducted on 7/19/21 at 3:19 p.m., noted Resident 40's urinary catheter bag lying on the floor while she was lying in bed. An observation conducted on 7/19/21 at 11:27 a.m., noted Resident 38's urinary catheter bag contacting the floor while up in his wheelchair. An observation conducted on 7/22/21 at 4:32 p.m., noted Resident 38 up in his wheelchair with his urinary catheter bag contacting the floor as well as the catheter tubing. There was a yellow, cloudy substance noted in the catheter tubing. An interview conducted with Corporate Nurse 18, on 7/23/21 at 3:50 p.m., indicated the expectations are to follow the State and Federal guidance that includes the Centers for Disease Control (CDC) involving the use of PPE and TBP. Urinary catheter bags and tubing are to remain off the floor. A policy titled "Catheter Care", undated, was provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m. The policy indicated the following, " ...Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...." 4.) During an observation, on 7/19/21 at 2:15 p.m.,			

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	Resident 37 was lying in bed, and the privacy bag covering the urinary catheter drainage bag touched the floor on the bottom portion of the cover. Resident 37's record was reviewed on 7/21/21 at 9:25 a.m. The record indicated Resident 37 had diagnoses that included, but were not limited to, cerebral palsy, spastic hemiplegia affecting right dominate side, and neuromuscular dysfunction of bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 7/1/21, indicated Resident 37 was severely impaired, never/rarely made decisions in cognitive skills for daily decision making, had an indwelling catheter, required extensive to total assist with all adls, and he had no urinary tract infection or other infections. A care plan, last reviewed on 12/5/20, indicated a problem for "BLADDER: I have a suprapubic catheter d/t Neurogenic Bladder. Goal: I will have no complications from use of my suprapubic catheter such as pain, infection, obstruction through next review period. Interventions: Change catheter and drainage bag per order. Check catheter tubing for proper drainage and positioning...Keep drainage bag of catheter below the level of the bladder at all times and off floor...." On 7/22/21 at 2:20 p.m., Resident 37 was observed lying in bed, the covered urinary catheter bag was observed attached to the bed frame and the bottom portion of the covering rested on the floor. On 7/22/21 at 3:00 p.m., the catheter bag cover still touched the floor. LPN 7 said she just came in to work and will fix it, because it is something they keep up off the floor.			

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	5.) During an observation on 7/18/21 at 11:56 a.m., Temporary Nurse Aide (TNA) 4 was walking down the resident hallway with no surgical mask on. TNA 4 indicated she arrived at work at 6:00 a.m. and her mask was at the nursing station. During an observation on 7/18/21 at 11:58 a.m., the Hospitality Aide was passing drinks to residents with his surgical mask below his nose. The Hospitality Aide apologized for not wearing his mask properly and pulled it up to cover his nose and mouth. During an observation on 7/18/21 at 12:04 p.m., CNA 6 was passing meal trays to resident rooms with her surgical mask below her chin not covering her mouth or nose. CNA 6 indicated it was the facilities protocol to wear the surgical mask in this manner and pulled the mask up to cover her mouth and nose. 6.) A care observation of a dressing change to the bilateral lower extremity areas of Resident S was conducted on 7-23-21 at 9:25 a.m., with LPN 1. Prior to entry into Resident S's room, LPN 1 was observed to exit the room of another resident, then entered the hallway, was then observed going to the medication cart and completing several tasks and then going to the treatment cart to obtain supplies for Resident S's dressing change. Neither hand hygiene nor handwashing was observed from the point of exit from the peer's room and through the beginning of care for Resident S when LPN 1 donned gloves to remove the dressing on Resident S's left ankle area. After removal of the old dressing, she disposed of the old dressing and removed her gloves. She was not observed to perform hand hygiene prior to changing gloves and continuing with the dressing change. Upon completion of the dressing change to the left ankle area, she removed her gloves, discarded			

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	them and left the room without performing hand hygiene or handwashing. Upon return to the room with supplies for the right foot, LPN 1 was not observed to perform hand hygiene or handwashing. She was observed to then don gloves to cleanse the undressed wound as per the physician orders and conduct the ordered treatment, followed by covering the wound with an adhesive bandage. In interview with LPN 1 at the completion of Resident S's wound care, she indicated she had washed her hands prior to leaving the peer's room, but had not conducted handwashing or hand hygiene prior to entry or upon re-entry to Resident S's room. A policy titled "Catheter Care", undated, was provided by Corporate Nurse 18 on 7/21/21 at 9:58 a.m. The policy indicated the following, " ...Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...." On 7-23-21 at 1:34 p.m., Corporate Nurse 18 provided a copy of a policy with a copyright date of 2021, entitled, "Hand Hygiene." This policy indicated, "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. this applies to all staff working in all locations within the facility. "Hand hygiene" is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.			

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	Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. (Note: The fore-mentioned table was not attached to the policy.) Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating and after using the bathroom...The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves." On 7-23-21 at 1:34 p.m., Corporate Nurse 18 provided a copy of a policy, dated 6-1-21, entitled, "Long-term Care Facilities Guidelines in Response to Covid-19 Vaccination," This information was identified as a product of the Indiana Department of Health, Division of Long Term Care. This policy indicated, "...New Admissions or Readmissions: The CDC recommends managing the unknown COVID-19 status for all new admissions or readmissions to the facility. The CDC allows for options that may include placing the resident in a single person room in the general population area or in a separate observation area so the resident can be monitored for evidence of COVID-19. Examples of readmissions are those who are readmitted after hospitalization over 24 hours, or those who have gone on family visits that are greater than 24 hours. Fully Vaccinated Resident Status: Quarantine is no longer recommended for residents who are being admitted to the facility if they are fully vaccinated and have not had prolonged close contact with someone with COVID-19 infection in the prior 14 days...All recommended PPE should be worn during care of newly admitted or readmitted residents under observation for unknown COVID			

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	status; this includes use of face mask, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves and gown. Cloth face coverings are not considered PPE and should not be worn by healthcare providers when PPE is indicated...Hand hygiene (use of alcohol-based hand rub is preferred). Adherence to strict hand hygiene must continue for all, particularly staff, including when entering the facility and before and after resident care. Alcohol Based hand rubs >60% are preferred unless hands are visibly soiled or when handwashing is advocated by CDC guidance. Face covering or mask (covering mouth and nose). Continue universal mask use by all staff (medical grade masks) and visitors (cloth is acceptable) and eye protection for staff when delivering care within 6 feet of the resident...Aerosol Generating Procedures (AGPs) in Red/ Yellow zones: Limit performance of aerosol-generating procedures (AGPs) on confirmed or presumed COVID-19 positive residents unless medically necessary. For any AGP that is performed on a resident with COVID or suspected COVID they should be performed in a private room with full Transmission-Based Precautions (TBP) with the door closed for duration of procedure and 1 hour after the procedure ends. This includes N-95 mask, eye protection, gown and gloves and keeping the door closed throughout the procedure and disinfecting all surfaces following the procedure..." The Indiana Department of Health, Division of Long Term Care's "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," revised 6-1-21 and 6-22-21, which can be located at coronavirus.in.gov, indicated, "There is emerging evidence that many persons			

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	with COVID-19 may only have mild symptoms or no symptoms at all. These persons, however, can still be infectious. In addition, CDC notes that transmission risks can be airborne for those infected with COVID 19. To prevent the spread of COVID-19 in your facilities among providers with no or mild symptoms, we recommend the following...Direct care providers should wear a surgical mask for the duration of their shifts. Indirect care providers should wear a mask during their shifts. N95 (transition away from the approved KN95) masks should be worn in COVID units and with any resident who is symptomatic or awaiting testing in transmission-based precautions (red or yellow zone). While supplies are limited, masks should be conserved and only a single mask should be worn by staff each shift. They should be changed when visibly soiled or wet. When possible, by supply and lower transmission in the facility, mask use can return to conventional usage and NIOSH-approved N95 respirators...Fully vaccinated HCP [healthcare personnel] may unmask with fully vaccinated residents unless residents are undergoing aerosol-generating procedures (AGPs). HCP may also choose to unmask during outdoor activities. Must keep mask on if visitors are present. Must keep mask on if other HCP enter the room who are unvaccinated. Must re-mask in hallways and common areas. Must mask in TBP [transmission based precaution areas]. To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident in all levels of care in all long-term care facilities and assisted living. Fully			

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	vaccinated HCP may choose to not wear eye protection in green zones and in yellow zones when residents are being monitored for new admission quarantine--irrespective of county positivity rates. HCP must keep on eye protection for any symptomatic or positive COVID-19 resident in transmission-based precautions (TBP). Cohort confirmed or presumed COVID-19 positive residents...Unknown COVID-19 status (Yellow): All residents in this category warrant transmission-based precautions (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed..." 3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(l)			
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual			

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	specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing			

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	services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to ensure Covid-19 testing was conducted and results documented for non-vaccinated staff, based upon the Covid-19 status of the facility and the community Covid-19 status for 1 of 4 staff reviewed for Covid-19 testing. (CNA 16) Findings include: In an interview with the Executive Director on 7-23-21 at 12:40 p.m., he indicated the facility's Covid-19 status has been Covid-19 free since prior to 1-1-2021, but did have outbreak testing conducted in April, 2021, related to one resident who was identified as "long-haul positive" by the contracted laboratory and the facility's Medical Director. He clarified, the only positive test result at the time of outbreak testing was the resident who was identified in this manner. He indicated the facility conducts routine monthly Covid-19 testing for all unvaccinated staff, based upon the community's positivity rate, which has remained in the low risk category of under five percent for several months, based upon the CMS (Centers for Medicare and Medicaid) weekly published rates for their county. In review of Covid-19 testing results for CNA 16, testing "negative" results were documented on 4-28-21 and 5-3-21. June, 2021 Covid-19 testing	F 0886	**F 886 Covid-19 testing** **Residents and Staff** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No resident identified for correction **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 have the potential to be affected. An initial audit was completed to ensure all staff are tested per facility guideline and results obtained and reviewed for outcome. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The Infection Preventionist/designee provided education to ED and DNS on the facility guideline for Covid-19 testing requirements and tracking lab results related to Covid -19	08/22/2021

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	results were unavailable. In an interview with the Executive Director on 7-23-21 at 4:40 p.m. indicated Covid-19 testing was conducted within the first 10 days of June, 2021 and sent to the contracted lab in two batches and "are waiting for some of the testing results." He indicated the facility is in contact with the lab to obtain results. As of 7-23-21 at 6:45 p.m., exit date of the survey, the test results had not been received. On 7-23-21 at 1:34 p.m., Corporate Nurse 18 provided a copy of an undated document entitled, "Covid Quick Tips Guide." It indicated asymptomatic, fully vaccinated employees are not required to be included in routine testing. Routine Covid-19 testing excludes any outbreak testing or testing when symptomatic for possible Covid-19. It indicated when the community positivity rate is under five percent the routine testing for unvaccinated staff is to be conducted monthly. On 7-23-21 at 1:34 p.m., Corporate Nurse 18 provided a copy of the Indiana Department of Health, Division of Long Term Care's "Long Term Care Facilities Guidelines in Response to COVID-19 Vaccination," dated 6-1-21. It indicated, "Resident and staff testing conducted as required by CMS. 42 CFR 483.80(h) (see QSO-20-38-NH) The CMS document referred to, QSO-20-38-NH, was revised on 4-28-21 and indicated routine testing of unvaccinated staff should be based upon "the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency." The county positivity rates are available from the CMS website. "For staff routine testing, document the facility's county positivity rate, the corresponding testing		testing. The ED or Designee will audit weekly for timely and accurate completion of Covid-19 testing for staff and residents for timely collection and tracking of lab results. Audit will be ongoing weekly and presented to QAPI monthly for review and recommendations. **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. **By what date the systemic changes be completed: August 22, 2021**	

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	frequency indicated (e.g., every other week), and the date each positivity rate was collected. Also, document the date(s) that testing was performed for all staff, and the results of each test. Document the facility's procedures for addressing residents and staff that refuse testing or are unable to be tested, and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases. When necessary, such as in emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Facilities may document the conducting of tests in a variety of ways, such as a log of county positivity rates, schedules of completed testing, and/or staff and resident records. However, the results of tests must be done in accordance with standards for protected health information. For residents, the facility must document testing results in the medical record. For staff, including individuals providing services under arrangement and volunteers, the facility must document testing results in a secure manner consistent with requirements specified in 483.80(h)(3)." 3.1-18(b)(1)(A)			
F 0947 SS=D Bldg. 00	483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management			

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	155157	A. BUILDING 00 B. WING	07/23/2021

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	training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Based on interview and record review the facility failed to inservice a Temporary Nurse Aide (TNA) on abuse for a staff member who was verbally abusive to a resident for 1 of 10 employee files reviewed (Resident F). Finding include: During an interview with Resident F on 7/18/21 at 12:40 p.m., indicated Temporary Nurse Aide (TNA) 19 verbally abused him over the weekend. Resident F requested something to drink with his supper meal and TNA 19 cussed at him and told him to get his own drink. During an interview with LPN 3 on 7/21/21 at 4:03 p.m., indicated she was the nurse on duty on 7/17/21 when she heard TNA 19 being verbally abusive to Resident F. LPN 3 indicated the resident asked TNA 19 for something to drink with his dinner on and TNA 19 told the resident "you can get it your own f------- self". Review of the record of Resident F on 7/22/21 at 1:55 p.m., indicated the resident's diagnoses included, but were not limited to, osteoarthritis,	F 0947	**F 947 Required in-service training for Nurse Aides** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident F no longer resides at the facility TNA 19 is no longer employed 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** All residents have the potential to be affected by the same deficient practice. An initial audit was completed of all employee files to ensure timely completion of abuse training. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	08/22/2021

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	chronic obstructive pulmonary disease, asthma, epilepsy, diabetes, arthritis, depression, weakness and post traumatic stress disorder. The Admission Minimum Data (MDS) for Resident F, dated 7/7/21, the resident was cognitively intact, decisions were consistent and reasonable. Review of the employee files on 7/23/21 at 3:22 p.m., TNA 19 was hired at the facility on 3/20/2020 and had no abuse training. During an interview with the Administrator on 7/23/21 at 5:33 p.m., indicated the facility did not have documentation that TNA 19 had been inserviced on abuse. The abuse policy provided by Corporate Nurse 18 on 7/18/21 at 2:45 p.m., indicated the facility would train new hire employees on abuse during their initial orientation and then annual afterward. 3.1-14(h)		**practice does not recur** Facility staff were educated on the facility guideline for Abuse Prevention and Reporting. Employee files will be audited by the ED or designee. Audit is to be reviewed weekly x 2 months, 2 x month 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. **By what date the systemic changes be completed:** August 22, 2021	
F 9999 Bldg. 00		F 9999	**F 9999 Final Observation** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** TNA 19 is no longer employed at the facility **How other residents having the potential to be affected by the**	08/22/2021
	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.			

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	(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. For 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. (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		**same deficient practice will be identified and what corrective action will be taken** All residents have the potential to be affected by the same deficient practice. An initial audit was completed of all employee files to ensure timely completion of reference checks and to provide annual in-services for abuse, resident rights and dementia training. **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 were educated on the facility guideline for Abuse Prevention and Reporting. Employee files will be audited by the ED or designee for completion of reference checks and annual in-services to include abuse, resident's rights and dementia training. Audit is to be reviewed weekly x 2 months, 2 x month 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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	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 preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to obtain reference checks and to provide annual inservices for abuse, resident rights and dementia training for 5 of 10 employee records reviewed. (Certified Nursing Assistants 6, 21, 28, 35, and 60) Findings include: Employee records were reviewed on 7/23/21 at 3:22 p.m., and indicated the records lacked completion for the following employees: 1. CNA 6 was hired on 6/28/21 and did not have references. 2. CNA 21 was hired on 3/30/20 and did not have resident rights, dementia training or abuse training in the past 12 months. 3. CNA 28 was hired on 7/26/16 and did not have resident rights or dementia training in the past 12 months. 4. CNA 35 was hired on 2/26/19 and did not have		QAPI recommendation. If none noted, then will complete audits based on a prn basis. **By what date the systemic changes be completed:** August 22, 2021	

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	an annual tuberculin skin test or resident rights training in the past 12 months. 5. CNA 60 was hired on 4/5/19 and did not have references or resident rights training, dementia training, or abuse training in the past 12 months. A Policy and Procedure for "References for Potential Hires: was provided by the Business Office Manager on 7/23/21 at 6:16 p.m. The policy indicated, but was not limited to: "The Company desires to hire the best-qualified candidates for job openings. To assist in that process, the Company's policy is that all candidates must undergo a screening of their former employment, their qualifications and their suitability for the job...The Recruiter or Hiring Manager will ensure that all applicants for employment are properly interviewed and employment references are completed prior to the new hire starting work...Two (2) former employer or equivalent references must be obtained. Reference checks will be conducted via Skill Survey for both Golden Living Centers and GL Administrative Services...." A Policy for "Employee Tuberculosis Testing" was provided by the Business Office Manager on 7/23/21 at 6:16 p.m. The policy included, but was not limited to: "Tuberculosis (TB) screening and testing is conducted in this facility for the purpose of early identification, and treatment of employees with latent TB infection (LTBI) or TB disease...Follow state or local requirements regarding TB screening and testing of employees. In the absence of state or local requirements, follow CDC recommendations below...." During an interview, on 7/23/21 at 5:33 p.m., the Administrator indicated that to the best of his knowledge all the information they had for the			

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	employee records was in the employee records.			