STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

(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. Survey dates: June 25, 26, 27, 28, 29, and 30, 2023. Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF: 9 SNF/NF: 85 Total: 94 Census Payor Type: Medicare: 9 Medicaid: 72 Other: 13 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 11, 2023.	F 0000	Majestic Care of Avon Respectfully requests a desk review for the survey XXJ411	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Josiah Marx	Executive Director	07/28/2023

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

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	(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to ensure the Resident Council received responses and follow-up for their requests and grievances related for 6 of 6 months of resident council notes reviewed. This deficient practice had the potential to effect 92 of 92 residents who resided in the facility. Findings include:	F 0565	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Timely follow-up related to resident concerns will be addressed in a timely manner as it pertains to resident council. How other residents having the potential to be affected by the	08/04/2023

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	On 6/29/23 at 12:25 p.m., the Resident Council (RC) Meeting Minutes were reviewed. On 1/10/23 the RC met and requested the creation of a Dietary Council group. There was no response. Additionally, the RC indicated Housekeeping/Laundry department "needs work." Although a grievance form was submitted late, on 1/19/23, it was not responded to until 2/16/23. On 2/14/23 the RC met and discussed new concerns related to the Nursing Department which included, staff use of cell phones, language barriers, and call light response times. There was no response. The RC discussed concerns related to the Dietary department which included, a request to have more consistent mealtimes, resident preferences provided on trays, and the RC requested the creation of a Dietary Council group for a second time. A grievance form was submitted on 2/14/23 which included follow up for meal service times, the response did not include any follow up for resident food preferences or a response for the creation of a Dietary Council group. On 3/15/23 the RC met and complained a second time about staff's use of headphones/earbuds. There was no response. On 4/11/23 the RC met and discussed concerns that call light response time was too long, and evening snacks were not being passed. There was no response. On 5/9/23 the RC met and discussed continued concerns related to call light response times and		same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents who reside in the facility could be affected by this potential deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> Food Council has been established within the facility to further address dietary concerns. The Executive Director or designee will review all grievances generated out of resident council meetings to ensure adequate and timely follow-up. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. **QAPI tool will be completed by AD or designee weekly x 4, An action plan will be completed for results less than 90 percent compliance of concerns being resolved. The results will be reviewed monthly in QAPI for 6 months and then PRN if no trends are noted.**	

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	irregular mealtimes. Although a grievance was submitted on 5/9/23, it was related to a question about Resident's use of masks during activities. There was no response related to call lights or mealtimes. An undated RC grievance form requested that the State Ombudsman be contacted to come and introduce themselves and explain the Ombudsman Program. The Social Service Director (SSD) responded on 5/10/23, "E-mailed Angie Calvert, long-term care Ombudsman for this to see if she would be willing to come in and speak to the residents." On 6/29/23 at 2:30 p.m., a Resident Council meeting was conducted with 5 residents who regularly attended the monthly meetings and included the attendance of the Resident Council President. When asked if the group had ongoing concerns that had not been addressed, they all agreed there were still a lot of issues with the Dietary Department. Mealtimes were never consistent, the food was not always prepared to their liking, food preferences were sometimes not available, and snacks were not available or not passed. The Residents indicated they had requested a Food Council group since they had so many concerns related to dining, but nothing came of it. During an interview on 6/29/23 02:43 p.m., with the Activity Director (AD) and the Resident Council President, the AD indicated, the two biggest ongoing concerns were related to call light response times and food issues. The facility had switched companies several months ago and things seemed to have gotten better related to the Dietary Department, but there were still ongoing issues. At one time a Food Council group had			

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	been scheduled but it was cancelled and had not been rescheduled. The AD indicated the process for grievance follow-up for the RC was not very effective. It was supposed to work that RC met and filled out official grievances forms which were then submitted to the Social Service Director (SSD). The SSD was responsible for ensuring they were given to the appropriate department heads for a response, but the AD did not receive responses in a timely manner or sometimes did not receive responses at all. The AD indicated the Residents still wanted to form a Food Council group and should have been able to. During an interview on 6/30/23 at 10:05 a.m., the SSD indicated he was supposed to receive grievance forms from the RC meetings and make copies to give to the appropriate department heads for a response. They system was not effective because it was very difficult to get response forms, and he often forgot to follow up with the departments heads to remind them to complete the responses. On 6/30/23 at 1:23 p.m., the State Ombudsman replied via e-mail that she, nor any of her field staff Ombudsman had received a request from the facility to come and meet with the RC. During an interview on 6/30/23 at 2:19 p.m., the SSD indicated he looked for the e-mail mentioned on the grievance form, but he must have forgotten to send it because he could not find a record of it. The SSD indicated if the Residents still wanted to form a Food Council group, they should have been assisted to do so. On 6/30/23 at 12:15 p.m., the AD provided a copy of current facility policy titled, "Resident Council," dated 06/2018. The policy indicated, "			

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	...The purpose of the Resident Council is to provide a forum for: a. Residents to have input in the operation of the facility, b. Discussion of group concerns, c. Consensus building and communication between residents and facility staff, and d. staff to disseminate information and gather feedback from interested residents ... 8. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issue will be responsible to address the item(s) of concern...." On 6/30/23 at 12:15 p.m., the AD provided a copy of current facility policy titled, "Resident's Rights," dated 10/2019. The policy indicated, "All Residents will be treated with dignity and respect and resident's rights will be followed ...." 3.1-3(o) 3.1-3(o)(4)			
F 0574 SS=E Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and			

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	email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;			

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	(v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. Based on observation, interview, and record review, the facility failed to ensure information for the Indiana Long-Term Care Ombudsman Program was easily available and accessible for Residents and/or their representatives to review for 5 of 6 days of the survey. This deficient practice had the potential 92 of 92 residents who resided in the facility. Findings include: Upon the survey entrance on 6/25/23 and on 6/26/23, 6/27/23, 6/28/23, and 6/29/23 information related to the Ombudsman program was not visibly posted in the facility. During an interview on 6/28/23 10:18 a.m., the Activity Assistant indicated she had worked since September and had never heard of the Ombudsman program and was unfamiliar with the term. She did not know if information about the program was available for Residents to review and would not know where it would be posted. On 6/29/23 at 2:30 p.m., a Resident Council meeting was conducted with 5 residents who regularly attended the monthly meetings and included the attendance of the Resident Council	F 0574	b="">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. b=""> Upon notice of alleged deficient practice, the ombudsman sign was posted.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. b=""> All residents have the potential to be affected by this alleged deficient practice. b="">What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. b=""> SSD/ED Educated about requirement. The sign has been made larger and has been posted in a common area for all residents to see and use as a resource. Residents will be informed of ombudsman services via every resident council. b="">How the corrective action(s)	08/04/2023

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	President. When asked if they knew who their Ombudsman was, they indicated they did not know. When asked if they understood what the Ombudsman program was, they indicated no and asked what the program was. The Ombudsman program was explained as described on the Ombudsman Indiana website as a resident right's advocate with the main "purpose is to promote and protect the resident rights guaranteed to residents under federal and state law." During an interview on 6/29/23 02:43 p.m., with the Activity Director (AD) and the Resident Council President, the AD indicated she kept a pamphlet of the Ombudsman program in the Resident Council binder and reviewed the program periodically during Resident Council meetings. The AD indicated the information and contact numbers were not posted anywhere in the building that she was aware of. On 6/30/23 at 11:55 a.m., a small 5x6 picture frame was observed newly posted on a wall in the front lobby. The frame was approximately 5 feet high, and the print was small. The incorrect Ombudsman's name was listed. During an interview on 6/30/23 at 11:57 a.m., the Director of Nursing Services (DNS) observed the frame and indicated it was small and would be difficult for a resident in a wheelchair to see the information posted that high. On 6/30/23 at 12:00 p.m., a laminated copy of an Ombudsman pamphlet was observed to be newly posted in a small alcove next to a large poster of the Resident's Bill of Rights. The pamphlet was posted approximately 6 feet high, and the print		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. /ol>	

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	was small. A passing, unidentified Resident was asked if they were able to read the information on the pamphlet. They were seated in a regular wheelchair, looked up and indicated, no, they were unable to read the information. On 6/30/23 at 12:15 p.m., the AD provided a copy of current facility policy titled, "Resident's Rights," dated 10/2019. The policy indicated, " ...each facility must post the names, addresses and telephone numbers of all pertinent state client advocacy groups, including the State survey and certification agency, the State licensure office, the State Ombudsman program, the protection and advocacy network, the area agency on aging, the local mental health center and the Medicaid fraud control unit ...." 3.1-4(j)(3)(C)			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care			

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	for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. A. Based on observation, interview, and record review, the facility failed to ensure randomly tested memory care (MC) resident rooms had water temperatures able to reach 100 degrees Fahrenheit (F) for 11 of 11 resident rooms tested for water temperature (Resident 8, 51, 52, 59, 67, 71, 75, 76, 77, 85 and 95). B. Based on observation, interview, and record review, the facility failed to ensure the resident rooms in the 800 hall and in MC were clean and a home-like environment for 22 of 22 residents' rooms observed on the 800 hallway and MC unit (Resident 4, 8, 9, 16, 21, 26, 43, 45, 46, 47, 52, 54, 57, 67, 76, 77, 81, 85, 95, 100, 113, and 252).	F 0584	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b>Water temps will be within regulatory levels, Resident rooms noted will be cleaned and restored to a homelike environment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents who reside in the facility could be affected by	08/04/2023

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	Findings include: A. On 6/25/23 at 1:52 p.m., Certified Nursing Aide (CNA) 27 indicated the facility had issues with water not getting hot enough on the memory care (MC) unit on the 100 hallway and 300 hallways. The residents' showers were only lukewarm, and the MC residents complained of being cold during showers. On 6/25/23 at 1:55 p.m., the Administrator (Admin) brought a digital thermometer and provided the warmest water temperatures in the MC resident rooms. He indicated the resident's bathroom water temperatures should have been between 100 and 120 degrees Fahrenheit (F). a. Resident 95's bathroom water temperature was 95 degrees F. b. Resident 51's bathroom water temperature was 95.6 degrees F. c. Resident 52's bathroom water temperature was 95.7 degrees F. d. Resident 77's bathroom water temperature was 97.5 degrees F. e. Resident 71's bathroom water temperature was 97.6 degrees F. f. Resident 59's bathroom water temperature was 97.7 degrees F. g. Resident 67's bathroom water temperature was 97.8 degrees F. h. Resident 76's bathroom water temperature was 98.4 degrees F. i. Resident 8's bathroom water temperature was 98.4 degrees F. j. Resident 85's bathroom water temperature was 98.5 degrees F. k. Resident 75's bathroom water temperature was 98.7 degrees F. On 6/25/23 at 2:05 p.m., the Administrator		this deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> The environmental services director has been educated related to the Homelike environment policy. The Environmental Services Director will educate the environmental team additionally. The Maintenance Director has been educated on water temperatures and the appropriate levels needed to meet regulatory requirements. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. /li>	

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	indicated he was not aware the residents' bathroom temperatures were running less than 100 degrees F. On 6/25/23 at 2:34 p.m., the Administrator indicated he would have the Maintenance Director come in tonight to reset the mixing valves and he would re-take the MC bathrooms' water temperatures again. It would be fixed tonight. On 6/25/23 at 4:17 p.m., the Administrator indicated the Maintenance Director came in and fixed the MC water temperatures. On 6/26/23 at 9:01 a.m., the Maintenance Director indicated he adjusted the mixing valve. He provided MC water temperature sheets from both days. B. On 6/26/23, Resident 252's room was observed to have a dark, dry fluid ring on the left side of the resident's bed, along with crumbs and trash. Housekeeping was notified. On 6/27/23 at 2:53 p.m., Resident 252's floor was sticky. The floor had a dark, dry fluid ring on the left side of the resident's bed, along with crumbs and trash. All entry ways into residents' rooms on the 800 hall were observed to be dirty. On 6/28/23 at 12:14 p.m., the floors around the MC nursing station were sticky. During a continuous observation, on 6/28/23 from 1:15 p.m. to 3:12 p.m., the MC rooms were observed for cleanliness. a. Resident 46's had a dirty floor, with part of the vinyl missing at the entry to the bathroom. b. Resident 21's bathroom was dark, the light was not working properly.			

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	155338	A. BUILDING 00 B. WING	06/30/2023

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	c. Resident 100's bathroom room floor was dirty and there was a brown substance on the toilet. d. Resident 47's bathroom room floor was dirty and had several quarter sized brown spots. e. Resident 45's floor was sticky, and there were black skid marks from the bed. f. Resident 4's floor was sticky, and the bathroom floor was dirty. g. Resident 57's floor was sticky, with part of the vinyl missing at the entry to the bathroom. h. Resident 77's floor was sticky. i. Resident 67's room had a hole in the wall from the bathroom doorknob. j. Resident 113's floor was sticky, and the bathroom floor was buckled under the counter. A long piece of countertop was missing from the front of the bathroom countertop. k. Resident 61's floor was sticky. l. Resident 76's floor was sticky, with a large brownish stain. The bathroom floor was sticky, with a large scrap into the floor. m. Resident 8's floor was sticky. n. Resident 85's floor was sticky. A urine collection "hat" was observed on his bathroom floor. o. Resident 54's floor was sticky. p. Resident 43's exterior bathroom door had 4 small holes. q. Resident 26's bathroom floor had stains around the toilet.. r. Resident 52's bathroom floor was buckled on the right side of the toilet. s. Resident 95's exterior door frame was observed with paint peeled, approximately 3 inches by (x) 9 inches. t. Resident 9's bathroom floor was buckled on the right side and behind the toilet and under the bathroom counter. u. Resident 16's floor was dirty, and a brownish/black spot was observed near a chair in			

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	her room. Resident 16 indicated she had tried to get it up but was unable and housekeeping would not clean it. A spider web was observed on the floor in the corner to the right of the personal terminal air conditioner (PTAC), an orange pill was behind the spider web. Her bathroom floors were dirty. On 6/27/23 at 3:57 p.m., the Environmental Services Supervisor (ESS) indicated he was a new manager and used an assignment sheet for the Environmental Services staff, but not a schedule. The facility had laminated floors and they were dirty and sticky. They tried to get in rooms every day to sweep and mop, but these floors were "awful." The previous company did not clean the floors before they used cheap wax. They just waxed over the dirt. During a tour of the facility's 100, 200, 300, and 800 halls, on 6/28/23 at 2:42 p.m., with the ESS, he indicated the floors were vinyl and waxed. The wax sealed in the debris. They have deep cleaned 15 rooms since they began services at this facility 3 months ago. He agreed all of the 800 hall was dirty except for one empty resident room. In the MC resident areas, the same debris was observed in the entry ways. The current, "Indiana Admission Agreement," provided after the entrance conference was reviewed. It indicated, " ...Facility's Obligation to Provide Care and Services. The Facility shall provide room, dietary services, nursing care, therapy services, laundry services, housekeeping services, telephone services, television, and other care and health care services as directed by the Resident's physician and as required by federal and state law for the health, welfare, and benefit of the Resident ...."			

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	A current policy, titled, "Water Temperatures, Safety of," dated December 2009, was provided by the Director of Nursing Services (DNS), on 6/28/23 at 10:00 a.m. A review of the policy indicated, " ...Water heaters that services resident rooms, bathroom, common area, and tub/shower area shall be set to temperatures of no more than 120 degrees F ...maintenance staff is [sic] responsible for checking thermostats and temperature control in the facility and recording these checks in a maintenance log ..." A current policy, titled, "Resident Rights," dated July 2020, was provided by the Licensed Practical Nurse (LPN) Unit Manager (UM), on 6/28/23 at 1:32 p.m. A review of the policy indicated, " ...All staff members recognize the rights of resident at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper deliver of care ...." 3.1-18(a) 3.1-19(a)(4) 3.1-19(f)(4) 3.1-19(f)(5) 3.1-19(r)(1) 3.1-19(r)(2) 3.1-19(bb)			
F 0641 SS=B 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 observation, interview, and record review, the facility failed to accurately code the use of oxygen on the quarterly Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for	F 0641	F 641 (B) 1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	08/04/2023

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	oxygen therapy (Resident 48). Findings include: On 6/26/23 at 10:50 a.m., Resident 48 was observed with 2.5 liters (L) of oxygen It was being administered per a nasal canula (NC), continually through an oxygen concentrator machine. The oxygen tubing and nasal cannula (NC) tubing were attached to the portable oxygen tank sitting on the floor next to the resident's bed. The tubing and NC tubing were laying on the floor un-bagged. On 6/29/23 at 9:36 a.m., Resident 48 was up walking in his room. Oxygen was being administered at 2.5 L via NC per the oxygen concentrator. On 6/28/23 at 2:58 p.m., Resident 48's record was reviewed. His diagnoses included, but was not limited to, late onset Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). A physician order, dated 1/6/23, indicated an order for oxygen 2 liters per minute via NC every hour every shift and as needed for shortness of breath. A quarterly MDS, dated 4/20/23, indicated no oxygen was in use during the review period. A COPD care plan, dated 9/16/19, with an intervention of oxygen as ordered, dated 8/27/20.		1.b> Residents' assessments will accurately reflect status. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> Residents who reside in the facility and have assessments can be potentially affected by this alleged deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> MDS coordinator has been educated related to accuracy of assessments. Every resident that utilizes oxygen in the facility has been audited. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>Assessments will be reviewed and monitored to ensure accuracy weekly x 4,	

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	The Resident Assessment Instrument (RAI) instruction guide indicated, coding instructions for section O of the MDS, CMS's RAI Version 3.0 Manual, October 2019, page 492, indicated, "...Coding Instructions for Column 2, check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14-day look-back period...O0100C, oxygen therapy, code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula...." 3.1-31(i)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide a resident with timely toileting assistance resulting in discomfort for the resident for 1 of 1 random observation (Resident 78). Findings include: During an observation, on 6/27/23 at 2:10 pm, Resident 78 was sitting in his doorway with his call light was on.	F 0677	b="">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. b=""> Residents who are affected will receive necessary services needed to maintain good nutrition, grooming and personal and oral hygiene.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/04/2023

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	At 2:14 p.m., an unidentified staff member walked by the resident and asked what he needed. He indicated he needed to use the bed pan and it was almost too late. He indicated he had been waiting 90 minutes. The 2 staff members then went into another room on the hall. At 2:16 p.m., CNA (Certified Nursing Assistant) 7 asked him what he needed, and he told her same information as above. She went into his room and turned off the call light, exited the room, and proceeded down the hall. The resident remained in the doorway. At 2:20 p.m., CNA 7 exited the other resident's room and walked by Resident 78 without assisting him. Resident 78 turned on his call light again. At 2:22 p.m., CNA 7 exited a resident's room, proceeded to the food cart, and moved it down the hallway. CNA 12 and CNA 13 proceeded down the 800 hall to Resident 78's room and asked him what he needed. Again, Resident 78 told the CNA he needed to use the bedpan. The resident was a mechanical lift. CNA 12 left to get the hoyer lift (mechanical lift) that was sitting in the 800 hall, near the nurse's station. CNA 13 stayed with Resident 78. At that time, CNA 12 indicated the lift was not working. At 2:25 p.m., CNA 11 exited a room with a mechanical lift, took the dirty linen down the hall, and then addressed another resident's needs. At 2:31 p.m., and CNA 11 and CNA 12 entered Resident 78's room to provide the resident care. At 2:25 p.m., during the interview with Resident		action(s) will be taken. b=""> All residents who reside in the facility could be affected by this alleged deficient practice. b="">What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. b=""> Education has been provided to all clinical CTMs related to call lights and response of call lights by DNS or Designee. b="">How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. b="">Call light time audits will be conducted weekly x4, bi-weekly x 4 and monthly x 3 until substantial compliance is accomplished.	

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	78, he indicated he had turned his call light on at 12:45 p.m. and had repeated indicated he had to use the bedpan twelve times. On 6/28/23 at 12:10 p.m., a record review was completed for Resident 78. His diagnoses included, but were not limited to, essential hypertension (high blood pressure), anemia (reduce red blood cells), ascites (fluid in the abdomen), insomnia, depression, type 2 diabetes (blood sugar disorder), heart failure and atrial fibrillation (abnormal heart rhythm). During an interview with the Administrator (Admin) on 6/27/23 at 3:00 p.m. He indicated the hoyer lifts were all working and that he did not know why staff reported them not working. A policy was requested on 6/27/23, but not provided by the end of the survey. 3.1-38(a)(3)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to ensure a resident who had a history of falls with fractures, had fall interventions in place to prevent the potential for additional falls for 1 of 8 residents reviewed for	F 0689	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Corrective action	08/04/2023

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	accidents (Resident 7). B. Based on observation, interview, and record review, the facility failed to ensure a memory care (MC) resident's room was free of medications for 2 of 2 random observations (Resident 16) and failed to ensure a resident with medications in her room was accessed for safety to self-administrate medications (Resident 252) for 1 of 8 residents reviewed for accidents. Findings include: A. On 6/28/23 at 9:25 a.m., Resident 7 was observed. She was seated in a regular high back wheelchair (WC) and was assisted by Certified Nursing Aide (CNA) 19 back into her room to lay down. CNA 19 conducted a stand and pivot transfer without placing a gait belt around the resident, neutralizing/stabilizing the low air loss mattress (LAL) or locking the WC's brakes. After she seated Resident 7 onto the LAL, the mattress ballooned on either side of the Resident and caused her to shift unsteadily to one side. She called out, "Whoa!" and patted the puffed up mattress. CNA 19 helped Resident 7 get her legs into bed and the mattress deflated slightly but it still appeared hammocked between the inflated sides. Her WC was observed at this time, and although there was a pressure reducing cushion in place on the seat, there was no Dycem (a thin rubber pad used to help prevent the cushion from sliding out of place) in place under the pad. On 6/29/23 at 10:21 a.m., Resident 7 was observed. Although she was reclined in her bed, she was scooted to the far edge of the open side of her mattress. The LAL mattress gave way under her weight, while it remained inflated on the other side. One of her legs hung off the side of the bed		includes ensuring that all residents have appropriate fall interventions in place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents who have fallen have a potential to be affected by alleged deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> An audit has been conducted for all residents pertaining to fall interventions. Transfer observations were completed. Staff were educated on transfers and use of gait belts. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>Fall interventions will be monitored in Facility QA weekly x4, bi-weekly x4 and monthly x 3 or until a 100% threshold is accomplished.	

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	and it appeared that she could slide out of bed. A nurse was immediately notified. On 6/29/23 at 10:22 a.m., Unit Manager (UM) 4 came down the hall and asked for a CNA to come help too. UM 4 entered the room and indicated, "[Resident 7's name] are you trying to get out of bed, you're sliding down." Resident 7 was very hard of hearing (HOH) and only smiled up at UM 4. UM 4 knelt down to the Resident's level and placed her hands on her leg to help keep her from sliding any further while she waited for a CNA. An aid entered the room and together they gently assisted Resident 7 into a seated position which again caused the LAL mattress to inflate around her. UM 4 indicated she needed to get a new mattress for Resident 7, as it appeared the LAL was no longer appropriate and could potentially cause an accident. Resident 7 pointed and requested to get into her WC. The WC was observed with UM 4 at that time, and she indicated it did not appear that Dycem was in place under the WC cushion. On 6/30/23 at 1:06 p.m., Resident 7 was observed as she independently, without assistance, walked out of her room and began to walk down the hall. She was not observed to have any socks shoes on. On 6/29/23 at 9:29 a.m., Resident 7's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Parkinson's disease (a degenerative brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia, delusional disorder and generalized anxiety.			

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	A nursing progress dated 4/17/23 at 3:13 a.m., indicated, "Resident was found on the floor in her room by the bathroom ..." She was sent to the Emergency Room (ER) and diagnosed with a hip fracture. An Interdisciplinary team (IDT) progress note dated 4/17/23 at 1:26 p.m., indicated, Resident 7 fell because she had poor safety awareness with her diagnoses of dementia and often tried to complete activities of daily living (ADLs) without assistance. She was referred to therapy for an evaluation. A nursing progress note dated 4/25/23 at 5:54 p.m., indicated, Resident 7 was found lying on her left side on the floor by her bed. An IDT progress note dated 4/26/23 at 3: 37 p.m., indicated Resident 7 had poor safety awareness. " ...Resident does utilize low loss air mattress which increases the risk for falls as it is easier to slide out of bed. The IDT agreed that a contour mat should be placed on the floor beside her bed to help prevent injuries. A nursing progress note dated 5/2/23 at 4:18 p.m., indicated, Resident slid down from her WC in the hallway. She did not sustain any injuries. An IDT progress note dated 5/3/23 at 10:32 a.m., indicated, her WC was assessed for proper positioning and Dycem was placed under the WC cushion. Resident 7's comprehensive care plans were reviewed. She had a care plan related to her risk for falls which was dated 10/5/2020. The Care plan indicated, "[Resident 7] is at risk for falls or fall related injury related to incontinence, poor safety			

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	awareness, impaired memory, psychotropic medication." Interventions for this plan of care included but were not limited to contour mat on floor to open side of bed, Dycem to under WC cushion and encourage and assist to wear appropriate non-skid footwear. During an interview on 6/30/23 at 1:10 p.m., UM 4 indicated, fall interventions needed to be in place for all resident at all times, but especially for Resident 7 as she had already had several falls with injuries and was a very high fall risk. On 6/30/23 at 1:45 p.m., the Director of Nursing Services (DNS) provided a copy of current facility policy titled, "Fall Management," revised 6/2023. The policy indicated, "It is the policy of Majestic Care to ensure residents residing within the facility will maintain maximum physical functioning ... a care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. The resident specific care requirements will be communicated to the assigned care team member utilizing the Kardex ... All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall will be reviewed by the team, IDT note will be written, and the care plan will be reviewed and updated as necessary ..." B1. On 6/30/23 at 2:24 p.m., MC Resident 16's record was reviewed. Her diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies (deposits of protein in the brain causing problems with thinking, movement, behavior, and moods), dementia with psychotic disturbance (neurological decline with hallucinations and delusions), and major depressive disorder.			

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A care plan, dated 4/12/23, indicated MC Resident 16 needed assistance with activities of daily living (ADLs). It included dressing, bathing, eating, oral care, and continence care.

A care plan, dated 10/27/22, indicated MC Resident 16 exhibited behavior symptoms of refusing medications, care, showers, and oxygen related to her Lewy bodies (dementia), depression, psychotic disorder with delusions, bipolar disorder (periods of depression and elevated moods), schizophrenia (breakdown in relation between thought, emotion, and behavior), Parkinson's disease (progressive nervous system disease) and hallucinations (an experience involving the apparent perception of something in present). The interventions included to provide her personal space as needed and maintain a safe environment for her and others.

On 6/28/23 at 2:08 p.m., an orange pill was observed in MC Resident 16's room. It was on the floor, in a corner, behind a spider's web, to the right of the PTAC (personal terminal air conditioning). A medication cup was observed on her bathroom counter, it had a blue pill in it.

On 6/28/23 at 2:13 p.m., MC Unit Manager (UM) indicated her expectations were for the Qualified Medication Assistant (QMA) to watch all the residents take the medication. The UM stood at the medication cart and looked up the orange pill and the blue pill. She indicated the orange pill was Midodrine (treats blood pressure) and the blue pill was carbidopa levodopa (treats Parkinson's disease - nervous system disease).

On 6/30/23 at 11:20 a.m., the Director of Nursing Services (DNS) indicated pills should not be in the

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	resident's rooms. Throughout the survey, MC Resident 71, MC Resident 76, and MC Resident 45 were observed wandering the halls, sometimes going into other resident rooms.B2. During an observation, on 6/28/23 at 9:52 a.m., Resident 252 had a prescription antifungal powder on her nightstand. The medication was miconazole 2% powder. On 6/26/23 at 10:17 a.m., Resident 252 had valproic acid capsule (treats seizures) sitting inside a lid on her bedside table. She indicated she would take the medication when she finished eating. On 6/28/23 at 2:03 p.m., a comprehensive record review was completed for Resident 252. Her diagnoses included, but were not limited to chronic respiratory failure, anemia (deficiency of red blood cells), gastritis (inflammation of the lining of the stomach), epilepsy (neurological events of sudden recurrent episodes of sensory disturbance), venous thrombosis (blood clot) and embolism (obstruction of an artery), osteoporosis (brittle bones), neuropathy (disease of peripheral nerves), pressure ulcers, and osteoarthritis. Resident 252's medical record lacked a medication self-administration assessment. During an interview with the DNS (Director of Nursing Services), on 6/29/23 at 2:10 p.m., she indicated the powder was removed from Resident 252's room. A policy titled; "Self-Administration of Medications" was provided by the DNS on 6/28/23 at 10:00 a.m. It indicated, " ...Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not			

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	authorized for self-administration, for return to the family or responsible party ....". 3.1-45(a)(1) 3.1-45(a)(2)			
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 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			

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	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident received care for constipation for 1 of 1 resident reviewed for bowel continence (Resident 14). Finding includes: On 6/25/23 at 11:18 a.m., Resident 14 indicated on 6/20/23 she was severely constipated. She had been trying to have a bowel movement for two hours and she could not go. She asked the nurse for an enema and was told the staff did not give enemas. The staff only gave laxatives. The resident then called 911 and asked them to take her to the hospital for an enema. The resident went to the hospital by ambulance and was given an enema at the hospital. After she returned to the facility, the staff asked the resident why she had called 911. The resident replied she called because she needed someone who would help her. The resident indicated prior to going to the hospital she was bloated and in severe pain. On 6/28/23 at 1:52 p.m., Licensed Practical Nurse (LPN) 10 indicated after three days of no bowel movement (BM), she would do a bowel assessment, then administer Miralax if the resident did not have a BM, she would administer milk of magnesia, if no BM she would administer a suppository. If the resident still did not have a BM after a suppository, she would call the physician and get an order for an enema. On 6/28/23 at 1:57 p.m., the resident was in bed talking with a visitor and indicated, they were her emergency contact. The resident indicated it was	F 0690	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Residents who have bowel issues will be accessed/monitored in a timely manner. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> No other residents were affected by this alleged deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> Nursing Education provided on Bowel assessment and Documentation/MD notification. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>The IDT team will run BM report daily and ensure any resident that has not had a BM in the last 3 days will receive assessment and Tx as necessary.	08/04/2023

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	over a week before she had a bowel movement (BM), prior to going to the hospital. She had an order for Miralax as needed but she did not ask for it because she had a reaction to a medication that gave her severe diarrhea the week prior. She indicated the nurse did not give her Miralax, milk of magnesia, or an enema. She indicated she was in pain, and she called 911 for help. Her emergency contact indicated they were at the facility the day she went to the hospital and saw the resident in "a lot of pain." On 6/28/23 at 2:20 p.m., the Unit Manager (UM) 4 indicated the day the resident went to the emergency room (ER), the nurse had called the physician and asked for orders for a bowel x-ray. The medical record lacked documentation of staff contacting and requesting a physician's order for an abdominal x-ray. The medical record for Resident 14 was reviewed, on 6/28/23 at 2:30 p.m. Diagnoses included but were not limited to hemiplegia and hemiparesis, (a severe or complete loss of strength, whereas hemiparesis refers to a relatively mild loss of strength, following Cerebral Infarction, which occurred as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), affecting right dominant side, pain, hypothyroidism, (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs), essential primary hypertension, (when you have abnormally high blood pressure that's not the result of a medical condition). A quarterly Minimum Data Set (MDS) assessment (a standardized comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 5/17/23, indicated the resident required extensive assistance for			

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toileting, and was frequently incontinent of bowel, (an inability to control the escape of stool from the rectum).

A care plan, dated 1/10/23 and revised 5/18/23, indicated the resident was at risk for constipation due to decreased mobility with a goal of the resident will pass soft, formed stool at the least every three days. Interventions included but were not limited to, administer medications/treatments as ordered, assess abdomen and bowel sounds, if no BM after three days or difficulty passing stool, document abnormal findings and notify physician, encourage daily activity as tolerated, follow facility bowel protocol for bowel management, notify physician if interventions are unsuccessful, observe for signs or symptoms of complications related to constipation, change in mental status, new onset, confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse), abdominal distention, vomiting, small or loose stools, fecal smearing, bowel sounds, diaphoresis, abdomen tenderness, guarding, rigidity, fecal impaction, and record bowel movement.

A nurse's progress note, dated 6/20/23 at 11:43 a.m., indicated the resident was in her room in bed with a complaint of constipation and Miralax 17 grams (gm) was given as ordered. According to the medical record, Resident 14 was in the hospital on 6/20/23 at 10:59 a.m.

On 6/20/23 at 12:02 p.m., a nurse progress note indicated the resident called 911 requesting to be sent to the emergency room for constipation. The resident was given Miralax earlier in the shift. The nurse offered to call the physician and get new orders for alternate treatment, but the resident refused. The on-call nurse practitioner was

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	notified of the resident sending herself to the emergency room. On 6/20/23 at 6:45 p.m., a nurse progress note indicated the resident returned from the emergency room with no new orders at that time. The resident was in bed with no complaints voiced, eating dinner. A review of the resident's daily bowel elimination record indicated from 6/6/23 to 6/20/23, within the previous 14 days the resident had five medium and one small bowel movement (BM). A review of the current, completed, and discontinued orders indicated the medical record lacked documentation of an order for an x-ray of the bowel on the date the resident went to the hospital. A review of medication administration record dated 6/1/23 to 6/30/23, indicated Polyethylene Glycol powder (Miralax) 17 gm by mouth was administered once, on 6/20/23 at 9:56 a.m. A review of hospital treatment records indicated the resident came to the ER, presented with abdominal pain, constant and worsening pain. The resident had x-ray of the bowel while in the emergency room. The findings were bowel gas pattern is nonobstructive. Mild gaseous distention of the colon. Mild colonic stool burden. The blood pressure on 6/20/23 at 10:59 a.m., was 142/105 and on 6/20/23 at 12:30 p.m. the blood pressure was 186/90. The resident was administered an enema; resident had a very large stool output, on 6/20/23 at 6:30 p.m. the blood pressure was 130/67. The medical record lacked documentation of			

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	abdominal assessment, pain assessment, assessment for fecal impaction or notification of the physician. On 6/28/23 at 10:00 a.m., the DNS provided and identified a document as the current bowel and bladder program policy titled, "Bowel and Bladder Program," dated July 2020. The policy indicated, "...Fecal continence/Continence: Each resident will be assessed at admission and with any change in bowel continence via the 3-Day Voiding/Elimination Pattern...after completion of the 3-Day Voiding/Elimination Pattern, the IDT will review and update the care plan as indicated...The care plan must reflect the results of the resident's assessment and include resident specific interventions for any potential reversable causes, and if irreversible, appropriate interventions for management of fecal incontinence...." On 6/28/23 at 2:50 p.m., the DNS provided and identified a document as a current facility policy titled, "Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol," dated September 2017. The policy indicated, "...3. In addition, the nurse shall assess and document/report the following: a. vital signs, d. presence of fecal impaction, f. abdominal assessment, g. digital rectal examination, h. onset, duration, frequency, severity of signs and symptoms...6. Check for diffuse or localized tenderness and listen for bowel sounds in area of suspected ileus or obstruction...Treatment Management...5. The physician will help identify the possible need for hospitalization to manage a gastrointestinal disorder; for example, when intestinal infarction, peritonitis, or mechanical obstruction is suspected...."			

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F 0695 SS=E Bldg. 00	3.1-41(a)(2) 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to provide oxygen therapy and respiratory care according to physician orders and residents' plans of care for 4 of 4 residents reviewed for oxygen therapy (Residents 6, 48, 251, and 252). Findings include: 1. On 6/26/23 at 11:39 a.m., observed Resident 6, lying in bed. The oxygen was not being administered and the tubing and trach mask were draped over the easy air machine (EasyAir compressor is a high performance portable medical air compressor designed to supply compressed air 24 hours a day), and oxygen concentrator at the bedside. On 6/27/23 at 2:03 p.m., the resident was sitting on the bed. His hair was oily with white and yellow flakes in his hair. The resident was more receptive and communicated with a white board. He had a trach speaking device but chose not to use it. The Larrytube (a flexible silicone tube designed to	F 0695	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> All residents requiring oxygen had a review of physician orders and care planned to ensure all information was correct. Resident who are non-compliant have been educated and care planned. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b>All residents requiring oxygen had a review of physician orders and care planned to ensure all information was correct. Audits will be completed to ensure o2 tubing and nebulizer masks and humidity bottles are labeled and dated correctly. What measures will be put into	08/04/2023

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	maintain the stoma right after the laryngectomy surgery) was in a cup filled with water next to the bed. A tracheostomy (trach) inner cannula tube (an inner tube inserted within the main outer cannula of a tracheostomy tube, which was usually inserted inside of a tracheostomy outer cannula tube), was in the stoma and was not secured with a trach collar. The resident was observed holding the trach oxygen mask over the stoma. The resident indicated he must leave the Larrytube out because it kept falling out. The resident removed the inner cannula and laid it on the overbed table next to a banana. The table was soiled with brown debris. The resident held up several alcohol pads and indicated, he cleaned the tube with the alcohol pads before he put it back into the stoma. He did not wash his hands and did not clean the table off before placing the cannula on the table. He had trach collars to secure it and they are sometimes put on but not always. Observed a trach inner cannula laying in a basin, with brown debris and hair on the cannula and red substance on the inside edge of the cannula. During the interview, the resident indicated he had expressed his fear of drowning during his care plan meeting, due to his stoma not being covered during his shower. On 6/28/23 at 10:41 a.m., the resident was sleeping in bed. The filter of the easy air machine was coated with a white debris. An inner cannula was in a cup filled with clear liquid. The humidity bottle attached to the easy air machine was empty and dated 6/24/23. The humidity bottle on the oxygen concentrator was dated 6/24/23. The oxygen liter flow was set at 5 liters (L). The oxygen tube and trach mask were laying across the concentrator. On 6/28/23 at 11:23 a.m., observed the resident's		place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> Audits will be completed to ensure o2 tubing and nebulizer masks and humidity bottles are labeled and dated correctly. Education provided to all staff related to Nebulizer/o2 labeling and dating as well as setting the o2 rate correctly 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Oxygen tubing will be dated and placed in bag, Oxygen level for resident will be accurate per order. Water will be dated and filled.	

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	suction canister was full of cloudy green liquid. The resident indicated he suctioned himself sometimes. Observed the nebulizer tubing with trach mask laying on the bedside table unbagged. Observed a bag with tubing inside of the bag, dated 1/2/23, the bag was tied to the bed stand drawer handle and was lying on the floor. On 6/28/23 at 10:32 a.m., during an interview with LPN 10, she indicated the resident did not put the inner cannula into the stoma and if it were in, she would secure it with ties and provided stoma care daily. The resident was observed holding the trach oxygen mask against the stoma with oxygen liter flow set at 5 L. LPN 10 indicated, the physician's order for oxygen was 4 L continuous via trach mask and indicated, the setting on the concentrator was set at 5 L. LPN 10 indicated, she needed to turn it down and would need to change the humidity bottles. One bottle was empty, and both were dated 6/24/23. The nurse then turned the oxygen flow to 4 L. On 6/29/23 at 9:24 a.m., observed the resident sleeping in bed with the oxygen trach mask lying on his chest just below the stoma. The oxygen liter flow was set at 3.5 liters. The nebulizer tubing and trach mask were in an undated bag on the bedside table. The unbagged suction tubing was lying across the suction machine. An inner cannula was lying in a cup that contained a greenish colored liquid. The filter on the easy air machine was coated with a white debris. The suction canister contained a cloudy greenish colored liquid. On 6/27/23 at 2:52 p.m., a medical record review of Resident 48 with diagnoses including but not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow			

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blockage and breathing-related problems), chronic respiratory failure with hypoxia, (lack of oxygen, low blood oxygen, oxygen starvation).

The physician's orders indicated, to change trach collar as needed (PRN), stoma care every shift, change suction canister and tubing weekly and as needed, oxygen 4 liters (L) per trach, self trach suctioning as needed, and tracheostomy stoma with spacer.

The treatment administration record, dated 6/1/23 to 6/30/23, indicated an order to change suction tubing and canister weekly and was initialed as being completed on 6/4/23, 6/11/23, 6/18/23, and 6/25/23. An order for endotracheal care to cleanse around stoma site every shift with normal saline, every shift was signed as completed. An order for tracheostomy care, change trach collar as needed for soilage, had not been signed as completed from June 1 to June 28. An order for 4L of oxygen via tracheostomy, every shift was signed as being administered.

The quarterly Minimum Data Set (MDS) assessment, dated 5/18/23, indicated the resident required extensive assistance of one person for eating and dressing, required total assistance of one staff for bathing, and was not suctioned during the assessment period.

A care plan, dated 5/22/22, indicated the resident had an endotracheal tube, and the trach stoma was at risk for complications related to history of laryngeal cancer, with interventions included, but were not limited to, suction as necessary, endotracheal tube care as ordered, cleanse around stoma every shift with normal saline, ensure trach ties are always secured. The medical record lacked documentation of the resident being instructed on

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	self-suctioning and infection prevention. A care plan, dated 6/22/22, the resident exhibited behavior symptoms of removing his endotracheal tube from the stoma and placing the tube on his bedside table. The interventions lacked documentation of teaching of self-administration of oxygen. 2. On 6/26/23 at 10:50 a.m., during an observation of Resident 48 in his room, the portable oxygen tank with connected unbagged oxygen tubing, including the nasal cannula, was observed lying on the floor, between the resident's bed and the resident's bathroom door. On 6/28/23 at 9:15 a.m., during an observation of Resident 48 in his room, the portable oxygen tank with connected unbagged oxygen tubing, including the nasal cannula, was observed lying on the floor, between the resident's bed and the resident's bathroom door. On 6/27/23 at 10:30 a.m., during an observation of Resident 48 in his room, the unbagged oxygen tubing and nasal cannula, attached to the portable oxygen tank was laying on the floor, between the resident's bed and the resident's bathroom door. On 6/29/23 at 9:36 a.m., Resident 48 was observed walking in his room with oxygen being administered at 2.5 liters (L) via nasal cannula (NC) from the oxygen concentrator. An undated bag was attached to the oxygen concentrator. The portable unbagged and undated oxygen tubing and nasal cannula was attached to the portable oxygen tank, observed lying on the floor. The resident indicated the staff placed the portable oxygen tubing on the floor when they switched the resident from the portable oxygen tank to the			

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	155338	A. BUILDING 00 B. WING	06/30/2023

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	main oxygen concentrator in the resident's room. On 6/29/23 at 9:39 a.m., Qualified Medication Aide (QMA) 6 indicated the oxygen tubing and nasal cannula should be dated and stored in a bag, and not lying on the floor. On 6/28/23 at 2:58 p.m., medical record review of Resident 48 diagnosis included, but was not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). A physician order for oxygen, dated 1/6/23, indicated oxygen to be administered at 2 L via nasal cannula every shift and as needed. The quarterly minimum data set assessment (MDS) (a standardized assessment tool that measures health status in nursing home residents), dated 4/20/23, indicated, the resident was cognitively intact and was not on oxygen therapy. A care plan for COPD, dated 9/16/2019 and revised on 8/27/20, with an intervention included but was not limited to, oxygen as ordered.3. During an observation on 6/25/23 at 11:59 a.m., Resident 252 was observed to have oxygen on at 3.5 liters per minute through nasal cannula tubing. The tubing and humidified water were not dated. She had a nebulizer machine on her nightstand with an aerosol mask attached to the machine. The mask and tubing were not dated and unbagged. During an observation on 6/26/23 at 2:03 p.m., Resident 252's oxygen was labeled 6/26/23. Her nebulizer mask was dated 6/26/23 and unbagged.			

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	A comprehensive record review was completed on 6/28/23 at 2:03 p.m. Resident 252 had the following diagnoses but not limited to chronic respiratory failure, anemia, gastritis, epilepsy, venous thrombosis and embolism, osteoporosis, neuropathy, pressure ulcers and osteoarthritis. 4. During an observation, on 6/25/23 at 12:06 p.m., Resident 251 was observed to have oxygen on at 4 liters per nasal cannula (NC). His humidified water and tubing were undated and disconnected from the NC tubing. During an observation, on 6/29/23 at 9:31 a.m., Resident 251 was observed to have oxygen at 4 liters per NC. He did not have humidified water. The tubing was undated. He had a clear plastic bag on the concentrator dated 6/27/23. A comprehensive record review was completed 6/28/23 at 2:33 p.m. Resident 251 had the following diagnoses but not limited to congestive heart failure, hyperlipidemia (abnormal elevated fatty acids in the blood), essential hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), chronic obstructive pulmonary disease, type 2 diabetes (blood sugar disorder), obstructive sleep apnea (complete or partial stoppage of breathing) and anemia (reduced red blood cells). During an interview with the Director of Nursing Services (DNS), on 6/29/23 at 10:24 a.m., she indicated she told her staff to change out the oxygen tubing for all residents on 6/26/23. A current policy, titled, "Departmental (Respiratory Therapy)-Prevention of Infection," was provided by the DNS, on 6/30/23 at 1:41 p.m. A review of the policy indicated, "...Use distilled			

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	water for humidification per facility protocol, mark the bottle with the date and initials upon opening and discard after twenty-four (24) hours. Infection control consideration related to medication nebulizers/continuous aerosol: store the circuit in plastic bag marked with date and resident's name and discard the administration "set up" every seven (7) days...." 3.1-47(a)(6)			
F 0732 SS=B Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.			

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	§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to update the daily staff posting for 1 of 6 days of observation. This deficiency had the potential to effect all residents in the building. Findings include: On 6/25/23 at 9:35 a.m., the daily staffing sheet (information regarding licensed and unlicensed staff responsible for resident care) was observed. It was dated for Friday, 6/22/23. Receptionist 30 provided a copy on 6/25/23 at 9:45 a.m. An updated staffing sheet for Sunday, 6/25/23, was not posted or available. On 6/29/23 at 1:56 p.m., the Director of Nursing Services (DNS) indicated her expectation was for the daily staffing schedule to be posted by the facility scheduler from Monday through Friday. It was not updated on the weekends, unless the facility scheduler worked on the weekend. A current policy titled, "Nurse Staffing Posting Information," with no date, was provided by the Regional Nurse Consultant (RNC), on 6/29/23 at 3:21 p.m. A review of the policy indicated, " ...It is the policy of this facility to make nurse staffing information readily available in a readable format	F 0732	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> The daily Staffing Schedule will be posted on the weekend. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b>No residents are affected by this alleged deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> The scheduler has been educated on the policy related to staff posting requirements. The Scheduler will print off weekend staffing levels and the Manager on Duty will post them upon arrival at the facility on Saturday and Sunday. 1.b>How the corrective action(s)	08/04/2023

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	to residents and visitors at any given time...The Nurse Staffing Sheet will be posted on a daily basis...."		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>The Weekend Staff Posting will be monitored weekly x4, Bi-weekly x4 and monthly x 3 by ED or designee. Until substantial compliance is achieved 90%.	
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, interview, and record review, the facility failed to ensure the kitchen had enough staff to provide meals in a timely manner for 92 of 92 resident who received food from the kitchen. Findings include:	F 0802	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Mealtime will be accurate and consistent for residents residing in the facility.	08/04/2023

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	1a. On 6/25/23 at 11:46 a.m., 15 memory care (MC) resident were observed in chairs in the dining room. Awaiting lunch that was due to begin at 12:00 p.m. They had no drinks. On 6/25/23 at 12:49 p.m., 25 MC resident were observed in the dining area waiting for lunch. They had no drinks. Staff were trying to keep them engaged by redirecting them to stay in the dining room. The first tray out to the MC dining room was at 12:57 p.m. The KMIT indicated the trays were late coming out because there were only to dietary staff working in the kitchen. She indicated there were only 2 of us and we are doing the best we can do. 1b. On 6/25/23 at 12:10 p.m., no food had been provided in the main dining room. The Administrator came in and started proving drinks. On 6/25/23 at 1:00 p.m., the residents in the main dining room were still awaiting lunch. It was supposed to be served at 12:30 p.m. On 6/25/23 at 1:20 p.m., the main dining room and halls noon tray service had not yet begun. An Nurse Manager indicated the halls were normally served at 12:30 p.m. Resident in room 600 A stated the noon meal was normally delivered at 12:30 p.m. 1c. On 6/25/23 at 1:06 p.m., Staff Member 41 indicated room trays were supposed to be served between 1:00 to 1:15 p.m. On 6/25/23 at 2:05 p.m., meal trays for the residents who ate lunch in their room were being		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents who eat in the facility can be affected by this alleged deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> Education provided to dietary related to meal timeliness and staffing level expectations. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>Mealtimes will be monitored via the facility QA process weekly x 4 biweekly x 4 and monthly x 3 or until substantial compliance is obtained at a threshold of at least 90 percent of meals are served on time.	

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	passed. On 6/25/23 at 1:19 p.m., a third unidentified staff person was observed in the kitchen rolling silverware. She did not help with getting lunch out to the residents. During an interview, on 6/25/23 at 1:21 p.m., the Kitchen Manager in training (KMIT) indicated she was supposed to have 3 to 4 dietary staff for lunch on Sunday. The kitchen was short staffed. She was observed hand wiping each tray as she went along. On 6/26/23 at 8:50 a.m., the KMIT indicated she was here all day on Sunday. She did not know what time dinner went out on Sunday. She indicated she could only do what she could do. During an interview about the Sunday kitchen staffing, the KMIT indicated Dietary Aides (DA) 34, DA 35, and KMIT were here for breakfast service. DA 35 left at 11:00 a.m. DA 26 called off before lunch, he left about 10:00 a.m.. KMIT indicated she worked a double shift from 6:00 a.m. until 9:30 p.m. DA 36, Kitchen Account Manager (KAM) 24, and KMIT were there for dinner service. On 6/29/23 at 12:25 p.m., the Resident Council (RC) meeting minutes were reviewed. The RC discussed concerns related to the Dietary department which included, a request to have more consistent mealtimes, the grievance form was submitted on 2/14/23 which included follow up for meal service times. On 6/29/23 at 2:30 p.m., a Resident Council meeting was conducted with 5 residents who regularly attended the monthly meetings and			

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	included the attendance of the Resident Council President. When asked if the group had ongoing concerns that had not been addressed, they all agreed there were still a lot of issues with the dietary department. Mealtimes were never consistent. During an interview, on 6/30/23 at 10:35 a.m., Registered Dietitian (RD) 39 indicated inconsistent meal times can affect the residents by causing lower intakes of food, and increased behaviors. Resident with diabetes mellitus (DM) would also be effected. The facility needed to work on consistent meal times. She indicated she communicated with the Regional Dietary Manager (RDM) and the Vice President of Operations (VPO). She would talk with the Kitchen Account Manager (KAM) first. On 6/30/23 at 10:45 a.m., the RDM indicated when the trays were returned from the residents, they should go to the dishwasher. On 6/30/23 at 10:47 a.m., the KAM indicated she came in at 12:30 p.m., but she did not help with the line (getting food out to resident). She went directly to the dishwasher station to start clean-up. She indicated the first food to go out was the MC residents should have been at 12:00 p.m. Then, the main dining room at 12:30 p.m. Room trays go out between 12:30 - 1:00 p.m. KAM indicated she did not help with the line (getting food out to the residents), she started clean up instead. The RDM added the room trays sometimes went out from 12:45 to 1:15 p.m. On 6/30/23 at 10:54 a.m., the RDM indicated when DA 26 went home, it put everything behind. He tried to quit, but they were able to get him to come back on another day.			

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	A current policy, titled, "Meal Distribution," dated 9/2017, was provided by the RDC, on 6/30/23 at 11:47 a.m. A review of the document indicated, " ...Meals are transported to the dining locations ...and are delivered in a timely and accurate manner...." 3.1-20(h)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the kitchen foods were dated, all refrigeration units had working thermometers, the kitchen was clean, and	F 0812	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Corrective actions to be	08/04/2023

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	staff facial hair was covered for 3 of 3 kitchen observations, and the facility failed to ensure staff used appropriate hand hygiene with making, delivering, and assisting to fed residents for 4 of 4 random observations (Residents 4, 59, 71, and 95). Findings include: 1. On 6/25/23 at 9:46 a.m., a trash can was observed uncovered. On 6/25/23 at 9:48 a.m., Dietary Aide (DA) 34 was observed wearing a surgical mask in the kitchen, the sides of his beard were exposed. On 6/25/23 at 9:49 a.m., the Kitchen Manager in Training (KMIT) provided a tour of the kitchen. She indicated the Kitchen Account Manager (KAM) 24 was her supervisor and was training her. On 6/25/23 at 9:53 a.m., DA 26 was observed in the kitchen with no hair net and no beard cover, only a surgical mask. During the initial kitchen tour, on 6/25/23 from 9:54 a.m. to 10:10 a.m., the following was observed. a. The double refrigerator had 10 undated eggs, and two pitchers of juice, undated. b. Two personal drinks were observed under a stainless steel table. The KMIT indicated both drinks were hers. c. The ice machine filters were observed to be dirty. The KMIT indicated they were cleaned each month. She would find out when they were to be cleaned again. d. The two vents above the single freezer were dirty. e. Several small flying insects were observed in the kitchen during the kitchen tour. The KMIT		accomplished are covering of trash cans, proper use of beard guard and kitchen attire. Proper labeling and dating of food and beverage. Kitchen cleanliness related to flying insects and vents and ice machine filters. Adding a working thermometer to the milk cooler. Proper Hand Hygiene and glove usage. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents who reside in the facility and eat meals have the potential to be affected by the alleged deficient practice(s). 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b>Related to the concerns associated with F 812 education has been provided to all dietary staff. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	

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	indicated they sprayed for insects about a week ago. f. The milk cooler had no thermometer. g. The walk-in refrigerator had items with no dates: 2 plastic bags of zucchini, a container of Parmesan cheese, and 2 watermelons. Three molded zucchini were observed unwrapped on top of a box. h. In the walk-in freezer, an angel food cake had no date. i. A trash can was observed with no lid. The KMIT indicated the trash cans should have been covered, but the kitchen did not have enough lids of all the trash cans. During a random kitchen observation, on 6/25/23 at 12:57 p.m., DA 34 was observed wearing his beard cover too low. The sides of his beard and mustache were out. A second kitchen tour was completed with KAM 24, on 6/26/23, from 8:42 a.m. to 8:57 a.m. a. The double refrigerator had undated whip cream. b. The milk cooler had a thermometer in it, but the thermometer did not work. There was water in the thermometer. c. The ice machine filters and the 2 vents above the single freezer were observed to be dirty. The KAM 24 indicated they need to get someone to come out and clean them. A third kitchen tour was completed with KAM 24, on 6/28/23, from 11:11 a.m. to 11:25 a.m. a. The KAM 24 indicated she forgot to put a thermometer in the milk cooler. b. At 11:12 a.m., DA 34 was observed wearing a surgical mask with a beard cover on just his chin. The sides of his beard were out. The KAM 24 indicated for him to cover his beard.			

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	c. At 11:25 a.m., DA 34 was observed wearing facial hair coverings, but he had pulled the surgical mask down, and his mustache was exposed. d. Rusty water was observed on the juice machine table. KAM 24 indicated the juice machine was attached to the table. e. KAM 24 indicated the kitchen did not have trash can lids for 2 of four trash cans observed. f. At 11:28 a.m., several flying insects were observed. The Regional Dietary Consultant (RDC) was observed swatting away a larger flying insect. The KAM 24 indicated the flying insects were coming from the onions, so they did a deep clean. g. Observed the ice machine filters and 2 vents above the single freezer with the Regional Dietary Manager (RDM), they were still dirty. 2. On 6/25/23 at 12:52 p.m., Dietary Aide (DA) 34 was observed to be wearing black gloves while making a chef salad for Resident 4. He did not remove his gloves, left the prep table, opened the door to the walk-in refrigerator and retrieved boiled eggs. He brought them back to the prep table and finished the chef salad. He did not change his gloves or wash his hands. Then, he was observed to leave the kitchen, brought the chef salad into the dining room and gave it to MC Resident 4. His thumb was completely on the plate. On 6/25/23 at 1:36 p.m., Dietary Aide (DA) 34 brought out a chef salad for an unidentified resident in the main dining room, and his fingers were touching the plate and lettuce. On 6/25/23, from 1:25 p.m. to 1:42 p.m., memory care (MC) Unit Manager (UM) was assisting MC Resident 95 and MC Resident 71, and Certified Nursing Assistant (CNA) 27 was assisting MC			

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	155338	A. BUILDING 00 B. WING	06/30/2023

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	Resident 59 with eating. a. CNA 27 touched Resident 71's forearm and used the same hand to give Resident 59 a drink. b. At 1:25 p.m., Resident 95 was observed eating his paper meal ticket. He had a small amount of paper in his mouth. MC UM was informed, and she gave him a bite of food. She did not remove the paper from his mouth. c. The MC UM was observed to move Resident 95's wheelchair with her bare hands. Without hand washing, she continued to assist him with eating. She realized he needed a spoon, after retrieving it, she touched the chair with her bare hands, and continued to assist him with eating. d. Resident 95 was observed to fork some of Resident 71's cake. The MC UM stopped him by touching his hands. She did not use hand hygiene before helping Resident 71 open her carton of milk more. e. MC UM asked Resident 71 if she wanted a straw for her milk. When she got up to retrieve the straw, she pushed her chair back with her bare hands. When coming back to the table, she used her bare hands to pull the chair up to the table again. She did not use hand hygiene before assisting Resident 95 with a bite of food and offered Resident 71 a drink. f. The MC UM was observed to rub her face with both hands, then crossed her arms. She did not use hand hygiene before she provided a bite of food to Resident 95. g. The MC UM was observed to pull out her phone to check the time, she did not use hand hygiene before giving Resident 95 another bite of food. h. The MC UM moved her chair using the handles with her bare hands and touched her hair with both hands, then gave Resident 71 a bite of food. i. The MC UM gave a drink to Resident 71 and did not hand hygiene before giving a bite to Resident			

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	95. A current policy, titled, "Labeling and Dating," dated 1/2017, was provided by the RDC, on 6/30/23 at 11:47 a.m. A review of the document indicated, " ...All opened and leftover items will be labeled with the date of opening/date stored and a discard/use-by date ...." A current policy, titled, "Staff Attire," dated 9/2017, was provided by the Licensed Practical Nurse (LPN) Unit Manager (UM), on 6/28/23 at 1:30 p.m. A review of the document indicated, " ...All staff members will have ...facial hair properly restrained ...." A current policy, titled, "Handwashing/Hand Hygiene," with no date, was provided by the Director of Nursing Services (DNS), on 6/30/23 at 1:10 p.m. A review of the document indicated, " ...This facility considers hand hygiene the primary means to prevent the spread of infection ...the preferred method if hand hygiene is with an alcohol-based hand rub ...before and after direct contact with resident ...After contact with a resident's intact skin ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure the memory care (MC) did not have crawling insects in resident rooms and the kitchen for 2 or 2 observations (Resident 57).	F 0925	1.b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.b> Resident's rooms will	08/04/2023

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	Findings include: 1. On 6/28/23 at 1:21 p.m., Resident 109, a MC resident, was observed in her bed. Her floor was sticky and three small, separate, gravel ant hills were observed on her outside wall. Her bed was about 3 feet away from the outside wall. The ants were observed crawling on the floor and through two of the ant hills. On 6/28/23 at 1:24 p.m., Qualified Medication Aide (QMA) 6 indicated she saw the ants and ant nests on the floor of Resident 57's room in the past and had reported it. She would let Environmental Services know about it and her expectation was for the housekeeping staff to keep the floors clean. On 6/28/23 at 1:28 p.m., Certified Nursing Assistant (CNA) 29 indicated she had reported the issues with the ant nests in Resident 57's room. The ants brought in that small gravel from outside. On 6/28/23 at 1:32 p.m., Resident 77 indicated sometimes she would see ants in her room, People came in twice a week to clean the floors. On 6/28/23 at 1:38 p.m., Environmental Services Supervisor (ESS) indicated the ants were building nests in the walls. He indicated he reported it to, "Group Me," so the facility Maintenance Director would get the report. The ES staff mopped over the ants and they just kept coming back. These ants bite, one of them bit him. It would get better if the Maintenance Director would just spray for them. On 6/29/23 at 9:55 a.m., Resident 57's room was		be maintained in a way that prevents crawling/flying insects for being in the rooms. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.b> All residents have a who reside on the MC unit have the potential to be affected by this deficient practice. 1.b>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1.b> Resident rooms listed in the 2567 will be monitored weekly. To ensure they are remaining pest free. 1.b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1.b>Resident rooms will be monitored x 4 weekly, x4 biweekly and x3 monthly until substantial compliance is accomplished at 100 percent.	

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	observed again. The first and second ant hill were gone, but the ants were still on the floor. The third ant hill, closest to her bedside table was still there. On 6/29/23 at 10:01 a.m., observed Resident 57's room again with ESS. The third ant hill was not removed yesterday. He indicated the contracted Pest Control sprayed outside the facility yesterday about 5:00 p.m., but none of the MC resident's room were sprayed. He cleaned up the ant hills yesterday with Micro-Kill. He indicated it was a disinfectant, it did not have bleach in it. On 6/29/23 at 10:05 a.m., Resident 57 was observed being moved to access the third ant hill. When the beside table was moved, Environmental Services Aide (ESA) 22 indicated he saw ants beside and behind the bedside table. He swept them up. On 6/29/23 at 10:08 a.m., the ESS indicated he was using Natural Fresh (aerosol air freshener) to finish cleaning up the third ant hill, It was an odor control spray. He indicated he was going to use a disinfectant next. On 6/29/23 at 10:14 a.m., the ESS indicated he asked the nurse to remove the resident from her room because the facility MM was planning to spray insecticides in her room. On 6/29/23 at 10:18 a.m., the Maintenance Director came into Resident 57's room and sprayed the outside wall at the floor. He indicated the spray can had no label. The spray can was observed to be completely white with no label or any words or warnings. On 6/29/23 at 10:20 a.m., the Maintenance Director provided a labeled spray can and indicated that			

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	was what he sprayed in the resident's room. The second can was labeled Raid and Ant Roach Spray. On 6/29/23 at 10:38 a.m., the Maintenance Director indicated he just knew the white spray can was the same as the can of Roach and Ant spray. He used it on a regular basis. The label was off of it because it was old. He indicated he starting working here 3 months ago. After he sprayed the pesticide, he would have environmental services come into Resident 57's room and clean that area. He indicated it would still kill the ants for 6 weeks. On 6/29/23 at 12:32 p.m., the Administrator indicated the white can used as an pesticide should have been labeled. On 6/29/23 at 12:33 p.m., the Regional Nursing Consultant indicated the can with the white label could have been thrown out and the facility would use the MSDS sheet as their policy. A Material Data Safety Sheet (MSDS), titled, "Real-Kill Ant & Roach Killer," dated 8/30/2016, was provided by the MM, on 6/29/23 at 11:38 a.m. A review of this document indicated to, " ...Dispose of in accordance with all local, state,/ [sic] provincial and federal regulations. For more information see product label ...." 2. During a kitchen tour, on 6/25/23 at 9:58 a.m., several small flying insect were observed. The Kitchen Manager in Training (KMIT) they sprayed for insects about a week ago. During a third kitchen tour, on 6/28/23 at 11:28 a.m., several flying insects were observed. The Regional Dietary Manager (RDM) was observed batting away a larger flying insect away from her.			

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	The Kitchen Account Manager (KAM) indicated the flying insects were coming from the bins of onions, so the kitchen staff did a deep clean. A current policy, titled, "Pest Control Policy," dated February 2021, was provided by the Director of Nursing Services (DNS), on 6/30/23 at 1:41 p.m. A review of the policy indicated, "To provide a safe and limited pest environment ...The facility will strive to maintain a pest free environment ...." 3.1-19(f)(4) 3.1-21(i)(2) 3.1-21(i)(3)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the	F 9999	a new MCF was hired and she has the amount of dementia trained hours as needed. ED re-educated on MCF requirements. If there is a change in the position the interim has the correct number of hours needed. HR will bring MCF and amount of dementia hours to the monthly QAPI committee meeting for 6 months and ongoing.	08/04/2023

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	Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. (x) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the memory care (MC) director was qualified with enough educational continuing education (CE) credits, the MC unit continuously had a qualified dementia care director, and the facility failed to provide a signed copy of the Special Unit Disclosure form to the Indiana Department of Health (IDOH) by 12/31/22. These deficient practice had the potential to effect 32 of 32 memory care residents. Findings include: During the entrance conference, on 6/25/23, a list of employees and the Special Unit Disclosure form were requested. The facility staff present were the Assistant Director of Nursing (ADON) and the Licensed Practical Nurse (LPN) Unit Manager (UM) 4.			

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	After the entrance conference, the facility provided a copy of the employee records listing all the employees currently working at the facility. The place for Dementia Care Director listed n/a (not applicable). Three MC residents records were reviewed. Resident 16, 61, and 71's care plans indicated they resided on a secured memory care unit and would benefit from specialized activity care programming. On 6/28/23 at 12:00 p.m., the Special Unit Disclosure form was requested from the Regional Nurse Consultant (RNC) 14. An unsigned document, titled, "Nursing Facility Schedule of Special Facility Qualification (Schedule Z)," dated 12/31/22, with a revised date of June 2023, was provided by the Administrator, on 6/29/23 at 10:13 a.m. It indicated the facility had a locked, secure unit for residents with Alzheimer's disease or dementia and had a designated director for the Alzheimer's and Dementia Special Care Unit; from 1/1/22 to 3/2/22, it was the Administrator, and from 3/3/22 to 12/31/22 it was the MC Facilitator 18. It indicated the designated director had a minimum of 12 hours of dementia-specific training within the first three months of initial employment. The Certification Statement, indicating the information was true was unsigned. The Preparer Certification Statement was unsigned. On 6/29/23 at 12:18 p.m., a signed copy of the Special Unit Disclosure form was requested again. The RNC 14 indicated he talked with the Vice President of Operations (VPO) 31. The facility would provide further information and the			

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	signature page. On 6/29/23 at 12:27 p.m., the Admininstrator indicated a new MC Director would start at the facility in 2 weeks. On 6/30/23 at 12:21 p.m., the Administrator indicated the RNC 14 and the VPO 31 were still looking into a signed Special Unit Disclosure form. On 6/30/23 at 12:53 p.m., the Executive Director (ED) indicated the titles Memory Care (MC) Facilitator and MC Director were used interchangeably, they are the same. The Memory Care Coordinator job description was provided. It indicated, "...Requirements ...Alzheimer's training course as required by state regulations...." On 6/30/23 at 12:53 p.m., the Administrator provided the previous MC Directors education. She was hired in as the MC Director from 3/3/23 until 12/31/22. Her education was reviewed. She had a total of 3 hours of dementia care training on 8/23/22. It was not within the first three months, and it did not total 12 hours. On 6/30/23 at 12:53 p.m., the Administrator provided his dementia care training, since he was listed as MC Director from 1/1/22 to 3/2/22. He had a total of one hour of dementia care training in 2022. On 6/30/23 at 2:08 p.m., the Administrator indicated he had reached out to the VPO and the Chief Financial Officer (CFO) and had not received any more information regarding the Special Unit Disclosure form.			