

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2025
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NAME OF PROVIDER OR SUPPLIER ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP COD 5202 ST JOE ROAD FORT WAYNE, IN 46835
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 14 and 15, 2025</p> <p>Facility number: 015503</p> <p>Residential Census: 100</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed January 17, 2025</p>	R 0000	<p>Arbor Glen Independent & Assisted Living Annual Survey 1/15/2025 Plan of Correction</p> <p>The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citations.</p> <p>Respectfully Submitted, Mary Kathryn Bolling</p>	
R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency</p> <p>Based on observation, interview, and record review the facility failed to maintain sanitary kitchen practices during observation. 100 of 100 residents residing in the facility were served food</p>	R 0273	<p>The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as</p>	01/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy (Mary K) Bolling	Administrator/ED	01/31/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>prepared in the kitchen.</p> <p>Findings include:</p> <p>During an observation on 1/14/25 at 9:12 AM a kitchen tour was conducted with Lead Cook 2. The floor of the walk-in cooler had red, purple and grey spots throughout the floor surface, too many to count. Light tan and brown crumb sized debris were scattered underneath the shelving units and on the floor. The floor was sticky when walked on. A large cart near the door of the walk-in cooler had a protective cover over the cart with one side unzipped and laid on top of the cart. Cups of fruit, bowls of salad, and plated pieces of pie were on trays in the cart, undated, uncovered and open to air. No dates were on the items or on the trays they sat on. Containers of cheese, fruit cocktail, salad mix, bacon bits and mandarin orange slices were in undated containers on a shelf. The floor outside the walk-in cooler, the walk-in freezer, and around the food prep areas were sticky to walk on and had dime to quarter sized red and grey spots on the floor, too many to count. Tan, brown and black crumb sized debris was present on the floor also.</p> <p>In an interview, on 1/14/25 at 9:14 AM, Lead Cook 2 indicated the floor was usually mopped weekly on delivery day (Wednesday) but spills should be cleaned up at the time of the spill. She indicated food and drink items should be labeled and dated when placed in a container for storage in the refrigerators.</p> <p>In an interview, on 1/14/25 at 11:40 AM, the Dietary Manager (DM) indicated all items in refrigerators should be labeled and dated. He indicated the protective cover over the food cart should be completely covered and zipped when</p>		<p>mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citation.</p> <p>R 273 410 IAC 16.2-5-5(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in Residents units) are maintained in accordance with state and local sanitation and safe food handling standards. Including 410 IAC 7-24.</p> <p>This RULE was not met as evidenced by: Based on observation, interview and record review the facility failed to maintain sanitary kitchen practices during observation. 100 of 100 Residents residing in facility were served food prepared in the kitchen. <i>During an observation on 1/14/25 at 9:12 AM a kitchen tour was</i></p>	

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	<p>not in use. He indicated staff had been provided with cleaning lists and should clean spills at the time of the spills.</p> <p>A current policy titled Weekly Cleaning List, undated, provided by the DM on 1/14/25 at 12:02 PM indicated dates on refrigerated items should be checked weekly by the cook and decks should be scrubbed.</p> <p>A current policy titled Labeling and Dating for Safe Storage of Food, dated 10/1/21, provided by the Administrator on 1/15/25 at 12:33 PM, indicated all food should be labeled with a received date and a use by date. The policy indicated a label and date should be recorded on any food removed from its original container and placed in another container.</p> <p>A current policy titled Cleaning, dated 10/1/21, provided by the Administrator on 1/15/25 at 12:33 PM, indicated the floor of the kitchen should be cleaned daily and after each spill and contamination. The walk-in refrigerator should be cleaned quarterly or more often if needed.</p>		<p><i>conducted with Lead Cook 2. The floor of the walk-in cooler had red, purple and grey spots throughout the floor surface, too many to count. Light tan and brown crumb sized debris were scattered underneath the shelving units and on the floor. The floor was sticky when walked on.</i></p> <p><i>A large cart near the door of the walk-in cooler had a protective cover over the cart with one side unzipped and laid on top of the cart. Cups of fruit, bowls of salad, and plated pieces of pie were on trays in the cart, undated, uncovered and open to air. No dates were on the items or on the trays they sat on. Containers of cheese, fruit cocktail, salad mix, bacon bits and mandarin orange slices were in undated containers on a shelf. The floor outside the walk-in cooler, the walk-in freezer, and around the food prep areas were sticky to walk on and had dime to quarter sized red and grey spots on the floor, too many to count. Tan, brown and black crumb sized debris was present on the floor also. In an interview, on 1/14/25 at 9:14 AM, Lead Cook 2 indicated the floor was usually mopped weekly on delivery day (Wednesday) but spills should be cleaned up at the time of the spill. She indicated food and drink items should be labeled and dated when placed in a container for storage in the refrigerators. In an</i></p>	

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			<p><i>interview, on 1/14/25 at 11:40 AM, the Dietary Manager (DM) indicated all items in refrigerators should be labeled and dated. He indicated the protective cover over the food cart should be completely covered and zipped when not in use. He indicated staff had been provided with cleaning lists and should clean spills at the time of the spills. A current policy titled Weekly Cleaning List, undated, provided by the DM on 1/14/25 at 12:02 PM indicated dates on refrigerated items should be checked weekly by the cook and decks should be scrubbed. A current policy titled Labeling and Dating for Safe Storage of Food, dated 10/1/21, provided by the Administrator on 1/15/25 at 12:33 PM, indicated all food should be labeled with a received date and a use by date. The policy indicated a label and date should be recorded on any food removed from its original container and placed in another container. A current policy titled Cleaning, dated 10/1/21, provided by the Administrator on 1/15/25 at 12:33 PM, indicated the floor of the kitchen should be cleaned daily and after each spill and contamination. The walk-in refrigerator should be cleaned quarterly or more often if needed.</i></p> <p>What Corrective action(s) will be accomplished for those</p>	

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			<p>residents found to have been affected by the deficient practice:</p> <p>1 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Ensuring that all Residents are receiving meals prepared in a regulatory compliant kitchen. Following all the Cleaning lists, temperature checks of food and label & dating of all food that enters the kitchen or is put into the Refrigerators, Freezer or Dry storage.</p> <p>2 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <p>1. Made a change in Supervision of Dietary Team.</p> <p>2. The Dietary team was educated on the significant issues/concerns and responsibility to oversee the kitchen cleanliness to ensure regulatory compliance. Inservice training was on or before 1/30/2025. All employees were trained to follow the cleaning lists, complete tasks and to clean as they go if they see or drop something on the counters or floors.</p>	

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R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance		<p>3. Ongoing training on Temping food & temp logs on Refrigerator, Walk in Refrigerator and walk in Freezer - following proper procedures for this.</p> <p>4. Label and Dating items before putting them in Reach-in refrigerator, Walk-in refrigerator, Walk-in Freezer or dry storage.</p> <p>3 How the corrective action(s) will be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place: -</p> <p>Administrator, DON or designee will be competing an Audit, cleanliness/temps/Label & Dating, checklist 3 times per week to ensure regulatory compliance, for 3 months; 2 times per week for 2 months; Then 1 time per week for 1 month and also indefinitely/ongoing. The Administrator, DON &/or Designee will evaluate the audits and develop an action plan if necessary.</p> <p>4 Compliance date: 1/30/2025</p>	

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	<p>Based on observation, interview and record review, the facility failed to ensure records documentation was completed after a transfer to the hospital for 1 of 1 resident reviewed (Resident 20).</p> <p>Findings include:</p> <p>On 1/14/25 at 10:21 AM, Resident 20 was observed exiting their room. Resident 20 was observed walking with the assistance of a rolling walker.</p> <p>In an interview on 1/14/25 at 10:24 AM, Resident 20 indicated they had a fall and had broken their hip on 10/9/24. Resident 20 indicated they had tripped on a damaged rug in the dining room.</p> <p>Resident 20's record was reviewed on 1/15/25 at 10:31 AM. Diagnoses included stroke, left side weakness, chronic back problems and chronic pain syndrome.</p> <p>Resident 20's Service Plan, dated 6/21/24, indicated the resident was independent with mobility using a rolling walker.</p> <p>A progress note, dated 10/9/24 at 2:50 PM, indicated Resident 20 had fallen in the lobby area. Resident 20 had reported right hip pain, and their right foot was turned outward. Resident 20 was transferred to the hospital by ambulance. The progress note did not include the disposition of their personal belongings, their chest x-ray or their skin test.</p> <p>In an interview on 1/15/25 at 12:59 PM, the Director of Nursing (DON) indicated the facility used a standardized transfer form for hospital</p>	R 0354	<p>R 354 410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>This RULE is not met as evidenced by: <i>Based on observation, interview and record review, the facility failed to ensure records documentation was completed after a transfer to the hospital for 1 of 1 resident reviewed (Resident 20). Findings include: On 1/14/25 at 10:21 AM, Resident 20 was observed exiting their room. Resident 20 was observed walking with the assistance of a rolling walker. In an interview on 1/14/25 at 10:24 AM, Resident 20 indicated they had a fall and had broken their hip on 10/9/24. Resident 20 indicated they had tripped on a damaged rug in the dining room. Resident 20's record was reviewed on 1/15/25 at 10:31 AM. Diagnoses included stroke,</i></p>	01/30/2025

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	<p>transfers. The DON indicated a copy of the transfer form was sent with each resident transferred to the hospital.</p> <p>On 1/15/25 at 1:03 PM, the DON provided paper documentation related to Resident 20's hospital transfer.</p> <p>Resident 20's Notice of Transfer or Discharge, (transfer form) dated 10/9/24, indicated the resident had been transferred to the hospital due to the facility being unable to meet the resident's needs. The transfer form did not include the disposition of their personal belongings, their chest x-ray or their skin test.</p> <p>Resident 20's Certificate of Medical Necessity for Medicare/Medicaid Ambulance Transportation Services, (ambulance form) dated 10/9/24, indicated the resident required an ambulance due to their inability to move. The ambulance form did not include the disposition of their personal belongings, their chest x-ray or their skin test.</p> <p>A document, titled "Fall," (fall note) dated 10/9/24 at 2:50 PM indicated Resident 20 fell in the lobby area. Resident 20 was unsure of how they fell. Resident 20 had reported right hip pain of 6 on a 1 to 10 scale, and their right foot was turned outward. Resident 20's vital signs were assessed and were within normal limits. The fall note indicated Resident 20 was alert and oriented to person, place, time and situation. The fall note indicated there were no predisposing environmental factors. The fall note indicated Resident 20 had been ambulating without their walker. The fall note indicated Resident 20 had been transferred to the hospital. The fall note did not include the disposition of their personal belongings, their chest x-ray or their skin test.</p>		<p><i>left side weakness, chronic back problems and chronic pain syndrome. Resident 20's Service Plan, dated 6/21/24, indicated the resident was independent with mobility using a rolling walker. A progress note, dated 10/9/24 at 2:50 PM, indicated Resident 20 had fallen in the lobby area. Resident 20 had reported right hip pain, and their right foot was turned outward. Resident 20 was transferred to the hospital by ambulance. The progress note did not include the disposition of their personal belongings, their chest x-ray or their skin test. In an interview on 1/15/25 at 12:59 PM, the Director of Nursing (DON) indicated the facility used a standardized transfer form for hospital transfers. The DON indicated a copy of the transfer form was sent with each resident transferred to the hospital.</i></p> <p><i>On 1/15/25 at 1:03 PM, the DON provided paper documentation related to Resident 20's hospital transfer. Resident 20's Notice of Transfer or Discharge, (transfer form) dated 10/9/24, indicated the resident had been transferred to the hospital due to the facility being unable to meet the resident's needs. The transfer form did not include the disposition of their personal belongings, their chest x-ray or their skin test. Resident 20's Certificate of Medical Necessity</i></p>	

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	<p>A current facility policy, titled Involuntary Transfer-Discharge, (policy) dated 10/1/21 was provided by the DON on 1/15/25 at 1:07 PM. The policy indicated the facility would provide continuity of care in the event of a resident transfer to the hospital. The policy indicated the facility must provide a copy of the following:</p> <ul style="list-style-type: none"> The reason for the transfer The date of the transfer The location of the receiving facility Information pertaining to appeal A hearing request form Contact information for the long-term care ombudsman Contact information for the protection and advocacy services commission Contact information for the state health department <p>The policy did not indicate the residents' chest x-ray, skin test or disposition of their personal belongings was to be included in the documentation.</p>		<p><i>for Medicare/Medicaid Ambulance Transportation Services, (ambulance form) dated 10/9/24, indicated the resident required an ambulance due to their inability to move. The ambulance form did not include the disposition of their personal belongings, their chest x-ray or their skin test. A document, titled "Fall," (fall note) dated 10/9/24 at 2:50 PM indicated Resident 20 fell in the lobby area. Resident 20 was unsure of how they fell. Resident 20 had reported right hip pain of 6 on a 1 to 10 scale, and their right foot was turned outward. Resident 20's vital signs were assessed and were within normal limits. The fall note indicated Resident 20 was alert and oriented to person, place, time and situation. The fall note indicated there were no predisposing environmental factors. The fall note indicated Resident 20 had been ambulating without their walker. The fall note indicated Resident 20 had been transferred to the hospital. The fall note did not include the disposition of their personal belongings, their chest x-ray or their skin test. A current facility policy, titled Involuntary Transfer-Discharge, (policy) dated 10/1/21 was provided by the DON on 1/15/25 at 1:07 PM. The policy indicated the facility would provide continuity of care in the event of a resident transfer to the hospital.</i></p>	

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			<p><i>The policy indicated the facility must provide a copy of the following: The reason for the transfer The date of the transfer The location of the receiving facility Information pertaining to appeal A hearing request form Contact information for the long-term care ombudsman Contact information for the protection and advocacy services commission Contact information for the state health department The policy did not indicate the residents' chest x-ray, skin test or disposition of their personal belongings was to be included in the documentation.</i></p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: By following the regulation & doing our Audits, we are ensuring that all Residents' transfer forms have all the documentation included upon discharge to the Hospital, SNF or another AL. 2 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p>	

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			<p>1. A Transfer Form Checklist, will be followed, ensuring that (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Are all included in the documentation.</p> <p>2. DON, Administrator or Designee will be auditing, after every transfer, to ensure that these items are completed.3. Ongoing training on Transfer protocol for all Nurses. 3 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: -Administrator, DON or designee will be competing an Audit, after every Transfer/minimum of 3 times per week to ensure regulatory compliance, for 3 months; 2 times per week for 2 months; Then 1 time per week for 1 month but also indefinitely/ongoing. The Administrator, DON &/or Designee will evaluate the audits and develop an action plan if</p>	

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R 0357 Bldg. 00	<p>410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance</p> <p>Based on interview and record review, the facility failed to ensure complete documentation related to the resident's death for 1 of 1 resident record reviewed (Resident 50).</p> <p>Findings include:</p> <p>Resident 50's record was reviewed on 1/15/25 at 9:40 AM. Diagnoses included heart disease and chronic obstructive pulmonary disease (emphysema).</p> <p>A progress note, dated 12/21/24 at 6:57 PM, indicated Resident 50 had a change in condition. Resident 50 had irregular breathing, increased secretions, increased rattling, low urine output and no verbal communication. The progress note did not include Resident 50's vital signs.</p> <p>On 12/22/24 at 9:44 AM, Resident 50's forehead temperature was 97.8 Fahrenheit.</p> <p>On 12/23/24 at 9:09 AM, Resident 50's forehead temperature was 97.3 Fahrenheit.</p> <p>A progress note, dated 12/23/24 at 9:53 AM, indicated Resident 50 had refused their medication. The progress note did not include Resident 50's vital signs or a notation of their condition.</p> <p>A progress note, dated 12/23/24 at 10:12 AM,</p>	R 0357	<p>necessary.4 Compliance date: 1/30/2025</p> <p>R 357 410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure complete documentation related to the resident's death for 1 of 1 resident record reviewed (Resident 50). Findings include: Resident 50's record was reviewed on 1/15/25 at 9:40 AM. Diagnoses included heart disease and chronic obstructive pulmonary disease (emphysema). A progress note, dated 12/21/24 at 6:57 PM, indicated Resident 50 had a change in condition. Resident 50 had irregular breathing, increased secretions, increased rattling, low urine output and no verbal</p>	01/30/2025

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NAME OF PROVIDER OR SUPPLIER ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP COD 5202 ST JOE ROAD FORT WAYNE, IN 46835
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	<p>indicated Resident 50's medications were discontinued due to the resident's refusal of medications. The progress note indicated Resident 50 was a hospice client. The progress note did not include Resident 50's vital signs or a notation of their condition.</p> <p>A progress note, dated 12/23/24 at 2:31 PM, indicated Resident 50 was alert and had reported pain in their arms. Resident 50 had pauses in their breathing pattern (apnea) and their lung sounds were diminished with some crackles. Resident 50 had declined having their blood pressure assessed. Resident 50's respiratory rate was 18 breaths per minute, their heart rate was 114 beats per minute, their oxygen saturation was 96% on oxygen at 1 liter per minute via nasal cannula and their forehead temperature was 97.5 Fahrenheit.</p> <p>On 12/24/24 at 9:46 AM, Resident 50's forehead temperature was 97.7 Fahrenheit.</p> <p>A progress note, dated 12/24/24 at 11:14 AM, indicated Resident 50 was grimacing and had labored breathing. The progress note indicated the hospice nurse was with the resident. The progress note did not include Resident 50's vital signs.</p> <p>A progress note, dated 12/24/24 at 12:16 PM, indicated Resident 50's breathing was less labored and displayed no signs of pain. The progress note did not include Resident 50's vital signs.</p> <p>A progress note, dated 12/24/24 at 1:22 PM, indicated Resident 50's breathing was not labored, and they had no signs of pain. The progress note did not include Resident 50's vital signs.</p> <p>A progress note, dated 12/24/24 at 5:08 PM,</p>		<p><i>communication. The progress note did not include Resident 50's vital signs. On 12/22/24 at 9:44 AM, Resident 50's forehead temperature was 97.8 Fahrenheit. On 12/23/24 at 9:09 AM, Resident 50's forehead temperature was 97.3 Fahrenheit. A progress note, dated 12/23/24 at 9:53 AM, indicated Resident 50 had refused their medication. The progress note did not include Resident 50's vital signs or a notation of their condition. A progress note, dated 12/23/24 at 10:12 AM, indicated Resident 50's medications were discontinued due to the resident's refusal of medications. The progress note indicated Resident 50 was a hospice client. The progress note did not include Resident 50's vital signs or a notation of their condition. A progress note, dated 12/23/24 at 2:31 PM, indicated Resident 50 was alert and had reported pain in their arms. Resident 50 had pauses in their breathing pattern (apnea) and their lung sounds were diminished with some crackles. Resident 50 had declined having their blood pressure assessed. Resident 50's respiratory rate was 18 breaths per minute, their heart rate was 114 beats per minute, their oxygen saturation was 96% on oxygen at 1 liter per minute via nasal cannula and their forehead temperature was 97.5 Fahrenheit.</i></p>	

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	<p>indicated Resident 50 had stopped breathing. No other vital signs were recorded.</p> <p>A progress note, dated 12/24/24 at 7:05 PM, indicated Resident 50's remains had been released to the funeral home.</p> <p>Resident 50's progress notes, dated 12/21/24 at 6:57 PM through 12/24/24 at 8:42 PM did not indicate the disposition of the resident's personal belongings or their medications.</p> <p>In an interview on 1/15/25 at 12:59 PM, The Administrator and the Director of Nursing (DON) indicated they were aware of the concerns related to the required documentation in the event of a facility death.</p> <p>A current facility policy, titled "Death," dated 10/1/21, provided by the DON on 1/15/25 at 1:19 PM, indicated the facility would maintain compliance of state and local laws.</p>		<p><i>On 12/24/24 at 9:46 AM, Resident 50's forehead temperature was 97.7 Fahrenheit. A progress note, dated 12/24/24 at 11:14 AM, indicated Resident 50 was grimacing and had labored breathing. The progress note indicated the hospice nurse was with the resident. The progress note did not include Resident 50's vital signs. A progress note, dated 12/24/24 at 12:16 PM, indicated Resident 50's breathing was less labored and displayed no signs of pain. The progress note did not include Resident 50's vital signs. A progress note, dated 12/24/24 at 1:22 PM, indicated Resident 50's breathing was not labored, and they had no signs of pain. The progress note did not include Resident 50's vital signs. A progress note, dated 12/24/24 at 5:08 PM, indicated Resident 50 had stopped breathing. No other vital signs were recorded. A progress note, dated 12/24/24 at 7:05 PM, indicated Resident 50's remains had been released to the funeral home. Resident 50's progress notes, dated 12/21/24 at 6:57 PM through 12/24/24 at 8:42 PM did not indicate the disposition of the resident's personal belongings or their medications. In an interview on 1/15/25 at 12:59 PM, The Administrator and the Director of Nursing (DON) indicated they were aware of the concerns related to the required</i></p>	

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			<p><i>documentation in the event of a facility death. A current facility policy, titled "Death," dated 10/1/21, provided by the DON on 1/15/25 at 1:19 PM, indicated the facility would maintain compliance of state and local laws.</i></p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: By following the regulation & doing our Audits, we are ensuring that upon the death of a Resident' all the appropriate documentation is completed. ((j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.)</p> <p>1.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p>	

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			<p>1. DON updated & trained Nursing staff on the checklist for the steps to follow and documentation needed, [(j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.] This is to ensure that all information is completed & in the documentation.</p> <p>2. Ongoing training on the protocol upon the death of a Resident, with all Nurses. 1 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: -Administrator, DON or designee will be competing an Audit 3 times per month to ensure regulatory compliance, for 3 months; 2 times per month for 2 months; Then 1 time per month for 1 month but actually indefinitely/ongoing. The Administrator, DON &/or Designee will evaluate the audits and develop an action plan if necessary.2 Compliance date: 1/30/2025</p>	