STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00383344, IN00382808, IN00382041, IN00382043 and IN00381766. Complaint IN00383344- Substantiated. Federal/State deficiencies related to the allegations are cited at F-675. Complaint IN00382808 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-677 & F-686. Complaint IN00382041- Substantiated. Federal/State deficiencies related to the allegations are cited at F-693. Complaint IN00382043- Substantiated. Federal/State deficiencies related to the allegations are cited at F-689 & F-842. Complaint IN00381766 Substantiated with no deficiencies cited. Survey dates: June 13th through June 22, 2022 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type:	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** /b>	

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

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

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	Medicare: 13 Medicaid: 64 Other: 27 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 28, 2022			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on interview, observation, and record review, the facility failed to accommodate Resident H's shower preferences for 1 of 6 residents reviewed for activities of daily living. Findings include: The clinical record Resident H was reviewed on 6/15/2022 at 10:45 a.m. The clinical diagnoses included, but were not limited to, chronic obstructive pulmonary disease and dementia. A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicated that Resident H was mildly cognitively impaired and needed assistance of one staff member for bathing, hygiene, and transferring tasks. An observation on 6/14/2022 at 11:15 a.m., indicated that CNA 11 went into Resident H's	F 0558	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) H was identified during the time of observation. All care team members have been educated on Resident rights, shower preferences, and ADL care. 2. 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. All Residents have the potential to be affected by this practice.	07/07/2022

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	room and offered to give her a shower. She stated she did not want a shower because she likes them later and the "girl on the next shift" will give it to her. An interview with Resident H on 6/14/2022 at 11:22 a.m. indicated that she likes her showers in the evening after everyone goes to bed, but they always try and give them to her in the morning. She stated she will ask the "girls on the next shift" to give her a shower and they "usually" do. She has always preferred her showers in the late evening. No care plan indicating shower preference or assistance on the clinical record. A care task dated 8/20/2021 indicated for Resident H to have showers on Tuesday and Friday night shift. Shower sheets for Resident H indicated showers were offered on Tuesday or Friday a.m. on 6/3/2022, 6/7/2022, 6/13/2022, and 6/17/2022. A policy entitled "Accommodation of Needs" was provided by the Director of Nursing on 6/20/22 at 4:05 p.m. The policy indicated, "The resident's individual needs and preferences will be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered." 3.1-3(v)(1)		2. A campus wide review was completed to ensure all Residents had documented shower preferences and scheduled days. All Residents were offered showers. 3. Pertinent facility staff have been re-educated on residents' shower preferences and scheduled days. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure shower preferences and showers are upheld. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.	

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			2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.			

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	(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and interview, the facility failed to provide privacy during a skin check and linen change for 1 of 6 residents reviewed for activities of daily living. (Resident F) Finding include: The clinical record for Resident F was reviewed on 6/17/2022 at 2:40 p.m. The clinical diagnoses included, but were not limited to, dementia and urinary tract infection. An Annual Minimum Data Set Assessment indicated that Resident F was cognitively impaired and needed assistance of 2 staff members for bed mobility, toileting, and hygiene needs. An observation on 6/17/2022 at 2:18 p.m. indicated LPN 10 and CNA 11 entering Resident F's room to complete a skin check and reposition. The door to the room was left cracked due to the unoccupied bed being turned in a way that would not allow the room door to be closed. The footboard of the unoccupied bed protuded into the doorway. No privacy curtain was pulled. Resident F's head of bed was lowered, her catheter bag was laid on her legs, and she was assisted to roll toward CNA 11. LPN 10 did a skin check and rolled a top fabric chucks pad that was	F 0583	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) F were identified during the time of observation. All care team members have been educated Resident Rights with a dignified experience. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Residents were provided a privacy curtain and that all Resident room furniture was positioned appropriately to allow for a dignified experience. 3. Pertinent facility staff have been re-educated on Resident	07/07/2022

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	coated in cream and had a yellow hue. Resident F did not have a brief on. She was assisted to roll towards LPN 10 and the chucks pad was removed by CNA 11. Resident F was repositioned, head of bed was elevated, and catheter bag was replaced to the right side of the bed frame. An interview with LPN 10 on 6/17/2022 at 2:23 p.m. indicated the door could not shut because of the unoccupied bed being placed against the wall and he would fix that immediately. LPN 10 then moved the bed and was able to close the door. An observation on 6/20/2022 indicated the unoccupied bed had been moved in a way that it would no longer be an obstacle to closing the door. A policy entitled, "Quality of Life - Dignity", was provided by the Director of Nursing on 6/21/2022 at 12:27 p.m. The policy indicated, " ...Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care ..." 3.1-3(p)(4)		Rights with a dignified experience. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all Residents are provided a dignified experience. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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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 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;			

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	§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. Based on interview, observations, and record review, the facility failed to promote a homelike environment for 12 of 15 residents reviewed for environment. (Residents 83, 41, H, F, P, Q, 81, 21, 60, 11, 31 and R) Findings include: 1. The clinical record for Resident 83 was reviewed on 6/17/2022 at 11:40 a.m. The medical diagnoses included, but were not limited to, failure to thrive and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set, dated 5/13/2022, indicated that Resident 83 was cognitively intact. An observation of Resident 83's room on 6/13/2022 at 1:57 p.m., indicated that the bathroom door would stick when it was closed all the way. Due to this, there was sharpie written on both sides of the door stating to not close the door completely. There was paint missing from the door. An interview with Resident 83 on 6/13/2022 at 1:57 p.m., indicated he does not close the bathroom door fully because last time he did he had to exit the other door into another resident's room to get out. He indicated the paint missing and sharpie is unsightly to him, but the door not working is the biggest issue. An interview with Resident 83 on 6/21/2022 at	F 0584	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) H, F, P, Q, 81, 21, 60 11, 31, R were identified during the time of observation. Director of plant operations was educated on preventative maintenance and home like environment. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Residents rooms, common spaces, and corridors are clean, comfortable and meet the guidance of a homelike experience. 3. Pertinent facility staff have been re-educated on preventative maintenance and home like environment.	07/07/2022

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	11:55 a.m. indicated the maintenance man had come in and fixed the door, but he would like the paint repaired and his room's entry door still sticks a bit as well. 2. The clinical record for Resident 41 was reviewed on 6/20/2022 at 3:03 p.m. An Admission Minimum Data Set Assessment, dated 4/5/2022, indicated that Resident 41 was cognitively intact. An interview with Resident 41 on 6/13/2022 at 3:09 p.m. indicated she had no lighting in her room except the light directly over her bed and she felt her room was not being cleaned well. An observations on 6/22/2022 at 11:04 a.m. indicated that neither over the bed lights in the room worked nor the ceiling light by the door. There was a baseball sized hole in the window screen. An interview with Resident 41 on 6/22/2022 at 11:04 a.m. indicated she would like the screen fixed as well as the lighting due to not having any but the one directly over her bed. 3. The clinical record Resident H was reviewed on 6/15/2022 at 10:45 a.m. The clinical diagnoses included, but were not limited to, choric obstructive pulmonary disease, neuromuscular dysfunction of the bladder, and dementia. A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicated that Resident H was mildly cognitively impaired. An interview with 6/14/2022 at 12:25 p.m. indicated there was missing paint and damage to the wall by		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. ED or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for x4 weeks, then weekly for x4 weeks, then monthly ongoing to ensure environmental/preventative maintenance services are provided as needed. The plan will be revised, as warranted. 4. 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. For quality assurance, the ED or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	her closet that bothered her because it was in her line of sight when she was laying in bed. An observations on 6/22/2022 at 11:00 a.m. indicated there was still missing paint and damage to the wall by her closet. 4. The clinical record for Resident F was reviewed on 6/17/2022 at 2:40 p.m. The clinical diagnoses included, but were not limited to, dementia and urinary tract infection. An Annual Minimum Data Set Assessment indicated that Resident F was cognitively impaired and needed assistance of 2 staff members for bed mobility, toileting, and hygiene needs. An interview with the family of Resident F on 6/17/2022 at 2:28 p.m. indicated there was damage behind her bed and to the wall by the door that included paint and "deep gouges" to the dry wall. An observations on 6/17/2022 at 2:28 p.m. indicated multiple long lines of damage to the wall and pain behind Resident F's bed as well to the wall by the door. A walk-through tour was completed with AIT (Administrator in Trainng) on 6/22/2022 at 12:03 p.m. At this time, Resident 83's bathroom door had writing upon it and missing paint, 3 of the 4 lights within Resident 41's room did not work, Resident H and F's room had damaged walls and painting as described. An interview with the AIT on 6/22/2022 at 12:03 p.m., indicated he would file work orders regarding these findings and address them based on priority. When asked if he felt the conditions of the room and lighting promoted a homelike			

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	environment, he indicated they did not. 5a. A tour was conducted of the Ventilator Unit on 6/13/22 at 1:08 p.m. The following was noted: - Resident P's room was noted with spillage, which was dried, located under the feeding pump in her room. The floor appeared dirty, and debris was noted on the floor as well. An interview conducted with Resident Q, on 6/13/22 at 11:47 a.m., indicated the staff only mop the floors 1-2 times a week but housekeeping does not come on a regular basis. An interview conducted with Resident R, on 6/13/22 at 11:56 a.m., indicated the staff clean the room weekly and they mop on occasion. An interview conducted with Certified Nursing Assistant (CNA) 13, on 6/13/22 at 12:07 p.m., indicated housekeeping was short staff at that time. They will go and assess the need for cleaning in the rooms on the Ventilator Unit. It's safe to say each room doesn't get cleaned daily but they are observed daily and the rooms that are in need of cleaning will get completed. 5b. A tour was conducted of the Memory Care Unit (300 hallway), on 6/13/22 at 2:35 p.m. The following was noted: - Resident 21's room with floor appearing dirty, - Resident 81's room noted with debris on the floor, - Resident 60's toilet lid noted with missing paint and hold under heating and cooling unit, - Resident 11's room noted with debris and spillage noted to the floor and missing paint to the wall beside the bed,			

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	- Resident 31's room noted with spillage on the floor, missing paint on the accent wall, and room was not homelike. An environmental tour was conducted, on 6/22/22 at 12:08 p.m., with the Administrator in Training (AIT). The following was noted: - Resident 60's toilet lid noted with missing paint and hole under the heating and cooling unit, - Resident 11's room noted with missing paint to the wall beside the bed, - Resident 31's room noted with missing paint on the accent wall and the room didn't appear homelike. There was candy bars, wipes and a television only in the room, & - Resident P's room noted with dried spots located under feeding pump with dirty floor. An interview conducted with the AIT during the environmental tour indicated the verification of such concerns with the missing paint in Resident 11's room, Resident 31's room, and Resident 60's toilet lid. The hole present underneath the heating and cooling unit in Resident 60's room and Resident 31's room not appearing homelike. 3.1-19(f)(5) 3.1-19(bb)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and			

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(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
	misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, interview and record review the facility failed to implement the abuse policy to report an allegation of sexual abuse to the Administrator immediately for 1 of 2 residents reviewed for abuse (Resident 71 and 35). Finding include: During an observation on 6/13/22 at 11:45 a.m., Resident 71 was following the surveyor down the hallway and attempting to physically touch the surveyor and the surveyors computer. Resident 71 was not able to be redirected. This was brought to the attention of LPN 7. LPN 7 indicated he had worked at the facility four days and had not seen Resident 71 be aggressive, but the resident did like to follow people and touch people. LPN 7 had	F 0609	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) 71 and 35 were identified during the time of observation. All care team members have been educated on reporting Resident abuse and policy associated with it. 2. 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.	07/07/2022

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	155491	A. BUILDING 00 B. WING	06/22/2022

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	not seen Resident 71 be inappropriate with any residents. During an interview with Resident 35 on 6/13/22 at 12:27 p.m., indicated Resident 71 constantly attempted to touch her hair, whisper in her ear and would pretend like he was going to grab her breast. Resident 71 also did this visitors. The staff would intervene, but when they would go back to work he would start doing it again. Resident 71 also attempted to come in her room and she would make him get out. Resident 71 was "very intrusive". Resident 71 had also touched Resident 35's daughter's hair when she came to visit. Resident 35's daughter was very upset about this and was going to report it to someone. The staff was aware of his behaviors and would document it. Resident 35 was not sure if management was aware of this. During an interview with CNA on 6/13/22 at 12:47 p.m., indicated Resident 71 would follow staff around, but she had not seen him be inappropriate with other residents. Resident 71 was bothering Resident 35's daughter when she was visiting on 6/12/22 and that incident was documented. During an observation and interview with LPN 1 on 10:51 a.m., Resident 71 was attempting to take items off the medication cart and take the surveyors computer. LPN 1 indicated the resident's behaviors had increased recently. LPN 1 indicated Resident 71 grabbed Resident 35's bottom twice the other day (unsure of date) at the nursing station. LPN 1 indicated she told Resident 71 this was inappropriate behavior. LPN 1 indicated she reported this behavior to the Social Service Director (S.S.D.). During an interview with Resident 35's family		1. All Residents have the potential to be affected by this practice. 2. All Care team members, including IDT to be educated on abuse and reporting policy. Resident 71 to be re-assessed for intervention, care plan, and possible placement at an all male location 3. Pertinent facility staff have been re-educated on reporting abuse and policy associated with it. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. ED/DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all incidents requiring state reporting are done so within guided timeline. The plan will be revised, as warranted. 4. 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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	member on 6/14/22 at 11:17 a.m., indicated she would like to meet with the Director Of Nursing (DON) and the surveyor. During an interview with the S.S.D. on 6/14/22 at 11:23 a.m., indicated she was unsure if the Administrator had been notified about Resident 71's sexually inappropriate behaviors. The S.S.D. indicated no one had reported it to her, she had read it in the progress notes this morning. Requested for the Administrator and DON come to the memory care unit. During an interview with Resident 35's family member, the Administrator and the DON on 6/14/22 at 11:41 a.m., Resident 35's family reported Resident 71 had been kissing and touching Resident 35. The family member indicated Resident 35 reports that Resident 71 followed the resident all day and she was having difficulty sleeping at night for fear of Resident 71. The Administrator and the DON indicated they were unaware of Resident 71's sexually inappropriate behavior and would investigate the situation. Resident 35's family member indicated she was taking Resident 35 home for a visit on this day so the resident could get some rest. During an interview with the DON on 6/14/22 at 11:55 a.m., indicated she had read LPN 1's progress note about Resident 71 touching Resident 35's bottom. LPN 1 reported to the DON that she did not physically see Resident 71 touch Resident 35's bottom, but she heard Resident 35 say to Resident 71 "don't touch my butt". During an interview with LPN 1 on 6/14/22 at 1:06 p.m., indicated she was sitting behind the desk and Resident 35 was standing at the nursing station, Resident 71 walked up behind Resident 35		1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	and Resident 35 said "stop touching my butt". LPN 1 indicated she had visually seen Resident 71 grab Resident 35's bottom, because she was sitting behind the desk. Resident 71 had no boundaries. LPN 1 indicated this incident happened on 6/9/22 and she documented it. LPN 1 reported it to the S.S.D. on 6/10/22. LPN 1 indicated she did not report it to the Administrator. During an interview with the Administrator on 6/14/22 at 2:14 p.m., indicated Resident 71 had increased supervision until they could discharge him to the psychiatric hospital. Review of the record of Resident 35 on 6/17/22 at 11:08 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, major depressive disorder, anxiety disorder, paranoid schizophrenia, sleep disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/31/22, indicated the resident was cognitively intact for daily decision making. Decisions consistent and reasonable. Review of the record of Resident 71 on 6/17/22 at 11:17 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, hallucinations, dementia with behavioral disturbance, mood disorder and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 5/2/22, indicated the resident was severely impaired for daily decision making. The progress note for Resident 71, dated 6/9/2022 5:21 p.m., Alert Note Note Text: Resident being sexually inappropriate with other resident's.			

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	Another resident came to desk to ask this nurse for something. Resident walked up behind resident and rubbed on her buttocks. Resident turned and stated stop it she did not like that. This nurse stated as well it was inappropriate and he should not continue to touch other's like that. The progress note for Resident 71 dated 6/12/2022 1:16 p.m., indicated resident alert and oriented, able to make wants and needs known to staff. Resident continues to be sexually inappropriate with staff and peers. Resident is putting hands up to female staff and residents chest and attempting to touch/squeeze. Resident has been told over and over to stop and is redirected but continue with behavior. Daughter of resident in (203) came in today and resident exhibited same behavior with her as well. This nurse put resident in book for N.P./MD to do a med review. The abuse policy provided by the DON on 6/15/22 at 2:00 p.m., indicated the Administrator must be notified of alleged abuse/neglect immediately. "If such incidents occur or are discovered after hours, the Administrator and DON must be called at home to inform of the such incident. 3.1-28(b)(2)(c)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to develop a smoking care plan for 1 of 3 residents reviewed for smoking. (Resident H)	F 0656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) H was identified	07/07/2022

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	Findings include: The clinical record Resident H was reviewed on 6/15/2022 at 10:45 a.m. The clinical diagnoses included, but were not limited to, choric obstructive pulmonary disease and dementia. A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicated that Resident H was mildly cognitively impaired and needed assistance of one staff for transferring tasks. A Significant Change Minimum Data Set Assessment, dated 9/7/2021, indicated that Resident H utilized tobacco products. A smoking assessment was completed for Resident H on 8/20/2021. An interview with Resident H on 6/14/2022 at 12:27 p.m. indicated she was smoker, but they (residents) aren't going out to smoke right now due to the weather advisory (high temperature advisory). No care plan was present on the clinical record at the time of review. An interview with the MDS Coordinator on 6/20/2022 at 3:11 p.m. indicated that smoking would be included in a care plan if applicable to the resident. Per interview with Director of Nursing on 6/21/2022 at 11:33 a.m., there is no specific care plan policy. 3.1-35(b)(1)		during the time of observation. Resident H was re-assessed and care planned as appropriate for smoking. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all Residents with the desire to smoke have updated care plans and have been assessed for safety of smoking to do so. 3. Pertinent facility staff have been re-educated on completing care plans and assessments for safety of smoking for residents. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all care plans and services are	

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			provided as needed. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0675 SS=D Bldg. 00	483.24 Quality of Life § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Based on observation, interview, and record	F 0675	1. What corrective action(s) will be accomplished for those	07/07/2022

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	review, the facility failed to ensure a call light was in place that could be utilized by a resident with limited mobility to his upper extremities for 1 of 1 resident reviewed for accommodation of needs. (Resident L) Findings include: The clinical record for Resident L was reviewed on 6/21/22 at 12:30 p.m. The diagnoses included, but were not limited to, muscular dystrophy, dependence of ventilator status, and anxiety disorder. Resident L was admitted to the facility on 3/16/22. An Admission Minimum Data Set (MDS) assessment, dated 3/23/22, indicated Resident L was cognitively intact, needed extensive assistance with 2 staff for bed mobility, transfer, personal hygiene, and impairment on both sides of upper and lower extremities. An interview conducted with Resident L, on 6/13/22 at 12:47 p.m., indicated he was not able to move his upper extremities. A touch pad call light was located to the right side of his bed, just slightly underneath the pillow. He indicated he was not able to utilize the call light. An interview conducted with Licensed Practical Nurse (LPN) 14, on 6/13/22 at 2:50 p.m., indicated Resident L was not able to move his upper extremities. The facility staff will place the soft touch call light to the right of his face, and he can move his head and hit it, but the call light needed to be positioned at the exact location or it doesn't work. For the most part Resident L will yell out staff names if he knows who was working or "nurse".		residents found to have been affected by the deficient practice. 1. Resident(s) L was identified during the time of observation. Resident L's call light was repositioned within effect placement and verified that Resident could utilize properly when placed under chin/neck. PT/ED/SLP to review call light options for best utilization and quality of Resident. All staff educated on call light policy. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all Residents have the ability to utilize their call light as appropriate. Audit includes positioning and placement. 3. Pertinent facility staff have been re-educated on ability of residents to utilize their call light as appropriate per resident needs. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	An observation and interview conducted of Resident L, on 6/14/22 at 11:29 a.m., noted the soft touch call light to the right upper part of the bed that couldn't be reached by moving his head back and forth. Resident L stated he doesn't have the head strength to be able to press on the call light enough for it to work. Even if the facility staff positioned it right where he could turn his head and make contact with his cheek, he wouldn't be able to put enough pressure with his face to activate the call light. The facility staff told me they would obtain a call light that he could blow into but that was 3 months ago when he first admitted to the facility. An interview conducted with Director of Respiratory Therapy, on 6/14/22 at 11:38 a.m., indicated the corporation was able to obtain a call light that the resident could blow into to activate such. An interview conducted with Registered Nurse (RN) 16, on 6/14/22 at 10:55 a.m., indicated Resident L had turned his call light on previously when she had worked with him. There are sometimes he says "nurse", but he knows I was right there outside of his room. If the call light was not positioned right, he was not able to press it. RN 16 indicated she wasn't aware there was a specialized call light one could blow into to activate. RN 16 then proceeded to contact the Business Office Manager and indicated they would order Resident L a specialized call light. A policy titled "Answering the Call Light", revised 7/18/2017, was provided by the Director of Nursing on 6/17/22 at 10:00 a.m. The policy indicated the following, "...The purpose of this procedure is to respond to the resident's requests and needs. Residents who are unable to utilize call		1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all call lights and services are provided as needed. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	bells should be considered for an adaptive call bell or device for alerting staff to needs...2. Demonstrate the use of the call light...." This Federal Tag relates to Complaint IN00383344. 3.1-37(a)			
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 ensure a resident who was dependent on staff assistance for activities of daily living (ADLs) was kept clean by having food spills on her shirt (Resident 11) and provided nail care for a dependent resident (Resident 93) for 2 of 6 residents reviewed for ADLs. Findings include: 1. The clinical record for Resident 11 was reviewed on 6/21/22 at 2:11 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, muscle weakness, and paranoid schizophrenia. A Quarterly Minimum Data Set (MDS) assessment, dated 6/8/22, noted severe cognitive impairment and the need for extensive assistance with 1-2 staff for bed mobility, dressing, transfer, toilet use, and personal hygiene. An observation conducted on 6/14/22 at 1:36 p.m. of Resident 11 feeding herself while she was in	F 0677	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) 11 and 93 were identified during the time of observation. Resident 11 was re-assessed for independent eating and provided a clothing protector at all meals. Resident 93 was provided nail care. All Care team members educated on ADLs and daily task completion. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide audit was	07/07/2022

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	bed and liquid was going down her neck and on the front of her shirt. A follow up observation, on 6/14/22 at 2:18 p.m., noted her lying in bed with her tray no longer in front of her and the liquid remained on her shirt. An observation conducted on 6/16/22 at 10:32 a.m., of Resident 11 lying in bed with appearance of sleep. There were crumbs and a white substance noted on her black shirt after breakfast time. No tray was in front of her during the observation. An observation conducted on 6/16/22 at 2:17 p.m., of Resident 11 up in a wheelchair at the nurses' station. There were brown spots noted to her cream-colored shirt. An observation conducted on 6/17/22 at 9:11 a.m., of Resident 11 sitting up in her bed with oatmeal, quarter sized, noted to her chin. There were bits of food, crumbs, and spillage to her black shirt. A follow up observation, on 6/17/22 at 10:20 a.m., noted her still in bed with oatmeal remaining to her face and food on her shirt. An interview conducted with Certified Nursing Assistant (CNA) 15, on 6/22/22 at 9:22 a.m., indicated Resident 11 was waiting for a new wheelchair. That's why the nursing staff were not able to get her up in the dining room for meals. She has the wheelchair now and she's back up for meals in the dining room. She doesn't mind wearing a clothing protector. Sometimes the pureed food is too thin, and it can spill down her shirt but we would just change her shirt if that happens. An ADL care plan, revised 3/4/21, indicated the need of assistance with ADLs and to assist with		completed to ensure all dependent Residents are offered clothing protectors, nail care, and assistance as needed to meet the standard of quality life by state guidance. 3. Pertinent facility staff have been re-educated on ADLs and daily task completion. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all ADLs and services are provided as ordered. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.	

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	155491	A. BUILDING 00 B. WING	06/22/2022

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	eating if necessary. 2. The clinical record for Resident 93 was reviewed on 6/17/22 at 12:37 p.m. The diagnoses included, but were not limited to, quadriplegia, dependence of ventilator status, and conversion disorder with seizures. A Quarterly MDS assessment, dated 5/19/22, indicated impairment on both sides of the lower and upper extremities, total assistance with 2 staff for bed mobility, transfer, personal hygiene and bathing. An observation conducted on 6/13/22 at 12:25 p.m., of Resident 93 with long nails to the right hand. An observation conducted on 6/15/22 at 2:20 p.m., of Resident 93 continued with long nails to the right hand. An observation conducted on 6/16/22 at 10:16 a.m., of Resident 93 continued with long nails to the right hand. An observation conducted on 6/17/22 at 9:12 a.m., of Resident 93 noted with his nails cut. A care plan for ADLs, revised 9/7/21, indicated to complete bed baths on Tuesdays, Thursdays, and Saturday nights. Shower sheets were reviewed and noted the following date(s) where nail care was not marked as provided or marked as refused: 5/16/22, 5/24/22, 5/27/22,		2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	6/3/22, 6/7/22, & 6/14/22. A policy titled "Activities of Daily Living", revised March 2018, was provided by the Executive Director on 6/21/22 at 10:15 a.m. The policy indicated the following, "...Appropriate care and services will be provided for residents who are unable to care out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with...a. Hygiene [bathing, dressing, grooming, and oral care]...." This Federal Tag relates to Complaint IN00382808. 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review the facility failed to provide an ongoing activity program for the memory care unit for 3 of 3 residents reviewed for activities (Resident D, Resident 52 and Resident 106).	F 0679	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) D, 52, and 106	07/07/2022

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	Findings include 1.) Review of Resident D's record on 6/17/22 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, arteriosclerotic heart disease, chronic respiratory failure, dementia with behavioral disturbance, psychotic disorder, anxiety disorder, restlessness and agitation. The Annual Minimum Data Set (MDS) assessment, dated 12/17/22, indicated the resident was severely impaired for daily decision making. It was somewhat important for the resident to listen to his favorite music, be around animals, do activities in groups of people, do his favorite activity and go outside and get fresh air. During an observation on 6/14/22 at 10:36 a.m., Resident D wandering the hallway no activities occurring on the memory care unit. The resident was attempting to open the outside doors and going up and down the hallway aimlessly. During an observation on 6/15/22 2:14 p.m., Res D sitting in the recliner with his eyes closed in his recliner, no TV/music or any type of activity occurring on the memory care unit. During an interview with Activity Assistant 5 6/15/22 at 2:50 p.m., indicated she worked part time on memory care unit. During an observation on 6/16/22 at 11:03 a.m., Resident D was sitting in the dining room in the same clothes as yesterday blue shirt blue sweats no shoes or slipper socks, eyes closed TV on. No activities occurring on the memory care unit.		were identified during the time of observation. All Residents were re-assessed for self interest, preference and ability to participate within an activity program. 2. 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. All Residents have the potential to be affected by this practice. 2. An audit was completed to in review of personal liking, preference and history of social events to increase participation and activities schedule/program on the memory care unit. 3. Pertinent facility staff have been re-educated on residents' ability to participate within an activity program. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. MCF or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks,	

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	During an observation on 6/16/22 1:16 p.m., Resident D sitting in someone else's room with his eyes closed with his meal tray in front of him he is in the recliner. No shoes on. Staff woke him up and he began eating really well. All the other residents were done eating and there were no activities occurring on the memory care unit. During an observation on 6/16/22 at 2:55 p.m., Resident D remains in another resident's room, the other resident was asleep in bed. The resident is sitting in the recliner, no TV or radio on. There were no activities on the memory care unit occurring. During an observation on 6/17/22 at 11:34 a.m., sitting in the recliner with his eyes closed, no TV or radio playing, no activity occurring in the memory care unit. During an observation on 6/20/22 at 9:51 a.m., Resident D observed up and wandering by nurses station. No activities occurring on the memory care unit During an observation on 6/20/22 10:19 a.m., Resident D in another resident's room in a recliner with eyes closed slipper socks in place. Abrasion fading but remains on right eye and nose. No TV or radio playing. No activities occurring on the memory care unit. During an observation on 6/20/22 11:50 AM Resident D was in another resident's room in a recliner with his eyes closed. There is a craft activity occurring in the dining room with three residents no resident's participating only the Activity Assistant 5. During an observation on 6/20/22 2:38 p.m.,		then monthly ongoing to ensure all activities as scheduled are provided and that participation is occuring. The plan will be revised, as warranted. 4. 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. For quality assurance, the ED or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	Resident D sitting in front of the nursing station no activities occurring on the memory care unit. During an interview with Resident D's family member on 6/20/22 2:48 p.m., indicated the resident loved to garden and the staff never took outside. The staff told the family member there was not enough staff to take him outside. When the family member came to the facility to visit there never any activities occurring. Resident D just wondered around. The was a drywall man his whole life hard working man. He liked fiddling with things worked on motorcycles had two motorcycles. No staff had ever talked to the family member about some things the resident would like to do. The family member had asked a many times for him to go outside and dig in some dirt and watch the birds. The resident always had a dog with him all the time. The resident might look at a motorcycle magazine. The family stated "lease look into this he just sits there and does nothing and he would love some sun on his face. During an interview with CNA 3 on 6/20/22 at 3:07 p.m., indicated she normally worked on the memory care unit 12 hours a day. CNA 3 indicated there were never any activities on the memory care unit. During an interview with LPN 4 on 6/20/22 at 3:09 p.m., indicated she normally worked the memory care unit 12 hours a day. LPN 4 had never seen anyone do activities for the residents. LPN 4 indicated the residents needed something to keep them busy it would help with falls, behaviors etc. During an observation on 6/21/22 12:02 p.m., Resident D was sitting in his room no activities occurring on the memory care unit. The resident has no music or TV on in his room. 2. The clinical			

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	record for Resident 52 was reviewed on 6/20/22 at 10:59 a.m. The diagnoses included but were not limited to, dementia, unsteadiness on feet, anxiety disorder, and repeated falls. A Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, noted Resident 52 with severe cognitive impairment and extensive assistance with 2 staff for bed mobility, transfer, toilet use, and personal hygiene. Also, limited assistance with one staff for locomotion on unit. A fall care plan, revised 5/27/22, included, but not limited to, the following intervention(s): - Encourage to participate in activities. An activity care plan, revised 5/26/22, included, but not limited to, the following interventions: - Provide materials of interest for independent leisure activity & - Provide assistance/escort to activity functions. An observation conducted on 6/14/22 at 4:45 p.m., of Resident 52 up in her wheelchair propelling self down the hallway and was located by the dining room. No staff were nearby, and no activities were taking place. An observation conducted on 6/15/22 at 2:48 p.m., of Resident 52 up in her wheelchair propelling self down the hallway close to the dining room. This was on the opposite end of the unit from the nurses' station. No nursing staff was near the resident. No activities were taking place. An observation conducted on 6/16/22 at 2:25 p.m., of Resident 52 up in wheelchair and propelling self in the dining room. No staff was nearby. One			

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	nurse was located in the nurses' station and no other staff was located in the hallway. On 6/16/22 at 2:55 p.m., Resident 52 was sitting right outside of the dining room and the nurse was in the middle of the hallway with the medication cart. There were 2 Certified Nursing Assistants (CNAs) walking towards the nurses' station on the other end of the unit. No activities were taking place. An observation conducted on 6/17/22 at 11:35 a.m., of Resident 52 up in her wheelchair and propelling herself in and out of other residents rooms. No activity was taking place. 3. The clinical record for Resident 106 was reviewed on 6/14/22 at 3:52 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, conversion disorder with seizures, psychotic disorder, and dementia. A Quarterly MDS, dated 5/17/22, noted severe cognitive impairment and the need for extensive assistance with 2 staff for bed mobility, transfer, toilet use, and personal hygiene. Also, supervision with one staff for walk in room and walk in corridor. An activity care plan, revised 5/20/22, listed the following interventions: - Daily activity programming & - Keep resident involved in activities and/or socialization to divert behaviors, loneliness, sadness. An observation conducted on 6/15/22 at 2:50 p.m., of Resident 106 walking in the hallway. No activities were taking place. An observation conducted on 6/17/22 at 9:10 a.m.,			

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	of Resident 106 walking in the hallway towards the dining room with a non-skid sock to the right foot and nothing to the left foot. No activities were taking place. An observation conducted on 6/17/22 at 10:21 a.m., of Resident 106 sitting in a chair in the dining room with only 1 non-skid sock on and no helmet. No staff were nearby and noted at the other end of the unit by the nurses' station. No activities were taking place. An observation conducted on 6/20/22 at 9:51 a.m., of Resident 106 sitting in a chair by the nurses' station. He proceeded to get up and start ambulating down the hallway. No activities were taking place. An observation conducted on 6/22/22 at 9:32 a.m., of Resident 106 sitting in a chair by nurses' station. He was looking down at the floor. No activities were taking place. A policy titled "Activity Programs", revised 7/2018, was provided by the Director of Nursing on 6/21/22 at 4:45 p.m. The policy indicated the following, "...2. Activities are schedules 7 days a week during the day and some evenings and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs...3. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident...6. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to residents who can not access the bulletin board...8. Residents are encouraged, but not required, to participate in scheduled activities...."			

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	3.1-33(a) 3.1-33(c)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview and record review the facility failed to provide audiology and optometry services for 1 of 1 resident reviewed for communication and sensory (Resident D). Finding include: During an observation and interview on 6/14/22 at 10:00 a.m., Resident D clothing was wet. CNA 3 and CNA 20 indicated they were in the process of changing Resident D's brief and clothes. CNA 3 indicated only one aide can go in at a time and then one aide stays outside the room in case he becomes aggressive. The resident is extremely hard hearing and it makes him anxious if more then one person provides his care. Our approach with him is we hold up his brief and hold up his clothes so he can see what we are about to do since he cannot hear well. The aides attempted to talk to the resident but he could not hear them. The	F 0685	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) D was identified during the time of observation. Resident D was provided a new consent to treat form. All Residents have been reviewed for ancillary consent forms/services. 2. 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. All Residents have the potential to be affected by this practice.	07/07/2022

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	resident was observed to not have hearing aides in or wearing glasses. Review of the record of Resident D on 6/17/22 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, arteriosclerotic heart disease, chronic respiratory failure, dementia with behavioral disturbance, psychotic disorder, anxiety disorder, restlessness and agitation. The patient choice and right to refuse consent for Resident D, dated 2/25/21, signed by the resident's family member indicated the resident was to receive audiology and optometry services. During an interview with Resident D's family member on 6/20/22 at 2:48 p.m., indicated when the resident came to the facility he had hearing aides and glasses and both were missing. The resident had wore hearing aides for 15 years or longer and now he can't hear or see good. The family member had signed a consent for audiology and optometry but was unsure if the resident had received these services. During an interview with the Social Service Director (S.S.D.) on 6/21/22 at 10:34 a.m., indicated Resident D had not seen audiology or optometry for last year. The S.S.D. was unsure when the last time the resident received these services, but was going to schedule them for him. The vision and hearing services policy provided by the Corporate Nurse on 6/21/22 at 4:45 p.m., indicated the facility was to ensure residents were provided with vision and hearing services as needed.		2. A campus wide audit was completed to ensure all Residents have been offered ancillary services with up to date and accurate consent forms signed/recorded. 3. Pertinent facility staff have been re-educated on residents' being provided ancillary services such as audiology and optometry. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. SSD or Designee will complete a campus wide o all new admissions, and then monthly ongoing to ensure all ancillary services are provided as needed. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.	

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	3.1-39(a)(1)		2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview, observation, and record review, the facility failed to provide prevalon boot as ordered (Resident 13) and failed to turn and reposition a resident with a history of pressure injuries (Resident L) for 2 of 5 reviewed for pressure ulcer/injury. Findings include: 1. The clinical record for Resident 13 was reviewed on 6/16/2022 at 2:23 p.m. Clinical diagnoses	F 0686	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) 13 and L were identified during the time of observation. Resident L was re-assessed and care planned for positioning/turning. Resident L provided a prevalon boot for safety and comfort.	07/07/2022

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	included, but were not limited to, diabetes mellutitus and obstructive uropathy. A Significant Change Minimum Data Set dated 6/10/2022, indicated that Resident 13 was cognitively intact, needed assistance of 1 staff with dressing, and had two stage three pressure areas. A skin care plan, updated on 5/16/2022, indicated for Resident 13 to have a right padded boot in place to reduce pressure to the right foot. A physician order, dated 5/7/2022, indicated for Resident 13 to utilize a right foot padded boot when up in the wheelchair to reduce pressure to right foot. The administration record for Resident 13's padded boot was signed as being administered on 6/13/2022 and 6/20/2022. The administration record was blank for this order on 6/17/2022. A wound center note, dated 6/1/2022, indicated, " ...All pressure needs to be relived from this round - use Prevalon boots!!!!..." An observations on 6/13/2022 at 4:17 p.m. indicated Resident 13 was up in his wheelchair and did not have his right padded boot in place. An observations on 6/17/2022 at 3:12 p.m. indicated Resident 13 was up in his wheelchair and did not have his right padded boot in place. An observations on 6/20/2022 at 3:46 p.m. indicated Resident 13 was up in his wheelchair and did not have his right padded boot in place. An interview with Resident 13 on 6/17/2022 at 3:12		2. 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. All Residents with wounds have the potential to be affected by this practice. All Residents needing additional DME can be affected by this practice. 2. A campus wide audit was completed to ensure all Residents with wounds have appropriate positioning care plans and those in need of DME are provided as necessary/recommended. 3. Pertinent facility staff have been re-educated on residents' needs for additional DME. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all orders and services are provided as ordered. The plan will be revised, as warranted. 4. How the corrective	

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	p.m. indicated he does not wear his boot because his foot slides off the footrest. 2. The clinical record for Resident E was reviewed on 6/15/22 at 12:20 p.m. The diagnoses included, but were not limited to, tracheostomy status, gastrostomy status, dependence on ventilator status, Amyotrophic Lateral Sclerosis, and weakness. An Admission Minimum Data Set (MDS) assessment, dated 5/3/22, indicated Resident E was dependent on staff with extensive assistance with 2 staff for bed mobility, personal hygiene, and total assistance with 2 staff for transfers and toileting. On 6/13/22, Resident E was observed up in her wheelchair from 11:45 a.m. until 2:34 p.m. On 6/14/22, Resident E was observed lying in bed, on her back, from 10:39 a.m. until 1:45 p.m. On 6/15/22, Resident E was observed lying in bed, on her back from 10:05 a.m. until 2:18 p.m. On 6/16/22, Resident E was observed up in her wheelchair from 10:20 a.m. until 2:19 p.m. Resident E was asked if she was repositioned and/or put back in bed since she had been up in her wheelchair and she moved her head left to right to indicate "no". An interview conducted with Certified Nursing Assistant (CNA) 18, on 6/16/22 at 2:22 p.m., indicated it was a fall intervention for Resident E to be up in her wheelchair from 10:00 a.m. until mid-afternoon. The facility staff get her up after breakfast and then lay her back down around 3:00 p.m. A care plan for "risk for skin breakdown", revised		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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	6/3/22, had an intervention listed to assist with bed mobility and to turn and reposition routinely. A care plan for pressure ulcers, revised 6/8/22, had an intervention listed to assist with bed mobility and to turn and reposition routinely. A policy titled "Pressure Ulcers/Skin Breakdown", revised April 2018, was provided by the Executive Director on 6/21/22 at 10:15 a.m. The policy indicated the following, "...Assessment and Recognition...1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s)...Treatment/Management...1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings...Monitoring...1. During resident visits, the physician will evaluate and document the progress of the wound healing - especially for those with complicated, extensive, or poorly-healing wounds...2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated...." This Federal Tag relates to Complaint IN00382808. 3.1-40(a)(2)			
F 0689 SS=E 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			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to provide adequate supervision for a resident with an elopement history for 1 of 2 residents reviewed for elopement (Resident C) and failed to implement fall interventions for 3 of 5 residents reviewed for accidents (Resident 59, Resident 52 and Resident 106). Findings include: 1.) Review of the record of Resident C on 6/15/22 at 12:45 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, anxiety disorder, dementia with behavioral disturbance, schizoaffective disorder and bipolar disorder. The plan of care for Resident C, dated 1/21/22 indicated the resident was an elopement risk due to exit seeking and impaired safety awareness. The goal was the resident would not leave the facility unattended. The interventions included, ask resident if he would like to go for a walk when the weather is nice around 3:00 p.m., assess for unmet needs when wandering/exit seeking, such as needing to toilet, pain, hunger thirst. intervene as indicated, elopement risk assessment quarterly, place resident profile in elopement book and redirect resident when wandering or is exit seeking (specify successful diversional activity). The Admission Minimum Data Set (MDS) assessment for Resident C, dated 5/30/22, indicated the resident was cognitively intact for	F 0689	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) C, 59, 52, 106 were identified during the time of observation. All Residents were re-assessed and care planned for fall intervention and supervision. Resident C has discharged from the campus. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all Residents have appropriate fall interventions and care plans to ensure safety. All Residents with a wandering history have been re-assessed for supervision and safety. 3. Pertinent facility staff have been re-educated on care planning for fall interventions and supervision. 3. What measures will be put	07/07/2022

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	daily decision making. The resident was consistent and reasonable for daily decision making. The resident had behaviors of wandering 1-3 days. The resident required limited assistance of one person for ambulation on the unit corridor. The elopement risk assessment for Resident C, dated 5/30/22, indicated the resident was at risk for elopement. During an interview with Maintenance Director on 6/16/22 at 10:36 a.m., indicated it was reported to him on 6/13/22 that Resident C was out in the memory care courtyard over the weekend and the Administrator had requested for him to put magnet alarms on the door leading out to memory care courtyard. The Maintenance Director indicated from his understanding the Resident C was not supervised by staff when he was in the memory care unit courtyard. During an observation on 6/16/22 at 2:05 p.m., of the memory care unit courtyard. There were two magnet alarms on the door in the dining room that leads out to the courtyard. The courtyard was enclosed by the building and a privacy fence. During an interview and observation with Maintenance Director on 6/16/22 at 2:15 p.m., indicated it was reported to him that during shift change one day over the weekend the door to memory care unit had accidentally been left unlocked and Resident C went out in the memory care courtyard unsupervised. Observation of the courtyard there was approximately a 5 foot metal fence with a lock that led into a breeze way and then an approximately 8 foot fence with a lock that led into a parking lot and a field. During an interview with QMA 2 on 6/16/22 at		into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all care plans and supervisions are provided as necessary. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	4:16 p.m., indicated on 6/10/22 around 7:00 p.m., one of the residents said who is out in the courtyard, QMA 2 yelled for the CNA and they went to out in the memory care courtyard, Resident C was out there walking around in the grass, another resident and their family was also out there. The key to memory care courtyard was on the medication cart keys. LPN 1 did not tell the QMA 2 during shift report that a resident and family member were out in the courtyard and LPN 1 must not have locked the courtyard door when she let them out. We brought Resident C back in without incident and I reported it to another units nurse, Administrator In Training (AIT) and the Director Of Nursing (DON). The nurse on the other unit came over and completed an assessment and we did 15 minute checks on him for the rest of the night. QMA 2 did not document the incident because he did not have access to document anywhere except for medications. QMA 2 indicated nurse from the other unit that assessed the resident for injury should have documented the incident. The other resident's family member asked QMA 2 if they needed to come in on the unit and QMA 2 told them no they were fine and to knock on the door or call the unit when they were ready to come in because he did have to lock the door to the courtyard. During an interview with the Administrator, AIT and the DON on 6/17/22 at 12:45 p.m., when queried about Resident C being unsupervised and without staff's knowledge in the memory care unit courtyard on 6/10/22, the Administrator indicated the memory care courtyard was secured, the resident was out for only out there for a few minutes and was redirected by staff to come back on the unit without incident. The Director Of Nursing (DON) indicated the facility did expect staff to know Resident C's whereabouts, but the			

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	staff did not do 15 minute checks on all residents. The DON indicated the facility did expect Resident C to be supervised in the memory care courtyard and the resident was supervised by the another resident's family member that was out in the courtyard. The Administrator indicated he did have the Maintenance Director install magnet alarms on the door to the memory care courtyard on 6/13/22. The DON indicated there was no guidelines that staff had to visualize every resident during shift change with the off going nurse. The AIT indicated on 6/10/22 he was on another unit and received a text on his phone from LPN 4 that Resident C was in the memory care courtyard without staff supervision. QMA 2 got the resident from the courtyard. Another nurse (unsure of the name) from another unit came and assessed the resident and there were no injuries. Interview with LPN 1 on 6/17/22 at 1:14 p.m., indicated on 6/10/22 she was the day shift nurse and when her shift was over Resident C was in his room. LPN 1 indicated no she did not tell QMA 2 during shift report that Resident C was in the courtyard. During an interview with LPN 4 on 6/20/22 10:28 a.m., on 6/10/22 she was getting ready to leave work and she heard the vent unit nurse screaming that Resident C was in the courtyard without staff. Resident C was trying to jump over the fence and the nurse was yelling for him him to get down. There were no staff in the courtyard, there was a family member with another resident. LPN 4 could see Resident C from the vent unit window trying to climb the fence. The other nurse was screaming from the window for him to get down off the fence and then the resident jumped down and started walking to the memory care door. The memory care staff came out and got him.			

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	During an interview with the Social Service Director (S.S.D.) on 6/20/22 at 1:45 p.m., indicated Resident C had attempted to elope the facility twice in the last six months and had eloped off the facility grounds twice in the six months. The elopement policy provided by the Administrator on 6/21/22 at 10:15 a.m., "Care Team Members who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken." 2.) During an observation and interview with Resident 59 on 6/13/22 at 12:07 p.m., Resident with big black purple left eye with bandage. The resident was unable to tell say what happened. Resident 59 was walking with a walker no bright tape on walker. Review of the record of Resident 59 on 06/21/22 12:21 PM indicated the resident's diagnoses included, but were not limited to, non displaced fracture of the right humerus, dementia, anxiety and major depression. The Interdisciplinary Team (IDT) progress note for Resident 59, dated 6/9/2022 at 9:26 a.m., IDT review of resident's fall. Resident was observed by the CNA on the floor in the hallway. She was assessed by the nurse prior to moving her. She did have a small abrasion to her forehead but no other injuries or c/o pain. She was assisted up by staff. Neurological checks were initiated due to unwitnessed fall. No deficits were noted. The area on her forehead was cleansed and dressing applied. She was fully dressed and had shoes on. It was noted by nurse that she did not have her Rollator walker with her. She has had falls in the			

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	past. Prior interventions were in place. Will suggest bright colored tape on walker to help cue resident to take it with her when ambulating. She does ambulate without assistance. Care plan updated. IDT members present all. The plan of care for Resident 59, dated 4/26/22, indicated the resident was at risk for falls related to fall history and seizures. The interventions included, but were not limited to, place bright colored tape on rollator/walker to remind resident to use while ambulating (6/10/22). The fall risk assessment for Resident 59, dated 6/21/22, indicated the resident was at high risk for falls. During an interview with LPN 7 on 6/21/22 at 3:04 p.m., indicated he unsure who is responsible to implement the fall intervention of bright tape on Resident 59's rolling walker. LPN 7 indicated he was going to check with therapy. Resident 59 does not have bright tape on her rolling walker During an interview with LPN 7 on 6/21/22 at 3:25 p.m., indicated he talked with the Director Of Nursing (DON) and she said it was therapies responsibility to implement fall interventions. The LPN indicated he was working on finding therapy so they could apply the bright colored tape on Resident 59's walker. During an interview with DON on 6/21/22 at 4:00 p.m., it communicated to therapy about the fall intervention for Resident 59 in morning meeting. The DON indicated she knew it was communicated to therapy about Resident 59 bight tape to be applied to her walker. 3.) The clinical record for Resident 52 was reviewed on 6/20/22 at 10:59 a.m. The diagnoses			

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	included but were not limited to, dementia, unsteadiness on feet, anxiety disorder, and repeated falls. A Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, noted Resident 52 with severe cognitive impairment and extensive assistance with 2 staff for bed mobility, transfer, toilet use, and personal hygiene. Also, limited assistance with one staff for locomotion on unit. A fall care plan, revised 5/27/22, included, but not limited to, the following interventions: - Encourage to participate in activities, - Resident to be taken to common area in front of nurses station for supervision after dinner meal, & - Ensure chair is placed against wall near nurses' station. An observation conducted on 6/14/22 at 4:45 p.m., of Resident 52 up in her wheelchair propelling herself down the hallway and was located by the dining room. No staff were nearby, and no activities were taking place. An observation conducted on 6/15/22 at 2:48 p.m., of Resident 52 up in her wheelchair propelling herself down the hallway close to the dining room. This was on the opposite end of the unit from the nurses' station. No nursing staff was near the resident. No activities were taking place. An observation conducted on 6/16/22 at 2:25 p.m., of Resident 52 up in wheelchair and propelling self in the dining room. No staff was nearby. One nurse was located in the nurses' station and no other staff was located in the hallway. On 6/16/22 at 2:55 p.m., Resident 52 was sitting right outside of the dining room and the nurse was in the			

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	middle of the hallway with the medication cart. There were 2 Certified Nursing Assistants (CNAs) walking towards the nurses station on the other end of the unit. No activities were taking place. An observation conducted on 6/17/22 at 11:35 a.m., of Resident 52 up in her wheelchair and propelling self in and out of other residents' rooms. No activity was taking place. A fall event, dated 6/12/22, indicated Resident 52 was found on the floor in the dining room after dinner. She had a laceration to her right eye and a skin tear to the right forearm. An interdisciplinary team (IDT) note, dated 6/13/22, indicated Resident 52 went to the hospital and returned with 10 stitches to her forehead. The root cause of the fall was resident trying to get up unassisted and resulting in her falling. The intervention was to bring resident to sit in common area after meals for more observation. 4.) The clinical record for Resident 106 was reviewed on 6/14/22 at 3:52 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, conversion disorder with seizures, psychotic disorder, and dementia. A Quarterly MDS, dated 5/17/22, noted severe cognitive impairment and the need for extensive assistance with 2 staff for bed mobility, transfer, toilet use, and personal hygiene. Also, supervision with one staff for walk in room and walk in corridor. More than 2 falls were marked as had occurred. A fall care plan for Resident 106, revised 5/18/22, included, but were not limited to, the following interventions:			

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	- Assist to wear appropriate non-skid footwear, - Resident is to wear helmet when up, & - Staff to monitor resident after meals when wife leaves for increased distress. An observation conducted on 6/15/22 at 2:50 p.m., of Resident 106 walking in the hallway. He had no helmet on and no staff near the resident during him walking down the hallway towards the dining room. An observation conducted on 6/17/22 at 9:10 a.m., of Resident 106 walking in the hallway towards the dining room with a non-skid sock to the right foot and nothing to the left foot. No helmet in place and no staff were nearby. An observation conducted on 6/17/22 at 10:21 a.m., of Resident 106 sitting in a chair in the dining room with only 1 non-skid sock on and no helmet. No staff were nearby, and noted at the other end of the unit by the nurses station. An observation conducted on 6/20/22 at 9:51 a.m., of Resident 106 sitting in a chair by the nurses' station. He was not wearing a helmet. He proceeded to get up and start ambulating down the hallway without his helmet in place. An observation conducted on 6/22/22 at 9:32 a.m., of Resident 106 sitting in a chair by nurses' station. He was not wearing a helmet and was looking down at the floor. An interview conducted with the Director of Nursing (DON), on 6/21/22 at 4:35 p.m., indicated Resident 106 will refuse to wear his helmet. The fall care plan did not reflect any indication of			

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(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
	refusal of Resident 106 to wear his helmet. A policy titled "Fall Management", Original Date of October 2019, was provided by the DON on 6/17/22 at 10:00 a.m. The policy indicated the following, "...Fall Risk...2. A care plan will be developed at time of admission with specific care plan interventions to address resident's fall risk factors...Post fall...4. 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 care plan will be reviewed and updated, as necessary...." This Federal Tag relates to Complaint IN00382043. 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			

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	155491	A. BUILDING 00 B. WING	06/22/2022

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	indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview, observations, and record review, the facility failed to ensure Resident H's urinary catheter bag remained below bladder level and failed to ensure that Resident H's urinary catheter bag and tubing remined off of the floor for 1 of 3 residents review for urinary catheters. Findings include: The clinical record Resident H was reviewed on 6/15/2022 at 10:45 a.m. The clinical diagnoses included, but were not limited to, chronic obstructive pulmonary disease, neuromuscular dysfunction of the bladder, and dementia. A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicated that Resident H was mildly cognitively impaired, had an indwelling urinary catheter, and needed assistance of one staff member for bathing, hygiene, and transferring tasks.	F 0690	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) H was identified during the time of observation. Resident H was re-assessed with his Catheter bag reposition appropriately. All nursing members have been educated on positioning and placement of bags/infection control. 2. 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. All Residents with a catheter have the potential to be affected by this practice.	07/07/2022

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	A urinary catheter care plan, revised on 5/16/2022, indicated to keep the drainage bag and tubing below level of the bladder. A physician order dated 5/4/2022 indicated for Resident H to change suprapubic catheter every months and as needed. An observation on 6/15/2022 at 2:25 p.m. indicated Resident H laying in bed with her urinary catheter bad and tubing laying on the floor at the side of the bed. An interview with Resident H on 6/15/2022 at 2:25 p.m. indicated CNA 28 had assisted to back to bed and to remove her pants. An observation on 6/15/2022 at 3:05 p.m. indicated Resident H laying in bed with her urinary catheter bag and tubing laying on the floor at the side of the bed. An observation on 6/16/2022 at 3:34 p.m. indicated Resident H sitting in her wheelchair with her urinary catheter bag hanging off the arm rest. An observation on 6/17/2022 at 10:17 a.m. indicated Resident H sitting in her wheelchair with her urinary catheter bag hanging off the arm rest on her way to the dining room for an activity. CNA 11 passed Resident H in the hallway and did not correct the urinary catheter bag placement. An observation on 6/17/2022 at 10: 35 a.m. indicated Resident H sitting in her wheelchair in the dining room with her urinary catheter bag remaining to hang from the arm rest of her wheelchair. A policy entitled, "Catheter Care, Urinary", was		2. A campus wide audit was completed to ensure all Residents with a catheter had appropriate diagnosis and position of catheter bag, along with care plan. 3. Pertinent staff have been re-educated on positioning and placement of bags/infection control. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all catheters and services are provided as ordered. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.	

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	provided by the Director of Nursing on 6/21/2022 at 12:27 p.m. The policy indicated, " ... The urinary drainage bag must be held or positioned lower than the bladder at all times ...Be sure the catheter tubing and drainage bag are kept off of the floor ..." 3.1-41(a)(2)		2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure a resident's gastrostomy tube (g-tube/feeding tube) feedings were administered at the correct rate (Resident B),	F 0693	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) B and E was	07/07/2022

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	notify the physician when a gastric volume residual (GVR) was greater than 150 milliliters (mLs) (Resident E), and failed to ensure an abdominal binder was in place per physician orders (Resident B) for 2 of 3 residents reviewed for feeding tubes. Findings include: 1a. The clinical record for Resident B was reviewed on 6/17/22 at 1:09 p.m. The diagnoses included, but were not limited to, tracheostomy status, gastrostomy status, dysphagia, and cerebral infarction. A Quarterly Minimum Data Set (MDS) assessment, dated 5/29/22, indicated Resident B was dependent on staff assistance with activities of daily living. This was extensive assistance of 2 staff for bed mobility, toilet use, and personal hygiene. There was impairment to one side of the upper and lower extremity. A physician order, dated 6/7/22, was noted for continuous feeding of Glucerna 1.5 at 55 milliliters an hour. The following observations were conducted where Resident B's feeding pump was set to 70 milliliters an hour: 6/13/22 at 12:25 p.m., 6/14/22 at 1:58 p.m., 6/15/22 at 10:10 a.m., & 6/15/22 at 2:20 p.m. An interview conducted with the Director of Nursing (DON), on 6/16/22 at 3:33 p.m.., indicated the feeding pump was on the wrong setting. It was on 70 mLs and it should have been on 55		identified during the time of observation. Both Residents were re-assessed for residual, feeding rate, and abdominal binder placement/positioning. 2. 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. All Residents with a G-tube have the potential to be affected by this practice. 2. A campus wide audit of G-tubes was completed to ensure all Residents had appropriate feeding rates, residual level and binder placement. 3. Pertinent facility staff has been re-educated regarding assessing for G-tube residual, feeding rates and abdominal binder placement/positioning. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all	

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	mLs. 1b. A physician order, dated 6/7/22, indicated to utilize an abdominal binder every shift. The following observations were conducted to where Resident B did not have an abdominal binder in place: 6/15/22 at 2:20 p.m. & 6/17/22 at 9:12 a.m. A care plan for feeding tube, revised 11/23/21, indicated the interventions for tube feeding per physician orders and abdominal binder in place at all times. 2. The clinical record for Resident E was reviewed on 6/14/22 at 3:37 p.m. The diagnoses included, but were not limited to, dependence on ventilator status, Amyotrophic Lateral Sclerosis, weakness, and abnormal weight loss. A physician order, dated 4/26/22, indicated to check residual before medication pass and to notify the physician if it was greater than (>) 150 milliliters (mLs). The May 2022 electronic medication administration record (EMAR) noted the following date(s)/time(s) where Resident E's residual was documented at >150 mLs but no physician notification was noted in the clinical record: 5/2/22- days, 5/3/22- days, 5/4/22- days, & 5/11/22- days. A care plan for tube feeding, revised 6/3/22,		orders and services are provided as ordered. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	indicated the following intervention to check gastric contents/residual volume per facility protocol and record. A policy titled "Enteral Nutrition", revised November 2018, was provided by the DON on 6/17/22 at 10:00 a.m. The policy indicated the following, "...4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian...6. If the resident has a feeding tube placed prior to admission or returning to the facility, the provider and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident...12. The provider will consider the need for supplemental orders, including...g. Checks for gastric residual volume (GRV)...." This Federal Tag relates to Compliant IN00382041. 3.1-44(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview, observations, and record review, the facility failed to change Peripheral Inserted Central Catheter (PICC) dressings as ordered for 2 of 2 residents reviewed for PICC lines. (Resident G and B)	F 0694	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident(s) B and G were identified during the time of observation. Both Residents' PICC	07/07/2022

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	Findings include: 1. The clinical record for Resident G was reviewed on 6/17/2022 at 2:29 p.m. The medical diagnoses included, but were not limited to, arthropathy and orthopedic aftercare. A Quarterly Minimum Data Set, dated 6/14/2022, indicated that Resident G was cognitively intact and needed assistance of one staff for bathing and transfers. A PICC line care plan, dated 5/16/2022, indicated to provide PICC care as ordered. A physician order, dated 4/22/2022, indicated to change PICC dressing every 7 days and as needed. The administration record reflected that the PICC dressing was wanted on 5/6/2022, 5/20/2022, and 5/24/2022. The scheduled change for 5/13/2022 was left blank and on 5/27/2022 was not completed due to the as needed changed on 5/24/2022. The PICC was removed on 6/2/2022. An interview with the resident on 6/14/2022 at 3:51 p.m. indicated the staff only changed his PICC dressing about every other week. 2. The clinical record for Resident B was reviewed on 6/17/22 at 1:33 p.m. The diagnoses included, but was not limited to, cerebral infarction, acute respiratory failure, and tracheostomy ((an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe)) status. An observation was conducted of Resident B's PICC line site, on 6/14/22 at 1:58 p.m., and the dressing was dated for 6/4/22.		dressings were changed according to physician order. 2. 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. a. All Residents with a PICC line have the potential to be affected by this practice. b. A campus wide audit of PICC lines was completed to ensure all Residents had appropriate dressing in place. c. Pertinent facility staff have been re-educated regarding PICC line dressings and appropriate changing of the dressings. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all PICC line dressings in place according to physician orders. The plan will be revised, as warranted. 4. How the corrective	

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	Another observation conducted of Resident B, on 6/16/22 at 10:15 a.m., with his PICC line dressing site dated for 6/15/22. A physician order, dated 6/7/22, indicated to change the dressing to the PICC line every 7 days. The electronic treatment administration record (ETAR), for June of 2022, indicated the PICC dressing change was signed off, as administered, on 6/7/22 and 6/14/22. A policy titled "Vascular Access Management", effective date of 3/1/18, was provided by the Executive Director on 6/21/22 at 10:15 a.m. The policy indicated the following, "...2) Site care, including skin antisepsis and dressing changes, are performed at established intervals and/or immediately if the dressing integrity becomes damp, loosened, or visibly soiled, or if moisture, drainage, or blood are present under the dressing...." 3.1-47(a)(2)		action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. b. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 0695	1. What corrective action(s)	07/07/2022

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	Based on interview, observations, and record review, the facility failed to store a nebulizer in a plastic bag when not in use for 1 of 4 residents reviewed for respiratory care. (Resident 83) Findings include: The clinical record for Resident 83 was reviewed on 6/17/2022 at 11:40 a.m. The medical diagnoses included, but were not limited to, failure to thrive and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set, dated 5/13/2022, indicated that Resident 83 was cognitively intact and received respiratory therapy. A physician order, dated 5/21/2022, indicated to change the nebulizer set up weekly when in use. An observation on 6/13/2022 at 3:39 p.m. indicated an undated nebulizer set up in the top of Resident 83's bedside table. Resident 83 indicated it has been there since last month, but he only uses it when he needed it. The drawer contained personal care items and loose papers. An observation on 6/14/2022 at 2:24 p.m. indicated an undated nebulizer set up in the top of Resident 83's bedside table. An observation on 6/14/2022 at 3:10 p.m. indicated an undated nebulizer set up in the top of Resident 83's bedside table. A policy entitled "Department (Respiratory Therapy) - Prevention of Infection" was provided by the Director of Nursing on 6/20/22 at 4:05 p.m. The policy indicated, " ...Store the circuit in plastic bag, marked with date and resident's name, between uses ..."		will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) 83 was identified during the time of observation. Residents Nebulizer was stored in appropriate baggage following observation. 2. 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. All Residents with a nebulizers have the potential to be affected by this practice. 2. A campus wide audit of nebulizers was completed to ensure all Residents had appropriate storage and placement. 3. Pertinent facility staff have been re-educated on proper storage of nebulizers. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks,	

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	3.1-47(a)(6)		then monthly ongoing to ensure all storage and placements are provided as ordered. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and			

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	diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record reviewed, the facility failed to ensure staff were knowledgeable about a Peripheral Inserted Central Catheter (PICC) subcutaneous securement device prior to removal of the PICC line for 1of 2 residents reviewed for PICC lines. (Resident G) Findings include: The clinical record for Resident G was reviewed on 6/17/2022 at 2:29 p.m. The medical diagnoses included, but were not limited to, arthropathy and orthopedic aftercare. A Quarterly Minimum Data Set, dated 6/14/2022, indicated that Resident G was cognitively intact	F 0726	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident(s) G was identified during the time of observation. Resident G was re-assessed for PICC placement and removal. All Nurses educated on PICC lines, insertion/removal and positioning. 2. 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.	07/07/2022

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	155491	A. BUILDING 00 B. WING	06/22/2022

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	and needed assistance of one staff for bathing and transfers. A hospital document, dated 4/19/2022, indicated a PICC line was placed to the left brachial at a total length of 54 centimeters (cm) and the guide wire was removed. A nursing progress note, dated 6/1/2022, indicated "unable to pull picc line out. Piccline is tugged under the skin at the site with a probable metal line thread. WILL notify incoming staff suggesting NP should pull out the picc line instead ..." A nursing progress note, dated 6/1/2022, indicated " ...Picc line in place as previous nurse states she was unable to remove PICC safely. Advised administration and was told it would be removed before end of shift ..." A nursing progress note, dated 6/2/2022, indicated a clarification order to discontinue PICC line. A nursing progress note, dated 6/2/2022, indicated "Asked by Unit nurse to assist in removing PICC line to upper left arm. Assessment of PICC was noted to have the PICC line and a metal wire present. This writer had not seen a PICC line like this before. Plastic hub at insertion site was opened and PICC line was removed. Tip was in place and measured at approx. 44 cm in length from tip to hub. Metal wire remained. Attempted to remove metal wire and had severe resistance with no progress made and resident wincing with pain if wire was pulled. This writer felt uncomfortable trying to force wire d/t resistance and inexperience with this type of line. Informed unit nurse. Occlusive dressing placed		a. All Residents with a PICC line have the potential to be affected by this practice. b. A campus wide audit of PICC lines were completed to ensure all Residents had appropriate placement, orders, and care of PICC. c. Pertinent facility staff have been re-educated on PICC lines, insertion/removal and positioning. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all PICC orders and services are provided as ordered. The plan will be revised, as warranted. 4. 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. a. For quality assurance, the DHS or designee will review any	

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	back over insertion site. Unit nurse notified [Redacted Provider] ..." An Emergency Room (ER) document dated 6/2/2022, indicated that Resident G was taken with a chief complaint of foreign body in the skin. The document stated, " ...presents today with foreign object in the left upper arm ...his ECF pulled the central line. The securement device was retained. He was then sent in today as they were not able to remove the device ..." A diagram was included in the document with an area marked in the middle of the upper left arm with explanation of "a small piece of plastic embedded in the left upper arm." Under medical decision making the document stated, " ...he has a securement device in the left upper arm soft tissue ...2 cc lidocaine was instilled in the area and I was able to remove the securement device without difficulty ..." An interview with the DON on 6/16/2022 at 3:09 p.m. indicated that she was not present for this time frame and believe it was a metal guidewire that had been retained. An interview with Resident G on 6/17/2022 at 12:29 p.m. indicated that he had went to the ER earlier this month when he had his PICC line removements. He stated there was a metal piece left in his arm. When the staff at the facility removed the PICC line they didn't take out the piece that kept it in so he had to go out to get that fixed. The orange hub was removed, but the metal piece was still in his arm. The ER physician explained to him what the device was and how to remove it "typically". The area was very tender to touch, so the ER gave him "stuff to numb me up" then "popped it out". He said it has healed up since then "pretty well".		findings daily, with subsequent corrective action and education for identified staff. b. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	An interview with the DON on 6/17/2022 at 1:01 p.m. indicated she felt the removal of the securement device was education issue that did not harm the resident. An interview with LPN 8 on 6/17/2022 at 1:28 p.m., indicated she was working when the PICC line was removed. She had asked RN 26 to remove the PICC line. She remembered after it was pulled there was a piece of silver material about the size of a pen tip flush with the skin in the PICC line insertion site. She called the provider on call and Resident G was sent to the ER to be examined. She hadn't seen something like that before. No specific policy was provided for subcutaneous securement devices. 3.1-14(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide			

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure insulin pens for individual residents were properly labeled with the resident's name and instructions for usage and medications were not found loose in the medication drawers during 1 of 3 medication cart observations. Findings include: During a medication administration observation and medication cart observation on 6-21-22 at 11:50 a.m., with LPN 8, multiple insulin pens were observed in the top drawer of the medication cart. The following concerns were observed: -a Basaglar insulin pen had the last name of a current resident and the date of "6/5" handwritten on the pen. There were no instructions for use and was without a prescriber's name. -a Lispro Kwikpen was labeled with the full name of a current resident, but did not have the date opened, did not have instructions for use and was without a prescriber's name. -a Lispro Kwikpen, had the first name of a current resident and the date of "6/10" handwritten on the pen. There were no instructions for use and was without a prescriber's name. -two (2) Lispro Kwikpens were labeled with a current resident's full name was present and full use instructions were present, but did not have	F 0761	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. No Resident(s) were identified during the time of observation. All nurses have been educated on labeling/dating/storage of medications and biologicals per policy. 2. 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. All Residents receiving insulin or medications provided by the campus have the potential to be affected by this practice. 2. A campus wide audit of medication carts and labeling of such medications ie insulin has been completed to ensure that it is resident specific and identifiable. No loose pills remain. 3. Pertinent facility staff have	07/07/2022

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	the date opened. -a Lantus pen, had the first name of a current resident and the date of "6/19" handwritten on the pen. There were no instructions for use and was without a prescriber's name. -a Basaglar insulin pen did not have a resident's name present, nor any instructions for use or a prescriber's name and did not have an no open date present. During a medication medication cart observation on 6-21-22 at 11:50 a.m., with LPN 8 of the 600 hall cart, multiple medications were observed on the floors of the medication drawers. A total of 5 drawers were checked for accuracy and cleanliness. The double-locked secured or "Narcotic Drawer," did not have any loose medications present. 4 of 4 single-locked drawers had a total of over 100 loose pills and capsules present, primarily lying in the back portion of each drawer and on the floor of those drawers. These medications were given to the Director of Nursing (DON) upon completion of the audit. In an interview at this time, LPN 8 indicated she had cleaned this medication cart within the last month. On 6-22-22 at 11:35 a.m., the Director of Nursing (DON) provided a copy of a policy entitled, "Labeling of Medication." This policy had an effective date of 2-2-18. This policy indicated, "1. Medication labeling must be typed or printed and clearly indicate a. Resident/Patient full name b. Patient location in the facility c. Prescription number d. Brand name, generic name or both e. Strength of drug, if applicable f. Prescribed dose of drug/medication g. Route of administration, h. Time of administration i. Quantity of drug/medication dispensed... j. Date dispensed k.		been re-educated on labeling/dating/storage of medications and biologicals per policy. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all medications and labeling occurs per pharmacy recommendation. The plan will be revised, as warranted. 4. 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. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

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	Expiration date, if applicable (i.e. time-dated drugs) l. Prescriber/Physician name m. Name, address, and telephone number of dispensing pharmacy n. Control number, if applicable o. Any other pertinent information as may be needed or required...10. Difficult Labeling a. MedScript LTC Pharmacy will attach the medication label to the companion box, baggie, or vial for medication labels that are difficult to attach to the medication container because of size or shape b. Medication Container(s) will have a small auxiliary label attached that will contain: i. Resident/Patient name ii. Medication name (generic, brand, or both iii. Medication strength, if applicable iv. Quantity dispensed v. Prescription number vi. Date dispensed vii. Directions for use. c. After medication(s) with difficult labeling are used, they must always be returned immediately to the labeled box, baggie, or vial..." On 6-22-22 at 10:50 a.m., the DON provided a copy of a policy entitled, "Medication and Biological Storage Requirements," with an effective date of 2-1-18. This policy indicated, "The pharmacy dispenses medication(s) in containers that meet legal requirements, including the standards set forth by the United States Pharmacopeia (USP). Medications are to be kept in these containers...Medication storage areas are to be kept clean, well lit, free of clutter..." 3.1-25(b) 3.1-25(g)(1) 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6)		5. Date of Compliance: 7-7-2022	

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F 0800 SS=F Bldg. 00	3.1-25(k)(7) 483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation and record review, the facility failed to ensure food temperatures, obtained immediately prior to the meal service for lunch on 6-13-22, were within optimal levels. This deficient practice has the potential to adversely affect the 98 residents of the census of 104 residents that eat foods served from the dietary department. Findings include: During an observation with the Assistant Dietary Manager, he was observed to conduct an initial food temperature check immediately prior to the lunch service on 6-13-22 at 11:58 a.m. The following temperatures were obtained that were out of range: -noodles temped at 117 degrees Fahrenheit. -pureed peas 92 degrees Fahrenheit with a recheck temperature of 116 degrees Fahrenheit. -pureed roast beef 116 degrees Fahrenheit. The "Retail Food Establishment Sanitation Requirements," (11-13-2004) established by the Indiana State Department of Health indicated for fruits, vegetables and potentially hazardous foods not otherwise specified, such as meats, fish or eggs, the initial holding hot temperatures should be at 135 degrees Fahrenheit or above. The initial hot holding temperature of roast beef was	F 0800	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. 98 Resident(s) were identified as potentially being impacted during the time of observation. All dietary members were educated on procurement of food and temperature. 2. 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. All Residents have the potential to be affected by this practice. 2. A campus wide audit of all meals has been conducted and will continue to be conducted daily. 3. Pertinent facility staff were re-educated on procurement of food and temperature.	07/07/2022

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	indicated to be at 158 degrees Fahrenheit or above. The associated chart for beef temperatures indicated for longer holding times, the temperature levels could decrease. This information can be found at 410 IAC 7-24-182(b)(3). 3.1-21(a)(2)		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DFS or Designee will complete a temperature audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all temps and food services are provided as guidance. The plan will be revised, as warranted. 4. 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. For quality assurance, the ED or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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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: 1. Food products being held in the refrigerator for re-use were properly and legibly dated for date placed in the refrigerator and date to be used by. 2. Food products being held in the portable refrigerator unit were not placed on the floor of the unit. 3. Meat being thawed for use was not directly placed on a cardboard box containing other food substances. 4. The Dietary Manager had her hair restrained while in the kitchen area. These deficient practices have the potential to aversively affect 98 of the 104 residents of the	F 0812	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. 98 Resident(s) B were identified with potential impact during the time of observation. All dietary members were educated on food procurement, storage, handling, appropriate PPE and dates/labels. 2. How other residents having the potential to be affected by the same deficient practice will be	07/07/2022

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	facility who receive foods from the dietary department. Findings include: 1. During the initial kitchen tour on 6-13-22 at 10:32 a.m., with the Dietary Manager, the upright refrigerator in use was observed. The following concerns were observed: -There were no labels for opened or "use by" dates observed on a package of sliced American cheese, a container of cucumber salad or a container of lettuce. -Multiple cups of a dark-colored juice were present with an unknown date listed as a yellow highlighter had been used and the information was smeared. -One-half of a yellow onion was wrapped in clear wrap with the documentation for use dates smeared and illegible. -A container of cottage cheese dated 5-10-22, was present. The Dietary Manager could not identify if that was the date placed in the refrigerator or use by date. -A pitcher of tea, with the use by date 6-10-22, was present. -A half-full bottle of coke, without a resident's name or other labeling was present. -A container of 8 sandwiches, with a preparation date of 6-9-22, was present. -A container of chicken gravy, with a preparation date of 6-9-22 was present. In an interview with the Dietary Manager at this time, she indicated she has been trying to educate the staff they have to date everything when they put it in the fridge and not to use a highlighter. She indicated she had purchased labels for receipt and to use by dates. She indicated she was unsure of dated items that are legible, if those are the dates put into the fridge or to use by dates.		identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit of meal preparation and services has and will continue to be completed. DFS educated on the aforementioned areas. Additionally ED will complete walk thru rounds at random on a daily basis to audit for aforementioned areas. 3. All dietary members were educated on food procurement, storage, handling, appropriate PPE and dates/labels. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DFS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all food and services surrounding procurement and preparation are provided as expected per guideline. The plan will be revised, as warranted. 4. How the corrective	

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	She specified her kitchen's standard are to keep items for 3 days in the fridge before disposing of items. The Dietary Manager was observed to dispose of any undated or illegibly dated items. The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004) indicates any food substances prepared or held for use for more than 24 hours "shall be clearly marked to indicate the date or day by which the food shall be consumed..." This information can be found at 410 IAC 7-24-191(a). 2. During the initial kitchen tour on 6-13-22 at 10:32 a.m., with the Dietary Manager, she indicated during the previous week, the kitchen's walk-in refrigerator had some temperature problems and a portable refrigeration unit was obtained for use. During the initial observation of the portable unit, it was observed the portable unit had no type of shelving present and all food boxes were sitting on the floor of the unit. The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004), located at 410 IAC 7-24-177(a)(3), indicates food items are to be stored at least 6 inches above the floor. 3. During the initial kitchen tour on 6-13-22 at 10:32 a.m., with the Dietary Manager, of the portable refrigeration unit, two (2) plastic packages of hamburger were observed to be located directly on top of 2 of cardboard boxes. The boxes of hamburger were located on top of a metal tray on the floor. The Dietary Manager indicated the two packages of hamburger were being thawed for use for later in the day or the next day. During an observation on 6-15-22 at 9:32 a.m., with		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. For quality assurance, the ED or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	

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	the Dietary Manager of the portable refrigeration unit, the Dietary Manager indicated 2 cardboard boxes contained hamburger. The boxes were located, sitting atop a metal baking sheet with nothing between the boxes. Located directly on top of the hamburger boxes was a plastic-encased role of hamburger. The plastic-encased package was dry to touch, but the box top of the cardboard box underneath the meat had dried red material on it. The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004), indicates food items shall be protected from contamination, such as placement of a food item being thawed directly onto a cardboard box and is located at 410 IAC 7-24-204(a). 4. During kitchen observations, the Dietary Manager was observed to have her hair unrestrained while in the kitchen. On 6-15-22 at 11:14 a.m., 11:20 a.m. and 11:26 a.m., the Dietary Manager was observed with her hair hanging loose, under her hair restraint when in the actual kitchen service area. The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004), indicates, food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linen and unwrapped single-serve or single use items, found at 410 IAC 7-24-138(a)(1)(2)(3). On 6-21-22 at 4:15 p.m., the Administrator provided a copy of a policy entitled, "Food			

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	Storage." This policy indicated, "Food will be stored in manner consistent with Food Code Guidelines and protected from contamination." It indicated will be stored at least 6 inches from the floor. On 6-21-22 at 4:15 p.m., the Administrator provided a copy of a policy entitled, "Labeling and Dating." This policy indicated, "Any ready-to-eat food or prepared food will be labeled with the date opened or prepared and the date of discard..."Use by or date of discard will include the day of opening or preparation. Example: leftovers shall be used within 3 days (72 hours) with Day 1 being the date of preparation. Leftovers that were initially cooked then cooled shall be used within 3 days (72 hours) with Day 1 being the date of preparation and may be reheated only once, i.e., Lasagna, Beef & Noodles...All foods shall be used or discarded on or before any manufacturers 'use by' or 'sell by' date. All items not in their original containers will be labeled and/or easily identifiable. On 6-21-22 at 4:15 p.m., the Administrator provided a copy of a policy entitled, "Food Production." This policy indicated, "All meats will be heated through to a minimum temperature as noted below. A probe thermometer will be used to check the internal temperature. 145 [degrees] for fish, pork or beef roasts, and bacon for a minimum of 15 seconds..." On 6-21-22 at 4:15 p.m., the Administrator provided a copy of a policy entitled, "Infection Control." This policy indicated, "...Dietary staff...Hair will be restrained..." 3.1-21(a)(1) 3.1-21(a)(2)			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative			

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	proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review the facility failed to document an incident of a resident who was at risk for elopement being in the memory care courtyard unsupervised for 1 of 2 residents reviewed for elopement (Resident C). Finding include:	F 0842	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) C was identified during the time of observation. Resident assessed for injuries	07/07/2022

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	Review of the record of Resident C on 6/15/22 at 12:45 p.m., indicated the resident's diagnoses included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, anxiety disorder, dementia with behavioral disturbance, schizoaffective disorder and bipolar disorder. The elopement risk assessment for Resident C, dated 5/30/22, indicated the resident was at risk for elopement. During an interview and observation with Maintenance Director on 6/16/22 at 2:15 p.m., indicated it was reported to him that during shift change one day over the weekend the door to memory care unit had accidentally been left unlocked and Resident C went out in the memory care courtyard unsupervised. During an interview with QMA 2 on 6/16/22 at 4:16 p.m., indicated on 6/10/22 around 7:00 p.m., one of the residents said who is out in the courtyard, QMA 2 yelled for the CNA and they went to out in the memory care courtyard, Resident C was out there walking around in the grass, another resident and their family was also out there. The key to memory care courtyard was on the medication cart keys. LPN 1 did not tell the QMA 2 during shift report that a resident and family member were out in the courtyard and LPN 1 must not have locked the courtyard door when she let them out. We brought Resident C back in without incident and I reported it to another units nurse, Administrator In Training (AIT) and the Director Of Nursing (DON). The nurse on the other unit came over and completed an assessment and we did 15 minute checks on him for the rest of the night. QMA 2 did not document		with care plan reviewed. 2. 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. All Residents residing on the memory care unit have the potential to be affected by this practice. 2. Secured courtyard was reviewed for locking/latching mechanisms and deemed appropriate. 3. Pertinent facility staff have been re-educated on documentation of events needing staff intervention. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. ED or Designee will complete an audit on door locks, latches and systems at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all doors are secured and latching as should be. The plan will be revised, as warranted.	

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	the incident because he did not have access to document anywhere except for medications. QMA 2 indicated nurse from the other unit that assessed the resident for injury should have documented the incident. During an interview with the Administrator, AIT and the DON on 6/17/22 at 12:45 p.m., when queried about Resident C being unsupervised and without staff's knowledge in the memory care unit courtyard on 6/10/22, the Administrator indicated the memory care courtyard was secured, the resident was out for only out there for a few minutes and was redirected by staff to come back on the unit without incident. The Director Of Nursing (DON) indicated the facility would expect the incident to be documented and verified there was no documentation of the incident in Resident C's record. The charting and documentation policy provided by the Administrator on 6/20/22 at 11:30 a.m., indicated all services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Entries may only be recorded in the resident's medical record by licensed personnel. This Federal Tag relates to Complaint IN00382043. 3.1-50(a)(1)		4. 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. For quality assurance, the ED or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during medication administration by touching medications with bare hands (Resident M and Resident N) and not performing hand hygiene after performing tracheostomy suctioning (Resident B). Findings include: 1. An observation was conducted with Licensed	F 0880	Immediate 1. 2 Residents were identified in this practice. All Residents have the potential to be effected by this practice.2. All staff members were educated on proper infection control practices, including handwashing and infection control protocol related to ice, water and storage of equipment.2. Systemic1. All residents have the potential to be affected by the alleged deficient	07/07/2022

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	Practical Nurse (LPN) 19, on 6/15/22 at 2:23 p.m. She removed Resident B's blanket and pulled up his gown to observe his feeding tube site. The ventilator alarm was sounding, and LPN 9 kept the same glove to her right hand and proceeded to perform suctioning to Resident B's tracheostomy. She finished the procedure and covered Resident B up. She then exited the room with the glove still in place to her right hand and didn't perform hand hygiene. A call light was sounding for Resident L, and she proceeded to enter Resident L's room with the glove still in place to her right hand. 2. An observation was conducted of medication administration with LPN 19. She was preparing medications for Resident N on 6/17/22 at 9:13 a.m. She prepared a total of 4 pills and proceeded to touch all 4 pills with her bare hands and then placed each pill in the medication cup. The medications were administered to Resident N and taken with water. No hand hygiene was performed after giving Resident N her medications. LPN 19 went back to the medication cart to unlock the cart for preparation of medications for Resident M. She touched the outside of her mask prior to preparing the medications for Resident M and didn't perform hand hygiene after touching her mask. She prepared 14 pills for Resident M and touched each pill with her bare hands. She then took the medications into Resident M's room to administer them with water. After LPN 19 finished administering medications to Resident M she didn't perform hand hygiene and used her bare hands to pick up a piece of dry toast and fed a couple bites to Resident M, on 6/17/22 at 10:15 a.m. A policy titled "Handwashing/Hand Hygiene", revised August 2019, was provided by the Director of Nursing on 6/17/22 at 10:00 a.m. The		practice.2. LTC infection control self-assessment reviewed by QA team including Medical Director, Infection Preventionist Consultant, DHS, ED and Campus Infection Preventionist.3. DHS/designee will complete daily audits and rounding to ensure all staff are following protocol and guideline. Audits will be conducted five times weekly X 4 weeks, then twice weekly X 4 weeks, then weekly X 4 weeks, then monthly ongoing.3. Training1. DHS/designee will conduct an in-service for all staff on infection control practices and protocol including handwashing and infection control protocol related to passing of ice, water and storage of equipment4. Monitoring1. DHS/designee will complete daily rounding to ensure proper storage, hand hygiene protocol and infection control procedures are communicated effectively, staff have complete understanding of infection control practices including a complete return demonstration with staff as needed and ensure through visual rounding that staff are complying with all infection control measures to encompass all shifts times 6 weeks and until compliance is maintained.2. DHS/designee will be responsible for the completion of Infection Prevention QA tool weekly times 4 weeks, bi-monthly times 2 months,	

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	policy indicated the following, "...7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations...b. Before and after direct contact with residents...c. Before preparing and handling medications...e. Before and after handling an invasive device...i. After contact with a resident's intact skin...p. Before and after assisting a resident with meals...." 3.1-18(l)		monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed.5. Date of Compliance: 7-7-2022	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to ensure a resident met criteria for the continued use on an antibiotic for prophylaxis for 1 of 5 residents reviewed for unnecessary medications. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed on 6/20/22 at 2:24 p.m. The diagnoses included, but were not limited to, dementia, pain, anemia, and retention of urine. A physician order, start date of 4/11/21, was noted	F 0881	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) 52 was identified during the time of observation. Resident was re-assessed for continued use of an antibiotic for prophylaxis. 2. 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.	07/07/2022

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	for cephalexin tablet 250 milligrams daily for infection. There was no care plan for the prophylactic use of the antibiotic or indication for the specific usage. An interview conducted with the Infection Preventionist, on 6/21/22 at 4:24 p.m., indicated Resident 52 didn't appear to meet criteria for the continued use of the antibiotic. A policy titled "Antibiotic Stewardship", revised December 2016, was provided by the Director of Nursing on 6/17/22 at 10:00 a.m. The policy indicated the following, "...1. The purpose of our Antibiotic Stewardship program is to monitor the use of antibiotics in our residents...4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements...d. Duration of treatment...f. Indications for use...."		1. All Residents receiving antibiotics have the potential to be affected by this practice. 2. A campus wide audit of all residents receiving antibiotics was completed to ensure all Residents on antibiotics are in accordance to the antibiotic stewardship program regulations. 3. Pertinent facility staff were re-educated regarding use of antibiotics according to the antibiotic stewardship program regulations. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all orders and services are provided as ordered. The plan will be revised, as warranted. 4. 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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			1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	
F 0926 SS=D Bldg. 00	483.90(i)(5) Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. Based on interview and record review, the facility failed to implement their policy by not completing quarterly smoking assessments for 3 of 3 residents reviewed for smoking. (Resident H, 5, and 80) Findings include: 1. The clinical record Resident H was reviewed on 6/15/2022 at 10:45 a.m. The medical diagnoses included, but were not limited to, choric obstructive pulmonary disease, neuromuscular dysfunction of the bladder, and dementia.	F 0926	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Resident(s) H, 5, 80 were identified during the time of observation. All 3 residents have had an updated smoking assessment completed. 2. 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.	07/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicated that Resident H was mildly cognitively impaired and needed assistance of one staff member for transferring tasks. Resident H did not have a smoking care plan. Resident H had safe smoking reviews completed on 8/21/2021 and 6/15/2022. 2. The clinical record for Resident 5 was reviewed on 6/17/2022 at 10:55 a.m. The medical diagnoses included, but were not limited to, cerebral infarct and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set Assessment, dated 5/27/2022, indicated that Resident 5 was cognitively intact and needed assistance of one staff member for transferring tasks. A smoking care plan, dated 10/29/2019, indicated Resident 5 was a supervised smoker with an intervention to complete smoking assessments quarterly and as needed. Resident 5 had safe smoking reviews completed on 5/3/2021 and 6/3/2022. 3. The clinical record for Resident 80 was reviewed on 6/17/2022 at 12:08 p.m. The medical diagnoses included, but were not limited to, chronic obstructive pulmonary disease and muscle weakness. A Quarterly Minimum Data Set Assessment, dated 5/11/2022, indicated that Resident 80 was cognitively intact and needed assistance of one staff member for transferring tasks. A smoking care plan, dated 11/15/2019, indicated		a. All Residents that smoke have the potential to be affected by this practice. b. A campus wide audit of all residents that smoke was completed to ensure all Residents had an updated smoking assessment. c. Pertinent facility staff were re-educated on updating resident smoking assessments. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. SSD, Memory Care Facilitator or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all orders and services are provided as ordered. The plan will be revised, as warranted. 4. 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. a. For quality assurance, the	

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	Resident 80 was a supervised smoker with an intervention to complete smoking assessments quarterly and as needed. Resident 80 had safe smoking reviewed completed on 5/3/2021, 6/2/2022, and 6/16/2022. An interview with the Clinical Regional Support nurse on 6/22/2022 at 11:18 a.m., indicated residents that smoke will be added to quarterly review. A policy entitled, "Smoking", was provided by the Director of Nursing on 6/16/2022 at 3:41 p.m. The policy indicated, " ...Each resident who smokes must have a smoking assessment completed upon admission, quarterly, and with a significant change in condition ..."		DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. b. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 7-7-2022	