| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155850 | A. BUILDING 00<br>B. WING | 08/18/2022 |

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| BELLTOWER HEALTH & REHABILITATION CENTER | 5805 NORTH FIR ROAD<br>GRANGER, IN 46530 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00382390.<br><br>Complaint IN00382390- Substantiated. Federal deficiencies related to the allegations are cited at F657and F677.<br><br>Survey dates: August 11, 12, 15, 16, 17 & 18, 2022<br><br>Facility number: 013644<br>Provider number: 155850<br>AIM number: 201381180<br><br>Census Bed Type:<br>SNF/NF: 85<br>Total: 85<br><br>Census Payor Type:<br>Medicare: 16<br>Medicaid: 54<br>Other: 15<br>Total: 85<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 8/25/22. | F 0000 | | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. | | | |

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

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| | §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation, record review and interview, the facility failed to refrain from demeaning practices by leaving a urinary catheter bag uncovered for 2 of 3 residents reviewed for urinary catheters. (Resident 60 and B) | F 0550 | 1. Resident 60 & B has been provided a dignity cover to ensure residents rights and privacy are maintained. There was no negative outcome related to the alleged | 09/23/2022 |

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| | Findings include:<br><br>1. A clinical record review was completed on 8/15/2022 at 11:18 A.M. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), hemiplegia, neurogenic bladder and obstructive uropathy.<br><br>A Quarterly Minimum Data Set (MDS) Assessment, completed on 7/6/2022, indicated Resident 60 was cognitively intact. The MDS indicated Resident 60 had an indwelling catheter (suprapubic catheter).<br><br>A Care Plan, dated 4/24/2022, indicated, " ... [Resident name] is at risk for infection r/t [related to] Foley catheter d/t [due to] retention ...." According to the care plan, Foley catheter care was to occur every shift.<br><br>During an observation, on 8/15/2022 at 3:02 P.M., the catheter drainage bag was hanging on the bed frame. The drainage bag could be seen from the hallway with the drainage bag full of dark yellow urine. The dignity cover did not cover the drainage bag.<br><br>On 8/16/2022 at 9:15 A.M., the catheter drainage bag was hanging on the bed frame. The drainage bag was seen from the hallway. The dignity cover did not cover the drainage bag, and dark yellow urine could be seen from the hallway.<br><br>On 8/16/2022 at 11:13 A.M., the catheter drainage bag was emptied with a small amount of dark yellow urine noted in the bottom of the drainage bag. The dignity cover did not cover the drainage bag, and dark yellow urine could be seen from the hallway. | | deficient practice.<br>2. Residents residing at the facility that have a urinary catheter will be provided a dignity bag to ensure resident rights are maintained.<br>3. Facility staff will be educated by the Director of Clinical education on Resident Rights with an emphasis on Dignity coverings for residents with a catheter in place.<br>· Nursing Administration will round 5x per week to ensure dignity bags are in place and if any violation is found it will be immediately corrected.<br>4. Catheter Covering Audit tools will be forwarded to QAPI for review. Results of those audits will be reviewed by the QAPI committee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | During an interview on 8/16/2022 at 1:58 P.M., CNA 3 indicated the Foley drainage bag should be covered for dignity. CNA 3 observed the drainage bag, and again, indicated the drainage bag should be covered for dignity, but indicated Resident 60 moved around in bed frequently. CNA 3 was informed the drainage bag had been emptied during the shift, and the position of the drainage bag did not move. CNA 3 indicated, "Well, that's on us."2. During a random observation, on 8/12/2022 at 9:41 A.M., Resident B's urinary catheter drainage bag was uncovered with visible urine in the bag.<br><br>A clinical record review was completed on, 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, lymphedema, anxiety and retention of urine.<br><br>A Significant Change MDS ( Minimum Data Set) assessment, dated 7/5/2022, indicated Resident B was cognitively intact and used a Foley catheter.<br><br>During an observation, on 8/16/2022 at 11:05 A.M., Resident B's urinary drainage bag was not covered with visible urine.<br><br>During an observation, on 8/16/2022 at 2:48 P.M., Resident B's urinary drainage bag was not covered with visible urine.<br><br>During an observation, no 8/17/2022 at 7:40 A.M., Resident B's urinary drainage bag was not covered with visible urine.<br><br>During an observation, on 8/17/2022 at 11:45 A.M., Resident B's urinary drainage bag was not covered with visible urine. | | | |

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| | During an interview, on 8/17/2022 at 11:46 A.M., CNA 10 indicated the drainage bag should have been covered.<br><br>On 8/16/2022 at 3:04 P.M., a policy was requested for Foley catheter care. The Administrator provided the policy titled, "Catheter-Urinary Catheter, Changing". The policy did not address the covering the drainage bag for dignity.<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided the policy titled," Patient/Resident Rights", dated 10/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...The Facility employs measures to ensure patient and resident personal dignity, well-being, and self-determination are maintained and will educate patients and residents regarding their rights and responsibilities. ...The Facility treats each resident with respect and dignity...."<br><br>On 8/16/2022 at 3:04 P.M., a policy was requested for Foley catheter care. The Administrator provided the policy titled, "Catheter-Urinary Catheter, Changing". The policy did not address the covering the drainage bag for dignity.<br><br>3.1-3(t) | | | |
| F 0580 SS=D Bldg. 00 | 483.10(g)(14)(i)-(iv)(15)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for | | | |

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| | requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to | | | |

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| | room changes between its different locations under §483.15(c)(9).<br>Based on record review, observation and interview, the facility failed to notify the physician of a significant weight loss for 1 of 4 Residents reviewed for weight loss.<br><br>Finding includes:<br><br>A clinical record review was completed, on 8/15/2022 at 11:10 A.M. Resident 65 was admitted on 7/6/22. Diagnoses included, but were not limited to: urinary tract infection, encephalopathy, moderate protein-calorie malnutrition, diabetes mellitus and hypertension.<br><br>A MDS (Minimum Data Set) assessment, dated 7/13/2022, indicated Resident 65 had a BIMS (Brief Interview for Mental Status) score of 6, which indicated severe cognitive impairment.<br><br>On 7/13/22 a careplan was initiated for Nutrition problem as evidenced by a diagnosis of protein calorie malnutrition. Interventions included: assist with meals, monitor diet acceptance, monitor lab results, order for Regular diet and weekly weights.<br><br>Admission weight on 7/7/2022 was documented at 183.8.<br>7/8/2022 -- 184.2<br>7/9/2022 -- 185.2<br>7/12/2022 -- 184.7<br>7/22/2022 -- 181.2<br>8/10/2022 -- 166.4<br><br>Resident 65 had a (9.47%) weight loss x 30 days.<br><br>On 8/15/2022 at 1:27 P.M., the Director of Nursing stated Resident 65 had a weight loss and was not sure if the Physician was notified. The Director of | F 0580 | 1. The Physician for resident 65 has been notified of the significant weight loss. Resident 65 has since discharged from facility following a successful rehabilitation stay. There was no negative outcome related to the alleged deficient practice.<br>2. Resident residing at the facility with active weight loss will have physician notification as well as registered dietitian. Residents will be weighed according to the facility weight schedule.<br>3. Licensed Nursing staff have been educated by the Director of Clinical Education on the requirements surrounding Notification of Changes by 9.23.22. Nursing Administration will monitor and track resident weights and will forward to Physician and facility Dietitian for further interventions if needed.<br>· Nursing Administration will audit weights on a weekly and monthly basis.<br>4. Resident weight monitoring will be forwarded to QAPI for review. Results of those audits will be reviewed by the QAPI committee monthly for a period of 12 months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | 09/23/2022 |

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| | nursing also indicated the Unit Manager is responsible for monitoring weights and notifying the Physician and Dietician of changes.<br><br>Review of nurses notes dated 8/10/2022 -8/14/2022 lacked documentation to show the physician was notified of significant weight loss.<br><br>3.1-5(a)(2) | | | |
| F 0636<br>SS=D<br>Bldg. 00 | 483.20(b)(1)(2)(i)(iii)<br>Comprehensive Assessments & Timing<br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions. | | | |

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| | (xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months. | | | |
| | Based on observation, record review and interviews, the facility failed to ensure a thorough assessment for bowel and bladder incontinence was completed for 2 of 2 residents reviewed for incontinence. (Resident 48 and 131)<br><br>Findings include: | F 0636 | 1. Resident 65 & 131 have had an updated Bowel& Bladder Assessment completed. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and that are incontinent of Bowel & Bladder have the | 09/23/2022 |

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| | 1. During the initial tour of the facility, conducted on 8/11/2022 between 10:30 A.M. - 11:15 A.M., Resident 48 was observed lying on a bare mattress in his room sleeping. There were soiled linens and clothing piled on the floor in his room.<br><br>On 8/15/2022 at 9:08 A.M., Resident 48 was observed sleeping in his bed without wearing his pants. He had an incontinence pull up style brief on and had been incontinent of bowel. He remained in bed without any toileting assistance from 9:08 A.M. - 10:15 A.M., when he was assisted by staff. During an interview with CNA 20, she indicated the resident "strips" his bed and places the bedding on the floor.<br><br>On 8/16/2022 at 9:45 A.M., Resident 48 was observed lying in bed with pajama pants on and outside, cargo style pants and a belt, wrapped around his ankles. He remained in his bed in the same position until 8/16//2022 when a nursing staff member obtained his blood sugar. He was not assisted to the toilet and/or assisting with his dressing at the time his blood sugar was obtained. At 10:52 A.M., CNA 20 removed the resident's outside cargo pants from around his ankles, but did not assist the resident to the toilet. At 11:58 A.M., Resident 48 was observed walking around his room, naked from the waist down. His wet, pajama pants were noted draped over his recliner. He was observed to obtain a clean pull up brief from a cupboard in his room and put the brief on. Next, he ambulated to the bathroom and was observed stuffing a long portion of toilet paper into his pull up brief. He then walked back to his bed and sat down and was in the process of putting his cargo pants and belt on, when CNA 6 walked into his room and told him she was going to go get him a clean pair of socks. | | potential to be affected. Resident assessments will be reviewed by nursing administration to ensure assessments have been maintained, any assessment found out of compliance will be completed immediately.<br>3. Licensed Nursing staff have been educated by the Director of Clinical Education on the requirement as it relates to assessment schedules and the completion of the assessment thereof.<br>· Nursing administration will audit assessments that are due on a weekly basis. Any incomplete assessments will be addressed with the licensed nurse assigned.<br>4. Scheduled Assessment audits will be forwarded to QAPI for review. Results of those audits will be presented by the DON and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | Review of the most recent MDS (Minimum Data Set) assessment, completed 6/28/2022 for quarterly review, indicated the resident was moderately cognitively impaired, was frequently incontinent of his bowels and bladder and required one person limited assistance for toileting and personal hygiene needs.<br><br>The most recent bowel and bladder assessment was completed on 2/3/2020 and indicated the resident was continent of his bowels and bladder.<br><br>The most recent care plan related to incontinence for Resident 48 indicated the following: "Problem: [resident name] is at risk for skin breakdown related to frequent bowel and bladder incontinence."<br><br>During an interview with the Director of Nursing on 8/18/2022 at 11:32 A.M., she indicated she would have expected the bowel and bladder assessments to be current with the resident's MDS assessment and any significant changes completed as appropriate. The corporate staff member responsible for the MDS process was not available for interview on 8/18/2022.<br><br>2. During an interview with alert and oriented Resident 131, conducted on 8/12/2022 at 9:41 A.M., she indicated she was not routinely toileted. She indicated she had to request to be toileted and changed. She indicated she had very little control over her bladder and often sat in wet briefs for over an hour waiting on assistance to toilet.<br><br>The clinical record for Resident 131 was reviewed on 8/12/2022 at 3:00 P.M. Resident 131 was admitted to the facility with diagnoses, including but not limited to: constipation, chronic | | | |

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| | obstructive pulmonary disease, muscle weakness, history of falling, dependence on supplemental oxygen and diastolic heart failure.<br><br>The most recent MDS assessment, completed on 8/5/2022 indicated the resident was occasionally incontinent of bladder and required limited staff assistance of one staff for toileting and personal hygiene needs.<br><br>The current care plan for toileting indicated the resident required limited assistance of one staff for toileting, the use of underpads and brief were indicated and check every 2 hours and change as needed for soilage were interventions on the care plan.<br><br>Review of the most recent bladder incontinence assessment, completed on 3/29/2022 for Resident 131 indicated the resident was not continent of her bladder, experienced urine leakage on the way to the bathroom and had nocturnal bedwetting issues. The portion of the form to determine what type of urine incontinence and what individualized toileting plan would be optimal for the resident was left blank.<br><br>During an interview on 8/15/2022 at 1:20 P.M., with the part- time MDS nurse, LPN 12 indicated it appeared the bladder incontinence assessment was only partially completed. She indicated the bowel incontinence assessment indicated the resident was continent of her bowels so no further assessment was required.<br><br>During an interview with the Director of Nursing, on 8/18/22 at 11:44 A.M., she indicated she would expect a bowel and bladder assessment to be completed and match the MDS assessment and be | | | |

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| | updated with any specific significant change in status.<br><br>The facility policy and procedure regarding bowel and bladder assessments was requested on 8/18/2022 at 11:32 A.M.<br><br>On 8/18/2022 at 3:40 P.M., the Director of Nursing indicated she could not locate the facility's policy regarding completing bowel and bladder assessments.<br><br>3.1-31(d) | | | |
| F 0637 SS=D Bldg. 00 | 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg<br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>Based on record review and interview, the facility failed to complete a significant change MDS (Minimum Data Set) assessment for a resident following the initiation of hospice care for 1 of 23 residents whose MDS's were reviewed. (Resident 281)<br><br>Finding includes: | F 0637 | 1. Resident 281 has had the significant change MDS completed as identified. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected. Residents with significant changes that meet criteria | 09/23/2022 |

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| | A clinical record review was completed, on 8/17/2022 at 9:03 A.M. Resident 281's diagnoses included, but were not limited to: hearing loss, benign prostatic hyperplasia, dysphasia, hypothyroidism, and metabolic encephalopathy.<br><br>A Progress Note, dated 3/28/2022 at 3:48 P.M., initiated by the Social Worker, indicated the Resident will stay in the facility for long term care and to refer to [name of hospice] for services when therapy ends.<br><br>A Physician Order, dated 4/5/2022, indicated that he was enrolled with [name of hospice] services.<br><br>During an interview, on 8/17/2022 at 10:49 A.M., the Case Mix Director indicated a Significant Change assessment was not done when he enrolled in Hospice and it should have been completed.<br><br>A policy was requested and the MDS staff indicated the facility refers to the RAI manual.<br><br>Long-Term Care Facility Resident Assessment Instrument 3.0 User's<br>Manual, Version 1.17.1, October 2019.<br><br>"The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT ' s determination was made that the resident had a significant change."<br><br>"If a nursing home resident elects the hospice | | according to the RAI manual will have a significant change MDS scheduled and completed.<br>3. MDS nurse will be educated by the Corporate MDS Nurse on the requirements of scheduling Significant Change MDS by 9.23.22. The MDS schedule will be brought to the daily clinical meeting for review and changes identified will be forwarded to the Interdisciplinary team for completion.<br>4. MDS calendars and Schedules will be forwarded to QAPI for review. Results of the schedules will be presented by the acting MDS nurse monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA)."<br><br>3.1-31(d)(1) | | | |
| F 0641<br>SS=D<br>Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on record review and interview, the facility failed to accurately complete an MDS (Minimum Data Set) assessment for the use of psychotropic medications and for the development of a stage II pressure ulcer in 2 of 25 residents whose MDS assessments were reviewed. (Resident 13 and 281)<br><br>Findings include:<br><br>1. A clinical record review was completed on 8/15/2022 at 9:47 A.M. Resident 13's diagnoses included, but were not limited to: dementia, delusional disorder, depression, anxiety and psychotic disorder.<br><br>Resident 13's medication orders, initiated at admission, included: Lorazepam (anti anxiety) 0.25 mg (milligrams) daily, Risperidone (antipsychotic) 0.125 mg daily and Sertraline (antidepressant) 100 mg daily.<br><br>An Admission MDS ( Minimum Data Set) assessment, dated 2/7/2022, indicated under section N for (Medications), the following was documented. N0410 Medications Received: Indicate the number of days the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. A. Antipsychotics = 7. C. Antidepressants | F 0641 | 1. Resident 13 has had the antipsychotic use added to the current MDS. Resident 281 does not presently have a Stg II pressure sore so therefore corrections can not be made. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected. MDS nurse will review MDS submitted for accuracy.<br>3. MDS nurse will be educated on the expectation as it relates to accuracy by the corporate MDS Nurse Consultant by 9.23.22<br>4. MDS calendars and schedules will be forwarded to QAPI for review. Results of the schedules will be presented by the acting MDS nurse monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | 09/23/2022 |

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| | =7. N0450- Antipsychotic Medication Review. A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? No- Antipsychotics were not received was checked.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 5/5/2022, indicated under section N for (Medications), the following was documented. N0410 Medications Received: Indicate the number of days the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. A. Antipsychotics = 7. C. Antidepressants =7. N0450- Antipsychotic Medication Review. A Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? No- Antipsychotics were not received was checked.<br><br>During an interview, on 8/15/2022 at 1:25 P.M., MDS RN 12 indicated it was an error and both MDS assessments were not completed accurately and should have been corrected.<br><br>On 8/15/2022 at 1:26 P.M., a policy was requested. RN 12 indicated the facility uses the RAI manual.<br>2. A clinical record review was completed, on 8/17/2022 at 9:03 A.M., and indicated Resident 281's diagnoses included, but were not limited to: hearing loss, benign prostatic hyperplasia, dysphasia, hypothyroidism, and metabolic encephalopathy. The record indicated the resident was admitted on 2/25/2022.<br><br>An Admission Observation, dated 2/25/2022, indicated Resident 281 had a stage II to the left heel measuring 6 x 5 cm (centimeters). | | | |

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The wound detail report dated 2/25/2022, indicated the wound type: pressure ulcer, left heel, present on admission, measured 6 x 5 cm with light exudate, serous in color and consistency, no odor, undermining or tunneling, with irregular edges, surrounding tissue pink/normal.

An Admission MDS (Minimum Data Set) assessment, dated 3/3/2022, section M indicated that there were no pressure ulcers.

During an interview, on 8/17/2022 at 1:58 P.M., the Case Mix MDS Director indicated the Admission assessment on 3/3/2022 did not capture the stage II pressure area to the left heel and should have.

They do not have a policy but follow the Resident Assessment Instrument.

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019.

"The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident."
"Code 0, no: if antipsychotics were not received
o Code 1, yes: if antipsychotics were received on a routine basis only:"

"In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the

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| | quality of life and quality of care of residents receiving these medications. "<br><br>"For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.<br>1. Review the medical record for the history of the ulcer/injury.<br>2. Review for location and stage at the time of admission/entry or reentry." | | | |
| F 0655<br>SS=D<br>Bldg. 00 | 483.21(a)(1)-(3)<br>Baseline Care Plan<br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the | | | |

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| | baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>Based on record review, observation and interview, the facility failed to develop a baseline care plan for nutrition for 1 of 11 residents whose baseline careplans were reviewed. (Resident 65)<br><br>Finding includes:<br><br>A clinical record review was completed, on 8/15/2022 at 11:10 A.M. Resident 65 was admitted on 7/6/22. Her current diagnoses included, but were not limited to: urinary tract infection, encephalopathy, moderate protein-calorie malnutrition, diabetes mellitus and hypertension.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 7/13/202, indicated Resident 65 had a BIMS ( Brief Interview for Mental Status) score of 6, indicating severe cognitive impairment. | F 0655 | 1. Resident 65 had a baseline care plan in place and was dated for 7.6.22. Resident 65 admitted on 7.6.22 with a baseline care plan initiated. The 7.13.22 care plan was part of the comprehensive care plan within the 21-day requirement. Resident 65 discharged from the facility following a successful rehab stay. There was no negative outcome related to the alleged deficient practice.<br>2. Newly admitted residents have the potential to be affected by the alleged deficient practice. Newly admitted resident will have the base line care plan initiated within 48-hours of admission as | 09/23/2022 |

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| | A baseline nutrition careplan was initiated on 7/13/2022 and indicated Resident 65 had a nutrition problem as evidenced by a diagnosis of protein calorie malnutrition.<br><br>During an interview, on 8/15/22 at 1:27 P.M., the Director of Nursing indicated the baseline careplan was initiated on 7/13/2022 and it was late and should have been done.<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided the policy titled, "Person Centered Care Plan Process", dated 10/19/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Develop and implement the baseline care plan within 48 hours of a resident's admission. 2. The baseline care plan will include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, resident goals, physician orders, dietary orders, therapy services, social services, and PASAR recommendation...." | | required.<br>3. Licensed Nursing staff will be educated on the regulation as it relates to initiating baseline care plans by the Director of Clinical Education.<br>· Nursing administration will perform admission assessment reviews with an emphasis on completed baseline care plans moving forward.<br>4. Care plan audits will be performed by Nursing Administration. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 8.23.22 | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest | | | |

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| | practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>Based on obervation, record review and interviews, the facility failed to ensure care plans were developed and implemented regarding identified needs for 4 of 24 sampled residents. (Residents 10, 37, B and 60)<br><br>Findings includes:<br><br>1. During the initial tour of the facility, conducted on 8/11/2022 at 11:15 A.M., Resident 10 was observed awake, lying in his bed. The resident's | F 0656 | 1. Resident 10 has had the care plan initiated that addressed the hearing impairment. Resident 37 has had a care plan initiated to address her need for teeth brushing. Resident B was not identified however facility knew who resident B is. Resident B has had the care plan for the catheter updated with additional interventions put into place. | 09/23/2022 |

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| | television was noted to be blaring at a high volume. After placing his television on the "Mute" mode, Resident 10 was not able to easily hear verbal communication. The resident indicated he could not hear and needed "drops" in his ears.<br><br>During an interview with Resident 10, conducted on 8/12/2022 at 9:45 A.M., CNA 20 was observed attempting to communicate verbally with Resident 10. She was noted to pull her facial mask down so Resident 10 could read her lips. During an interview with CNA 20, she confirmed Resident 10 was very hard of hearing.<br><br>The clinical record for Resident 10 was reviewed on 8/12/2022 at 2:30 P.M. The most recent quarterly Minimum Data Set (MDS) assessment for Resident 10, completed on 8/5/2022 , indicated he was alert and oriented, had moderate difficulty with hearing, did not have a hearing aide or device, was had clear comprehension of verbal communication.<br><br>Review of the current health care plans for Resident 10 indicated there was no plan to address communication and/or hearing needs.<br><br>During an interview with the Social Services Director, on 8/17/2022 at 11:30 A.M., she indicated the resident was scheduled to see the in house audiology services in August or September 2022. She did not comment on why there was no care plan developed to address the resident's hearing and communication difficulties.<br>2. During an interview, on 8/11/2022 at 3:12 P.M., Resident 37 indicated she had to ask the staff to brush her teeth.<br><br>A clinical record review was completed on | | Resident 60 has had the care plan updated to include need for contracture management. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. Resident care plans will be reviewed according to the MDS schedule and modified as needed.<br>3. Interdisciplinary Team will be educated by the Director of Clinical Education on the requirement as it relates to care plan updating with an emphasis of care planning special needs of residents. This education will be completed by 9.23.22<br>4. Care Plan audits will be conducted monthly and forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | 8/15/2022 at 2:35 P.M. Resident 37's diagnoses included, but were not limited to: cancer, diabetes, depression, lymphoma and urine retention.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 6/6/2022, indicated Resident 37 was oriented and cognitively intact and required extensive asssit of 1 staff for bed mobility, dressing, toilet use and personal hygiene.<br><br>Resident 37's current care plans lacked a care plan for assistance needed to complete any type of adl's (activities of daily living).<br><br>During an interview, on 8/18/2022 at 10:47 A.M., CNA 15 indicated she brushes the residents teeth every day, but is not assigned the resident every day.<br><br>During an interview, on 8/18/2022 at 2:28 P.M., the Director of Nursing indicated if the resident required assistance then there should have been a care plan.<br><br>3. During an observation, on 8/12/2022 at 9:41 A.M, Resident B was observed to have a urinary catheter with the drainage bag uncovered.<br><br>A clinical record review was completed on 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, pain, lymphedema, depressive disorder, osteoarthritis of both knees, pressure ulcer stage II left thigh, and retention of urine.<br><br>Physican orders for Resident B included: Oxybutynin 5 mg (milligram) twice a day. Change Foley catheter 16 F every 1st day of the month. Catheter leg strap in place to secure catheter and | | | |

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| | facilitate flow of urine. Change Foley drainage bag every week.<br><br>A Bladder Observation form, dated 6/16/2022. indicated Resident B had a catheter.<br><br>A current care plan, dated 8/13/2022, indicated the resident had a history of urine retention and used a Foley Catheter for retention. The only intervention documented was Foley Catheter.<br><br>During an interview, on 8/15/2022 at 1:25 P.M., MDS RN 12 indicated the comprehensive care plan was not developed and should have been.4. During an initial interview and observation on 8/11/2022 at 11:05 A.M., Resident 60 was observed to have a contracture to the left lower extremity and to the left hand/fingers. A splint was not observed to be in place for the left hand/fingers. Resident 60 indicated, Occupational Therapist 4 had placed a splint to his left hand, but after he was discharged from therapy, the splint was not placed anymore.<br><br>A clinical record review was completed on 8/15/2022 at 11:18 A.M. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), hemiplegia, and neurogenic bladder and obstructive uropathy.<br><br>A Quarterly Minimum Data Set (MDS) Assessment on 7/6/2022, indicated Resident 60 was cognitively intact. The MDS indicated Resident 60 had limited range of motion to one side of the lower and upper extremities.<br><br>An Admission MDS on 3/15/2022 indicated no limited range of motion to Resident 60's extremities. | | | |

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| | Resident 60 receive Occupational Therapy from 4/1/2022 through 6/28/2022.<br><br>A Care Plan could not be located for maintenance of the left-hand contracture.<br><br>During an interview and observation on 8/16/2022 at 9:18 A.M., Resident 60 indicated, he is unable to straighten his left hand. He indicated he has sharp pain at least daily in the left hand. He indicated his sister-in-law was told the therapy department told Medicaid there was nothing more they could do for him. Resident 60 was observed to have his left hand rested across his abdomen. He is not able to move the left hand without using the right hand to create the movement.<br><br>During an interview on 8/16/2022 at 11:48 A.M., the Regional RAI (Resident Assessment Indicator) Case Mix Director indicated, if the MDS (Minimum Data Set) Assessment had documentation of limited mobility, a care plan should be developed for the limited mobility.<br><br>On 8/16/2022 at 2:03 P.M., Occupational Therapist 4 indicated, Resident 60 was using a hand splint, but was not part of his plan of care. He was applying the hand splint "on the side and determining compliance".<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided the policy titled, "Person Centered Care Plan Process". The policy indicated, " ...The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of care ...3. Following RAI (Resident Assessment Instrument) Guidelines, develop and implement a | | | |

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| | comprehensive person-centered care plan that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment ...."<br><br>3.1-35(a) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on record review, observation and | F 0657 | 1. Resident B was not | 09/23/2022 |

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| | interview, the facility failed to ensure care plan meetings were held timely and failed to update care plans for pressure ulcers and contractures for 2 of 25 residents whose care plans were reviewed. (Residents B & 32 )<br><br>Findings include:<br><br>1. During an interview, on 8/12/2022 at 9:38 A.M., Resident B indicated she had a care plan meeting a couple of months ago and indicated if they have one they don't tell me about it.<br><br>A clinical record review was completed on 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, lymphedema, depressive disorder, and retention of urine.<br><br>A Significant Change MDS (Mimimum Data Set) assessment was completed on 7/5/2022 and indicated Resident B was cognitively intact.<br><br>A Care Conference Sheet indicated the resident had attended a care meeting on 4/14/2022.<br><br>The clinical record lacked a Care Conference Sheet indicating a care plan meeting had been conducted after the completion of the Significant Change MDS.<br><br>During an interview, on 8/16/2022 at 10: 30 A.M. Social Service Director indicated there should have been a care plan meeting after the significant change MDS was completed.<br>2. A clinical record review was completed, on 8/16/2022 at 1:25 P.M., and indicated Resident 32's diagnoses included, but were not limited to: hypertension, hyperlipidemia, hemipareses, hemiplegia, vascular dementia with behavioral | | identified however facility aware of whom resident B is. Resident B has been provided a care plan invitation including the responsible party. Resident 32 has been provided with a care plan invitation.<br>2. Residents residing at facility have the potential to be affected by the alleged deficient practice.<br>· Care plan invitations will be sent to residents and/or responsible parties in conjunction with the MDS schedule.<br>3. The interdisciplinary team including Social Services will be educated by the administrator on developing the care plan schedule including documentation of care conference attendance by 9.23.22.<br>4. Care plan participation audits will be forwarded to QAPI for review. Results of the participation will be presented by Social Services monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | disturbances, contracture of multiple sites, contracture of left wrist, left knee and left upper arm, and chronic pain.<br><br>A Care Plan, dated 3/2/2021, had an intervention of splinting trails with licensed therapist wrist and elbow splint 3-4 hours or as tolerated.<br><br>The Occupational Therapy Discharge Summary indicated she was discharged on 3/12/2021 and patient will tolerate wearing the left upper extremity elbow, wrist and hand orthotic devices for up to 8 hours to reduce the risk of severe contractures.<br><br>During an interview, on 8/17/2022 at 2:21 P.M., the Director of Nursing indicated that the care plan was not revised and should have been.<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided a policy titled, "Nursing Policies and Procedures Person Centered Care Plan Process," revised 7/1/2016, and indicated the policy was the one currently used by the facility. The policy indicated "... 7. The Interdisciplinary Team (IDT) will review for effectiveness and revise the care plan after each assessment. This includes both the comprehensive and quarterly assessments. ...9. The IDT will invite participation from the resident and the resident's legal representative (if applicable). The IDT will document an explanation in the resident's medical record of the invitation, participation or lack of participation of the resident and or their representative if determined not practicable for the development of the resident's care plan. ...11. Residents will actively participate<br><br>Thia Federal tag relates to Complaint IN00382390 | | | |

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| F 0677 SS=D Bldg. 00 | 3.1-35(d)(2)(B)<br><br>483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§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;<br>Based on observation, record review and interviews, the facility failed to ensure 3 of 4 dependent residents received assistance related to daily living needs regarding fingernail care and bathing needs. (Residents 10, B and 60)<br><br>Findings include:<br><br>1. During the initial tour of the facility, conducted on 8/11/2022 between 10:30 A.M. - 11:20 A.M., Resident 10 was observed awake, lying in his bed. The resident was dressed in a hospital gown and his fingernails were noted to be long and jagged and had a dark colored substance underneath them.<br><br>Resident 10 was observed on 8/12/22 at 9:49 A.M., lying in his bed in a hospital gown. The resident was noted to have long dirty fingernails.<br><br>Resident 10 was observed on 8/15, 8/16 and 8/17/2022 lying in his bed, dressed in a hospital gown. The resident's fingernails were noted to be long and dirty in appearance on all three days. The fingernails on the resident's right hand were noted to be longer than the fingernails on his left hand.<br><br>On 8/16/2022 at 11:30 A.M., CNA 6 and CNA 20 were observed getting ready to give Resident 10 a bed bath. The complete bed bath process was | F 0677 | 1. Resident 10 had his fingernails trimmed, cleaned and nail care added to care plan. Resident B was not identified however facility aware of whom resident B is. Resident B is provided showers and bathing by the Hospice provider. Resident B's shower preference will be added to the active plan of care. Resident 60 has received a shower per his preference. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and who are dependent for ADL care have the potential to be affected by the alleged deficient practice.<br>3. Facility nursing staff have been educated by the Director of Clinical Education on providing care to dependent residents with an emphasis on shower preferences and documentation of refusals of care by 9.23.22.<br>· Nursing administration will audit shower sheets weekly for accuracy.<br>4. Shower audits will be forwarded to QAPI for review. | 09/23/2022 |

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| | observed. The resident's hands were washed, dried and lotion was applied. The resident requested his fingernails be trimmed and the aides indicated they thought he might be diabetic and they would have to check with the nurse.<br><br>Resident 10 was admitted to the facility with diagnoses, included, but not limited to: chronic obstructive pulmonary disease, muscle weakness, difficulty in walking, incontinence and obesity.<br><br>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 8/5/2022, indicated the resident was alert and oriented, requires extensive assistance of two staff for bed mobility, toileting , personal hygiene and bathing needs.<br><br>The current care plans for Resident 10 indicated the resident required extensive assist of 2 staff for bathing and dressing, and extensive assistance of one staff for all other needs. There was no specific plan to address nail care.2. During an interview, on 8/12/2022 at 9:36 A.M., Resident B indicated she had 1 shower in the last few months and does not get one as often as she should.<br><br>A clinical record review was completed on, 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, lymphedema, depressive disorder, anxiety and retention of urine,<br><br>A Significant change MDS (Minimum Data Set) assessment, dated 7/5/2022, indicated Resident B had a BIMS score of 15 indicating cognition intact, required extensive assist of 2 staff for bed mobility, dressing and toilet use and supervision for eating, and total assist for bathing.<br><br>A current care plan, dated 5/23/2022, indicated the | | Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | resident required assistance with ADL's (activities of daily living) related to decreased mobility, chronic respiratory failure, heart failure, lymphedema, and osteoarthritis. Transfers: extensive assist x 1-2. Eating: supervision/set up assist. Toileting: extensive assist x 1-2. Dressing: extensive assist x 1 Interventions included, but were not limited to: resident prefers to have a shower. Provide with the required amount of assistance required to complete the ADL's.<br><br>A shower schedule indicated the resident was to receive a shower on Tuesday and Friday evenings.<br><br>The CNA Point of Care History sheet, dated 6/1/2022 through 6/30/2022, indicated Resident B had received 2 complete bed baths from June 1st through June 30th, 20 partial bed baths, and no type of bathing or showers on 6/5, 6/18, and 6/19/2022.<br><br>The CNA Point of Care History sheet, dated 7/1/2022 through 7/31/2022, indicated the resident had received 4 complete bed baths, 14 partial bed baths and no type of bathing or showers on; 7/2, 7/6, 7/7, 7/8, 7/14, 7/16, 7/17, 7/21, 7/22, 7/23, 7/24, 7/28, and 7/29/2022.<br><br>The CNA Point of Care History sheet, dated 8/2/2022 through 8/18/2022, indicated Resident B had received 5 partial bed baths, no complete bed baths and no type of bathing or showers on 8/1, 8/3, 8/5, 8/6, 8/9, 8/10, 8/11, 8/12, 8/13, 8/15, 8/16, 8/17 and 8/18/2022.<br><br>During an interview, on 8/16/2022 at 1:40 P.M., CNA 24 indicated that the hospice aides does her bathing 3 times a week. She indicated the staff would still fill out a shower sheet, even if she | | | |

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| | refused, and by the shower documentation Resident B had not had showers or bed baths per her schedule and should have. 3. During an initial interview on 8/11/2022 at 10:50 A.M., Resident 60 indicated he had not received a shower in a couple of weeks.<br><br>A clinical record review was completed on 8/15/2022 at 11:18 A.M. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), hemiplegia, and neurogenic bladder and obstructive uropathy.<br><br>A Quarterly Minimum Data Set (MDS) Assessment on 7/6/2022, indicated Resident 60 was cognitively intact. The MDS indicated Resident 60 was dependent with two or more staff members for bathing. He had limited range of motion to one side of the upper and lower extremity.<br><br>A Resident Preference Questionnaire was completed on 3/7/2022. The questionnaire indicated, Resident 60 preferred showers on the day shift, two times a week, with no preference to the day of the showers. He did not prefer to have only bed baths.<br><br>A Care Plan, on 3/24/2022, indicated Resident 60, "...[Resident name] requires assistance with ADL's [activities of daily living] r/t [related to] CVA [cerebral vascular accident] with right side hemiplegia." The goal of the care plan indicated, "Will maintain a sense of dignity by being clean, dry, odor free and well-groomed over next 90 days" with a target date of 6/26/2022. According to the care plan, Resident 60 required extensive assistance of one staff member for bathing...."<br><br>A review of the CNA (Certified Nursing | | | |

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| | Assistant) documentation for bathing indicated, from 7/16/2022-8/15/2022, Resident 60 received a partial bed bath on 8/11/2022 at 9:35 P.M., 8/12/2022 at 11:36 P.M., and 8/13/2022 at 12 :55 P.M. No rejection of bathing was documented from 7/16/2022-8/15/2022<br><br>On 8/16/2022 at 9:20 A.M., Resident 60 indicated he has not had a shower since his prior interview. He indicated he received a bed bath every day, and his hair gets washed with a wet washcloth.<br><br>On 8/16/2022 at 10:50 A.M., a review of completed shower sheet was completed. The shower sheets indicated on 7/22/2022, 7/2/2022, and 8/3/2022 a bed bath was completed.<br><br>During an interview on 8/16/2022 at 10:06 A.M., LPN 1 indicated, shower sheets are completed after a shower and the unit manager collects the shower sheets for filing. If a resident refused a shower, this is documented on the shower sheet, and a Nurses Note written of the refusal.<br><br>On 8/16/2022 at 10:07 A.M., CNA 2 indicated a shower schedule is available for CNA's. She indicated they do not have many residents that refuse showers. She indicated a Shower Sheet and documentation the EMR (electronic medical record) are completed when a shower is completed, and if the resident refused a shower, that is documented in the EMR.<br><br>On 8/16/2022 at 11:53 A.M., the Regional RAI (resident assessment indicator) Case Mix Coordinator indicated, resident preferences should be addressed in the ADL care plan.<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided a policy titled, "Quality of Life-Resident | | | |

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| | Right For." The policy indicated, " ...Policy: 3. The facility staff will allow and promote the right of personal freedom and dignity for the patient/resident ...Procedures: 10. Facility staff assists the patient/resident in activities of daily living ...."<br><br>This Federal tag relates to Complaint IN00382390.<br><br>3.1-38(a)(3) | | | |
| F 0685 SS=D Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§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.<br>Based on observation, record review and interviews, the facility failed to ensure 1 of 2 residents reviewed for hearing and/or vision needs was assisted with prompt treatment for a significant hearing loss. (Resident 10)<br><br>Finding includes:<br><br>During the initial tour of the facility, conducted on 8/11/2022 at 11:15 A.M., Resident 10 was observed awake, lying in his bed. The resident's television was noted to be blaring at a high volume. After placing his television on the | F 0685 | 1. Resident 10 had the hearing evaluation already scheduled prior to the survey exit. Resident 10 was seen by the Audiologist on 8.24.22. Resident 10 had his hearing impairment added to his current care plan. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility with hearing and vision needs have the potential to be affected by the alleged deficient | 09/23/2022 |

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| | "Mute" mode, Resident 10 was not able to easily hear verbal communication. The resident indicated he could not hear and needed "drops" in his ears.<br><br>During an interview with Resident 10, conducted on 8/12/2022 at 9:45 A.M., CNA 20 was observed attempting to communicate verbally with Resident 10. She was noted to pull her facial mask down so Resident 10 could read her lips. During an interview with CNA 20 she confirmed Resident 10 was very hard of hearing<br><br>The clinical record for Resident 10 was reviewed on 8/12/2022 at 2:30 P.M. The most recent Quarterly Minimum Data Set (MDS) assessment for Resident 10, completed on 8/5/2022 , indicated he was alert and oriented, had moderate difficulty with hearing, did not have a hearing aide or device, and had clear comprehension of verbal communication.<br><br>Review of the current health care plans for Resident 10 indicated there was no plan to address communication and/or hearing needs.<br><br>An unsigned consent for services, including audiology services was scanned into the resident's electronic chart on 4/6/2022.<br><br>A Nursing Progress Note, dated 7/22/2022 at 6:06 P.M., indicated the resident reported he was having difficulty hearing. Stated that he was able to hear this writer's voice. Looked into resident's ears with flashlight and clear of earwax. Message will be left for nurse practitioner regarding resident's concern."<br><br>During an interview conducted on 8/16/2022 at 9:30 A.M., with the Social Services Designee, | | practice.<br>3. Social Services has been educated by the administrator on the requirement as it pertains to Hearing/Vision needs of residents by 9.23.22<br>· Social Services will audit hearing and vision needs of residents on a monthly basis. Contracted partners will be contacted with an appointment scheduled should the outside contractor not see a resident in need.<br>4. Hearing and Vision audits will be forwarded to QAPI for review. Results of those audits will be presented by Social Services monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | Employee indicated audiology was supposed to be at the facility on 8/23/2022. She indicated she thought the resident was seen on 4/6/2022 by the audiology consultants but no report was available.<br><br>During an interview with the SSD, on 8/17/2022 at 10:43 A.M. she indicated she was mistaken and audiology had not seen the resident in April. She indicated Audiology was next to be in the building August 23 and then in September because the list was so long for them when they got here.<br><br>There was no documentation provided regarding any assistance provided by the facility to have Resident 10's hearing evaluated.<br><br>3.1-39(a) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>Based on record review, observation and interview, the facility failed to ensure weekly skin | F 0686 | 1. Resident 13 has had a new skin assessment completed with | 09/23/2022 |

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| | assessments and weekly wound measurements were completed consistently for a resident who had an unstageable pressure area in 1 of 3 residents who were reviewed for pressure ulcers. (Resident 13)<br><br>Finding includes:<br><br>During a random observation, on 8/12/2022 at 1:30 P.M., Resident 13 was observed to have a dressing to the right foot.<br><br>A clinical record review was completed on 8/15/2022 at 9:47 A.M. Resident 13's diagnoses included, but were not limited to: dementia, depression, anxiety and psychotic disorder.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 5/5/2022, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, and toilet use.<br><br>A Care plan, dated 5/4/2022 indicated Resident 13 require assistance with ADL's (activities of daily living) related to dementia. Bed Mobility: extensive assist x1. Transfer: extensive assist x 1.<br><br>A Nurse's Note, dated 6/7/2022 at 10:10 A.M., indicated Resident 13 was noted with a DTI (deep tissue injury) blood fluid filled blister measuring 8 x 8 cm (centimeters) to the right heel, a 5 x 5 cm to the left heel, and 1.8 x 2 cm blister to the right big toe.<br><br>A Nurse's Note, dated 6/9/2022 at 4:56 P.M., indicated Resident 13 was seen by the NP (Nurse Practitioner) this morning during rounds. Right big toe measured 5.2 x 2 DTI with reddish purplish in color with skin intact. Right heel DTI measured 8 x 8 cm with skin intact. Left heel DTI measured 5 | | no additional findings noted. Resident 13 is being followed by the facility treatment nurse. There was no negative outcome related to the alleged deficient practice.<br>2. Resident residing at the facility and with active pressure areas have the potential to be affected. Current skin assessments have been reviewed and completed if found out of compliance.<br>3. Licensed Nursing staff has been educated by the Director of Clinical Education on the requirement as it relates completing skin assessments on a weekly basis.<br>· Nursing administration will be auditing skin assessments weekly moving forward any found to be out of compliance will be forwarded to the licensed nurse responsible for completion.<br>4. Skin assessment audits will be forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | x 5 cm with skin intact. Resident verbalized pain with touch and appeared more alert today. New orders received for x-ray to bilateral heels. New order received for CBC, CMP and SED rate labs. Labs to be drawn tomorrow.<br><br>A Nurse's Note, dated 6/10/2022 at 12:38 P.M., indicated the nurse entered room and noted right lateral mid foot resting against footboard. The CNA and nurse positioned resident toward HOB (head of bed). Redness noted to Lateral mid foot but blanches.<br><br>A Nurse's Note, dated 6/14/2022 at 4:36 P.M., indicated the daughter at bedside, treatment to both heels completed. Heels noted to be floating but stuck together, daughter stated that same thing happened earlier today as well. Blistered area on the right heel opened. Reddened area noted to Left lateral foot. The NP made aware and will round tomorrow. Air mattress functioning. Hospice ordered boots for heels but have not arrived at this time. Heels elevated with 2 pillows propped under calves.<br><br>Resident 13's physician orders included: Ensure twice a day ordered 2/1/2022. Weekly Skin Check by Licensed Nurse on Thursdays ordered 2/15/2022. Skin prep to any scab area left foot and toes once a day ordered 3/25/2022. Do not put socks on residents feet due to wounds, family request, ordered 6/22/2022. Turn and Reposition: every shift ordered 6/29/2022. Cleanse right heel with Normal Saline, pat dry apply Betadine (antiseptic agent) to both areas cover with Optilock (absorbant dressing) and secure with Kerlix, and change daily and as needed, ordered 8/12/2022.<br><br>Current care plans, dated 6/22/2022, indicated: | | | |

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| | Unavoidable DTI to right great toe. Daily Wound Treatment: Apply skin prep to Right Great toe area twice a day until areas resolved.<br>Unavoidable to right heel. Twice daily Wound Treatment right heel and right great toe, cleanse with NS (normal saline) pat dry and apply Betadine then cover with Optilock and secure with Kerlix change daily and PRN (as needed) .<br>Unavoidable to left heel. Every Shift Wound Treatment: Left heel apply santyl (debrieding agent) to wound bed, cover with non-adherent dressing, the kerlix.<br><br>Nursing Weekly skin assessments were not completed on the following dates: 5/11, 5/18, 6/3, 6/10, 7/15, 7/29 and 8/5/2022.<br><br>A weekly Wound Management Detail Report, dated 6/6/2022, indicated an unstageable deep tissue right heel measured 8 x 8.<br><br>A weekly Wound Management Detail Report, dated 6/9/2022, indicated an unstageable deep tissue right heel measured 8 x 8.<br><br>A weekly Wound Management Detail Report, dated 6/15/2022, indicated an unstageable deep tissue right heel measured 8 x 8.5.<br><br>The clinical record lacked the weekly Wound Management Detail Reports from 6/15/2022 to 7/21/2022.<br><br>A weekly Wound Management Detail Report, dated 8/9/2022, indicated the area to the right big toe was healed.<br><br>During an interview, on 8/17/2022 at 8:03 A.M., the Wound Nurse indicated MDS staff do the care plans and was not sure why they are unavoidable | | | |

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| | and indicated the nurses are responsible to do the weekly skin assessments,but per the documentation they had not been completed each week. The Wound Nurse indicated she had recently taken the Wound Nurse position in July, and was unsure why the wounds did not get measured before.<br><br>On 8/17/2022 at 8:28 A.M., Resident 13 was observed sitting in the recliner with her right foot dressed with kerlix and her left foot with a sock on it. Above the head of the bed was a hand written note, undated and indicated" Attn Do Not put socks on [residents name] feet!!! Thank you". The Wound Nurse indicated that it was for the right foot per the daughter.<br><br>On 8/17/2022 at 8:29 A.M., the Wound Nurse was observed completing wound care to the resident's right foot. She washed her hands and applied gloves. She removed the old dressing, revealing a black hardened area measuring approximately 5 x 3 cm (centimeters). The area was cleansed with normal saline and patted dry. The area was painted with betadine then covered with an Optilock dressing then covered with kerlix. The right grt toe was observed to have a small brown spec area to the tip of the toe, and the left heel had dry scaly skin.<br><br>On 8/17/2022 at 1:30 P.M., the Director of Nursing provided the policy titled, " Practice Guidelines for Preventions and Management of Pressure Ulcers", dated 9/7/2017, and indicated the policy was the one currently use by the facility. The policy indicated"... Weekly skin checks should be performed and documented by licensed staff on all patients/residents paying attention to: The surface of the skin that come in contact with the bed and chair. Bony prominence's( heels, tailbone, | | | |

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| | shoulder blades, elbows, back of the head etc.) ... It is recommended that the nursing progress notes reflect the nurse's observation and management of wounds from a shift to shift perspective and with each dressing change. ... At a minimum, weekly documentation is recommended to provide a review of the wound. Weekly documentation should include the date observed and: Location with staging/depth description for pressure wounds (e.g., partial thickness, full thickness); Measurements ( length, width, depth and the presence, and location of any undermining, tunneling or sinus tract.) measured per facility protocol; Presence, type, color, odor, appearance and approximate amount of any exudate; Presence, location, nature, and frequency of pain; Wound bed characteristics (Color, type of tissue e.g., granulation tissue, slough or eschar which give evidence to healing or non-healing); Description of wound edges and surrounding skin as appropriate (e.g., rolled edges, redness, induration, maceration)....<br><br>3.1-40 | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interviews, the facility failed to ensure 1 of 1 | F 0689 | 1. Resident 10 had the anti-roll backs on the w/c during the | 09/23/2022 |

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| | residents reviewed for falls received timely care after a fall and interventions were implemented to prevent recurrence. (Resident 10)<br><br>Finding includes:<br><br>During the initial tour of the facility, conducted on 8/11/2022 between 10:30 A.M. - 11:00 A.M., alert and oriented Resident 10 indicated he had fallen from his wheelchair while at a party. He indicated he had hit his head when he fell and had went to the emergency room.<br><br>The clinical record for Resident 10 was reviewed on 8/12/2022 at 2:30 P.M. Resident 10 was admitted to the facility with diagnoses included, but not limited to: chronic obstructive pulmonary disease, Muscle weakness, Difficulty in walking and seizures<br><br>The most recent Minimum Data Set (MDS) assessment for Resident 10, completed on 8/5/2022 as a quarterly review, indicated Resident 10 was alert and oriented, required total assistance of two staff for bed mobility, had only transferred out of bed 1 -2 times with assistance of two staff and required total staff assistance of two staff for personal hygiene needs. The assessment indicated the resident was unsteady with surface to surface transfers and was non ambulatory.<br><br>The current care plan related to accident risk indicated the following: "... Problem: Resident at risk for falling R/T (related to) impaired mobility & (and) balance, seizure disorder, use of diuretic, HTN (hypertension)" The goal for the plan was "Resident will remain free from fall related injury." The approaches included: "Approach: Seating Eval Anti lock brakes , Approach: Orient to changes in environment such as new furniture, | | survey. Resident 10 had an additional w/c present in the room during the initial tour. Resident 10 has had a seating evaluation performed with the present plan of care updated for falls/accidents. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and are at risk for falls have the potential to be affected by the alleged deficient practice.<br>3. Licensed Nursing staff have been educated by the Director of Clinical Education on accidents and supervision with an emphasis on ensuring interventions are in place following a fall incident.<br>4. Fall Reports will be forwarded to QAPI for review. Results of those reports will be presented by the Director of Nursing and/or designee monthly for a period of 12-months<br>5. Date of Compliance 9.23.22 | |

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| | room changes, etc., Approach: Assure the floor is free of glare, liquids, foreign objects.. Approach: Provide proper, well-maintained footwear., Approach: Keep personal items and frequently used items within reach., Approach: Keep call light in reach times. Approach: Provide an environment free of clutter. andApproach: Teach safety measures use call light for assistance, and wear non-skid footwear while out of bed." All of the approaches were implemented on 1/31/2022 upon the resident's admission to the facility, except for the approach to provide a seating evaluation and anti lock brakes on the wheelchair which was added on 7/11/2022...."<br><br>Review of a Nursing Progress Note, dated 7/9/2022 at 9:02 P.M., indicated the following: "...Resident requested to go to ER post fall after dinner at about 3 PM. This nurse with QMA (qualified medication aide) went to assess resident. Resident was alert and oriented, PERRLA (pupils equal and reactive), unlabored breathing, no s/s (signs and/or symptoms) of distress. Resident stated he fell backwards from his w/c (wheelchair) and hit back of his head, small bump noted, no bruises noted. Resident stated he hit his arm and pinpoint on small reddish area R (Right) arm. Resident also stated he hit his L (left) leg, dressing noted in place , no bleeding or drainage noted. VS (Vital signs) stable : T (temperature) 97.6, P (pulse) 82, R (respirations) 20, BP (blood pressure) 147/70, BIOX (blood oxygenation level) 98% on RA (room air). After resident was assessed with no c/o (complaints) pain at that time he said he change his mind and do not want to go to ER (emergency room) Hour later QMA reported resident requested to go ER again. MD (medical doctor) notified with NO (new order) to send resident to ER per his request for eval and Tx. Resident's daughter called and | | | |

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| | notified on his request, daughter wanted him to go to SJRMC, (name of hospital) which is very close to facility. Tri-County ambulance called for transportation, no available crews at that time. 911 called and arrived in facility within 5 minutes. SJRMC ER called with report. Resident went to ER on stretcher, alert and oriented, in no visible distress...."<br><br>A subsequent Progress Note, dated 7/11/2022 at 4:53 P.M., indicated the following: "...IDT (Interdisciplinary team) met to discuss post incident from fall on 7.9. Resident noted on floor in room. Staff report that resident fell backwards in w/c initially resident refused to be sent to ER as he was attending a party his family had planned for him. Following the party it was decided resident would agree to go to ER for further evaluation. Resident did return with no new orders provided to facility. Resident did not sustain any significant injury related to the incident. Staff verbally educated on ensuring resident is properly seated in w/c and to ensure w/c brakes are locked. Resident will be referred to PT for w/c positioning & Maintenance will assess resident for antilock brakes. MD & family notified of incident as well as of the updates to the plan of care. IDT will continue to follow resident and will modify the plan of care when indicated. Care plans reviewed/revised and remain appropriate at this time...."<br><br>Review of the facility investigation worksheet for Resident 10, provided on 8/18/2022 at 9:00 A.M., indicated the resident fall in his room at 3:00 P.M. on 7/9/2022. The form, completed by a nurse, indicated the QMA had reported the resident had fallen after dinner. The form indicated the resident had reported falling backwards out of his wheelchair and had hit his head, arm and leg. The | | | |

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| | portion of the investigative form to indicate what the resident was attempting to do, if the resident was calling for help, if the call light was available, if the resident was standing/sitting or lying prior to the fall, if there were any assistive devices in place and any witnesses was left blank. The Neurological Evaluation Flow Sheet for Resident 10's fall on 7/9/2022 indicated it was not initiated until 7:30 P.M., nearly 4 and 1/2 hours after the reported fall.<br><br>The Fall investigation form indicated a physical therapy evaluation for wheelchair positioning and anti lock brakes were to be placed on the resident's wheelchair as interventions to prevent recurrence.<br><br>During the Resident Council meeting, conducted on 8/16/2022 at 1:00 P.M., Resident 10 was observed seated in a wheelchair at the meeting. The resident was noted to be sliding out of the wheelchair and assistance had to be requested from staff, to keep the resident from falling from the wheelchair.<br><br>During an interview with the Rehab Director , Employee 24 on 8/17/2022 at 1:55 P.M., she indicated Resident 10 had never been on caseload. She indicated she did not know about the need for a wheelchair evaluation after his fall. She indicated referrals were usually discussed at the morning meetings.<br><br>On 8/17/22 at 2:05 P.M., two wheelchairs were observed in Resident 10's room. Neither wheelchair was equipped with anti lock brakes. The larger wheelchair, indicated by Resident 10 as his preferred wheelchair, did have anti tip bars on the wheelchair. The other wheelchair was smaller and did not have wheelchair pedals or anti lock | | | |

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| | brakes. The resident pointed to the smaller wheelchair and stated " They put me in that wheelchair It was too small, I was sliding down, someone rolled over my foot and I made an ass of myself at the Resident Council meeting... no one cares- it was a waste of time."<br><br>During an interview with the DON on 8/18/22 at 11:34 A.M., she indicated the resident was with his family when he fell (on 7/9/2022) but the nurse at the time, did not initiate the documentation at the time and had to come back in and had initiated it at a later time. The DON confirmed the nurse did not document as she should have.<br><br>A policy and procedure regarding falls was requested on 8/7/2022 at 2:30 P.M. A policy and procedure, titled "Leadership policies and procedures: Accident/Incident Reporting" was provided on 8/18/2022 at 9:00 A.M. The policy indicated "....4. Information related to accidents and incidents is documented on the appropriate worksheet Incident/Accident and Medication Error. A. The worksheet is completed on the same shift as soon as practicable by the person witnessing or identifying the incident or accident... 6. The Director of Nursing designates the responsible party to complete the follow -up. The designees conducts a complete investigations of all accidents and incidents and documents the findings on the second page of the worksheet and on supplemental investigation worksheets if applicable...."<br><br>3.1-45(a) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence. | | | |

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| | §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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(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.<br><br>§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.<br>Based on record review, observation and interview, the facility failed to provide catheter care consistently for a resident with a indwelling Foley catheter for 1 of 4 residents reviewed for catheters. (Resident B) | F 0690 | 1. Resident B was not identified however facility is aware of who resident B is. Resident B received a catheter cover to preserve her dignity. Resident B has had the care plan modified to | 09/23/2022 |

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| | Finding includes:<br><br>During an observation, on 8/12/2022 at 9:41 A.M., Resident B was observed with a Foley catheter drainage bag on the side of the bed uncovered.<br><br>A clinical record review was completed on 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, lymphedema, depressive disorder and retention of urine.<br><br>Current physician orders for Resident B indicated Foley catheter care - may be completed by nursing assistant every shift- first & second. Privacy bag in place: every shift- first & second.<br><br>A current care plan, dated 8/13/2022, indicated Resident B had a history of urine retention and is using a Foley Catheter for the retention. The only intervention documented on the care plan was Foley Catheter.<br><br>The CNA Catheter care documentation, dated 7/1/2022 to 7/30/2022 indicated Resident B did not receive catheter care by a CNA on the following dates and times:<br>7/3, 7/4 and 7/5/2022 on either shift.<br>7/8/, 7/9 and 7/10/2022 on either shift.<br>7/12/2022 on either shift.<br>7/17 and 7/18/2022 on either shift.<br>7/22 and 7/26/2022 on either shift.<br><br>The CNA Catheter care documentation, dated 8/1/2022 to 8/18/2022 indicated Resident B did not receive catheter care by a CNA on the following dates and times:<br>8/1 and 8/3 and 8/5/2022 on either shift.<br><br>During an interview, on 8/16/2022 at 1:41 P.M., | | included additional interventions for catheter care. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility with Foley Catheters have the potential to be affected by the alleged deficient practice. Existing residents with Foley catheters have received catheter care including dignity coverings. Existing Catheter Care plans have been reviewed and additional interventions put into place if found out of compliance.<br>3. Nursing staff have been educated by the Director of Clinical Education on the expectation surrounding catheter care with an emphasis on documentation of care provided and ensuring catheter bags are covered to preserve the residents' dignity.<br>· Nursing administration will perform random rounds daily to validate catheter bags are covered. Any found out of compliance will be addressed immediately.<br>4. Catheter Audits will be forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | CNA 24 indicated the residents' catheter care was not documented and she did not receive catheter care every shift and should have.<br><br>A policy was requested for catheter care on 8/16/2022 but one was not provided by the survey exit date.<br><br>3.1-41(a)(1) | | | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. (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-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on observation, record review and interview, the facility failed to identify a residents significant weight loss and failed to prevent a significant weight loss for 2 of 4 residents reviewed for nutrition. (Resident 60 & 65) | F 0692 | 1. Resident 60 has been seen by the facility Dietitian with interventions put into place. The Physician for resident 60 has been notified of weight loss identified including interventions. Resident | 09/23/2022 |

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| | Findings include:<br><br>1. During an initial interview on 8/11/2022 at 10:59 A.M., Resident 60 indicated he felt like he had lost a lot of weight.<br><br>A clinical record review was completed on 8/15/2022 at 11:18 A.M. Diagnoses included, but were not limited to: cerebral vascular accident (stroke), hemiplegia, and neurogenic bladder and obstructive uropathy.<br><br>A Quarterly Minimum Data Set (MDS) Assessment on 7/6/2022, indicated Resident 60 was cognitively intact. The MDS indicated Resident 60 did not have significant weight loss.<br><br>A review of resident 60's weight indicated the following:<br>8/2/22 204.8 pounds<br>7/8/22 208.2 pounds<br>5/6/22 221.0 pounds<br>3/30/22 219.7 pounds<br>3/9/22 228.0 pounds<br><br>Resident 60 had a 10.18 percent weight loss from 3/9/2022 through 8/2/2022.<br><br>A Progress Note on 7/8/2022 at 2:47 P.M., by the Scheduling Coordinator, indicated, "Writer noted resident to have had a notable weight loss of 11lbs, previous weight of 219.2 and current weight of 208.2. Dietician notified."<br><br>A Progress Notes was not found from the Dietician regarding weight loss.<br><br>On 7/6/2022 a Nutritional Review was completed by the Dietician. The review indicated, "Weight loss less than 1 percent in 30 days, and weight | | 65 has discharged from facility following a success rehabilitative stay so therefore corrections cannot be made. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at facility have the potential to be affected by the alleged deficient practice. Existing resident will be weighed according to facility policy.<br>3. Nursing staff has been educated by the Director of Clinical Education on the policy & procedure titled Preventing weight loss with an emphasis on putting interventions in place with notification to the Physician and Dietitian if weight loss is identified.<br>· Nursing Administration will review weekly weights and monthly weights moving forward. Any weight variations will have both Physician and Dietitian Notified and ordered interventions put into place.<br>4. Weight audits will be forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | loss 3.9 percent in 90 days."<br><br>A Physician's Order on 7/11/2022, indicated, weekly weight for four weeks. The weights were as follows:<br>7/12/2022 208.8 pounds<br>7/22/2022 207.7 pounds<br>7/28/2022 203.6 pounds<br>8/2/2022 204.8 pounds<br><br>A Care Plan on 3/16/2022 indicated, " ...[Resident name] is currently on a 7 EasytoCHEW [diet] for dysphagia. At risk nutrition problems and WT [weight] fluctuations related to obesity, and functional deficits... The goal indicated, [Resident name] will maintain nutritional status as evidenced by no significant weight change through next review and will receive appropriate diet as ordered by physician... An intervention on 3/16/2022, indicated, "Monitor intakes of meals, fluid, and snacks...."<br><br>During an interview on 8/16/2022 at 9:45 A.M., the Dietary Manager indicated he does not monitor monthly weights and weight loss. He indicated the Dietician comes in on a weekly basis. When questioned about the procedure for monitoring monthly weights, he indicated he needed to consult the Dietician. He sent a text message to the Dietician to obtain the answer.<br><br>On 8/16/2022 at 9:52 A.M., the Dietary Manager indicated, the Dietician responded to the text message. The Dietician indicated, "That is a good question, but the truth is no one monitors but me for the past two years." She indicated to consult with the Scheduling Coordinator who acquires the monthly weight.<br><br>On 8/16/2022 at 10:15 A.M., the Staffing | | | |

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| | Coordinator was interviewed. She indicated resident weights were completed monthly, and she monitored them for fluctuation in weight. If a weight gain or loss of three pounds was identified, she would send an email to the Nurse Managers and Dietician. If a three-pound weight gain or loss was identified, a Physician Order was automatically placed for weekly weights for four weeks. She indicated the Dietician will compare the long-range weights for significant weight loss or gain. She indicated she only monitors weights month to month, and if she noticed something was off, she would review weight from the prior months.<br><br>On 8/16/2022 at 2:34 P.M., the Director of Nursing (DON) indicated, the Scheduling Coordinator was responsible for monitoring the facility weight. The DON indicated the Scheduling Coordinator compared the weights recorded in the EMR (electronic medical record) and reported findings to the Dietician. The DON indicated she reviewed the weight variances on a weekly basis. She indicated Resident 60 had not been of concern. She indicated during her monthly reporting for QAPI (Quality Assurance Performance Improvement) meeting, Resident 60 had a five percent weight loss for June 2022 and 7.9 percent weight loss for July 2022. Has not been on the radar at all. Only had two people to [name of ED] for QAPI for weight loss. Resident 60 was not identified for interventions.2. During an observation on 8/11/2022 at 12:10 P.M., Resident 65 was observed in her room with lunch on her side table, nothing had been eaten. Resident 65 indicated she was not very hungry.<br><br>During an interview, on 8/11/2022 at 12:30 P.M., Resident 65's son indicated his mom picked at her food and family brings in food such as soups and | | | |

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| | other things she enjoys. The son also indicated family tries to be here during meal time to assist her. He indicated family has never seen staff assisting his mom with her meals.<br><br>During an observation on 8/12/22 at 1:10 P.M., Resident 65's lunch was untouched and still on her bedside table.<br><br>A clinical record review was completed, on 8/15/2022 at 11:10 A.M. Resident 65 was admitted on 7/6/2022. Her current diagnoses included, but were not limited to: urinary tract infection, encephalopathy, moderate protein-calorie malnutrition, diabetes mellitus and hypertension.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 7/13/2022, indicated Resident 65 had a BIMS (Brief Interview for Mental Status) score of 6, which indicated severe cognitive impairment.<br><br>A Careplan, dated 7/13/2022, was initated for a Nutritional problem related to the diagnosis of protein calorie malnutrition. Interventions included, but were not limited to: assist with meals, monitor diet acceptance, monitor lab results, serve regular diet and weekly weights.<br><br>Admission weight on 7/7/2022 was documented at 183.8.<br>7/8/2022 -- 184.2<br>7/9/2022 -- 185.2<br>7/12/2022 -- 184.7<br>7/22/2022 -- 181.2<br>8/10/2022 -- 166.4<br><br>Resident 65 had a (9.47%) weight loss x 30 days.<br><br>Meal consumption documention, dated 7/6/2022 | | | |

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| | to 8/15/2022, indicated Resident 65 consumed 1-25% for 18 meals out of 46 meals documented.<br><br>During an observation on 8/15/22 at 1:15 P.M., Resident 65's untounched lunch tray was on the bed side table. The resident indicated she did not know if she had eaten lunch or not.<br><br>During an interview, on 8/15/2022 at 1:27 P.M., the Director of Nursing indicated Resident 65 had a weight loss and was not sure if the Physician had been notified. The Director of Nursing also indicated the Unit Managers are responsible for monitoring weights and notifying the Physician and Dietician of weight changes.<br><br>On 8/15/2022 at 1:45 P.M., the Director of Nursing provided a form titled Functional Abilities Assessment-Admission, dated 7/6/2022. The form indicated Resident 65's Eating-Admission Performance was a substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Eating ability was checked as maximum assist.<br><br>During an interview, on 8/17/2022 at 10:30 A.M., Licensed Practical Nurse 9 indicated the Physician did not address the weight loss.<br><br>On 8/16/2022 at 4:32 P.M., the Administrator provided the policy titled, "Preventing or Mitigating Undesirable Weight Loss". The policy indicated, " ...The Registered Dietician Nutritionist/Designee will review the patient/resident's nutritional status to prevent and control undesirable weight loss ...4. Address significant weight loss or gain in the dietary progress notes and by developing and/or updating the plan of care ...." | | | |

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| | 3.1-46(a)(1) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 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.<br>Based on observation and interview, the facility failed to ensure oxygen tubing and nasal cannula tubing were stored properly for 1of 1 residents reviewed for oxygen. (Resident 131)<br><br>Finding includes:<br><br>During the initial tour of the facility, conducted on 8/11/2022 between 10:00 A.M. - 11:20 A.M., the oxygen tubing and nasal cannula tubing was noted to be draped over a white table behind the concentrator in Resident 131's room.<br><br>On 8/12/2022 at 9:45 A.M., the oxygen tubing and a nasal cannula, and the humidified water container were noted on the floor in front of the oxygen concentrator.<br><br>On 8/15/22 at 10:09 A.M., Resident 131's oxygen tubing, connected to the oxygen concentrator in her room,was draped all over the top of the oxygen concentrator and floor.<br><br>Review of the facility policy and procedure, titled | F 0695 | 1. The Oxygen tubing for resident 131 was immediately placed into the bag attached to the concentrator. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility with current oxygen use have the potential to be affected by the alleged deficient practice.<br>· Residents with active Oxygen orders have had the Oxygen tubing checked and placed into the concentrator bag.<br>3. Nursing staff has been educated by the Director of Clinical Education on the requirement related to properly storing oxygen tubing by 9.23.22.<br>· Nursing Administration will round weekly to ensure Oxygen tubing is stored and dated as per policy.<br>4. Oxygen Audits will be | 09/23/2022 |

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| | "Oxygen Storage Requirements", provided by the Director of Nursing on 8/18/2022 at 9:00 A.M. indicated the policy did not include instructions for oxygen tubing storage requirements.<br><br>3.1-47(a) | | forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 3-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |
| F 0727<br>SS=D<br>Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>Based on interview and record review, the facility failed to ensure they had a Registered Nurse on staff for eight hours on a weekend day for 1 out of 8 daily assignment sheets reviewed.<br><br>On Sunday 8/14/2022, the schedule indicated that there were four Licensed Practical Nurses and two Qualified Medication Aides on duty that day.<br><br>On 8/18/2022 at 12:39 P.M., the Regulatory Specialist provided a Custom Time Detailed Report and indicated that there was no Registered Nurse on duty on Sunday 8/14/2022 and there should have been. | F 0727 | 1. The lack of RN coverage for 8.14.22 has since surpassed so therefore corrections could not be met. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.<br>· Subsequent schedules have been reviewed and the RN requirement will be maintained.<br>3. The Nursing Staffing | 09/23/2022 |

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| | 155850 | A. BUILDING 00<br>B. WING | 08/18/2022 |

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| BELLTOWER HEALTH & REHABILITATION CENTER | 5805 NORTH FIR ROAD<br>GRANGER, IN 46530 |

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| | On 8/18/2022 at 12:50 P.M., the Regulatory Specialist provided a policy titled, "Leadership Policies and Procedures", revised on 11/1/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...2) The adequacy and competency of staff is determined by a facility assessment of the resident population. The facility assessment includes residents' care needs in accordance with their care plans and considering the number, acuity and diagnosis of the facility's resident population: A. Nursing: 3) Except when waived, uses the services of a RN for at least eight (8) consecutive hours a day, seven (7) days a week...."<br><br>3.1-17(b)(3) | | Scheduled has been educated by the Administrator on the RN 8-hour per day requirement by 9.23.22. Any violations of the RN requirement will be directed to the Director of Nursing.<br>4. RN tracking audits will be forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 3-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |
| F 0756 SS=D Bldg. 00 | 483.45(c)(1)(2)(4)(5)<br>Drug Regimen Review, Report Irregular, Act On<br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist | | | |

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| | during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. | | | |
| | Based on record review and interview, the facility failed to address a pharmacy recommendation timely for 2 of 5 residents reviewed for medication regime. (Resident 36 & 40)<br><br>Findings include:<br><br>1. A clinical record review was completed on 8/15/2022 at 2:49 P.M. Resident 36's diagnoses included, but were not limited to: dementia, depression, and psychotic disorder. Received antipsychotics, antidepressant and diuretic medications.<br><br>Resident 36 current physician orders, dated 8/2022, indicated she had received Venlafaxine | F 0756 | 1. The AIMS assessment has been completed for resident 36 and the reduction of the Venlafaxine is being reviewed by the Medical Director. Resident 40's antidepressant is being reviewed by the Medical Director. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and with pharmacy recommendations in place have the potential to be affected by the alleged deficient practice.<br>· Current pharmacy | 09/23/2022 |

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| | (antidepressant) 200 mg(milligrams) daily, Aripiprazole (antipsychotic) 7.5 mg daily, Melatonin (hormone) 5 mg daily and Wellbutrin(antidepressant) 300 mg daily.<br><br>A Pharmacy Consultation Report, dated October 1, 2021, indicated Resident 36 receives Aaripiprazole which may cause involuntary movements including tardive dyskinesia (TD), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the past 6 months. Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol. If this therapy is to continue, it is recommended that a) the prescriber document as assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g. uncontrollable movements).<br><br>The Pharmacy Consultation Report was signed by and RN with no other documentation and dated 11/8/2021.<br><br>A Pharmacy Consultation Report, dated November 2, 2021, indicated Resident 36 receives Aaripiprazole which may cause involuntary movements including tardive dyskinesia (TD), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the past 6 months. Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol. If this therapy is to continue, it is recommended that a) the | | recommendations will be provided to the medical director for review with recommendations either granted or denied pending appropriate rationale.<br>3. Licensed Nursing Staff along with the Medical Director/Nurse Practitioner will be educated by the Director of Clinical Education on the requirement as it relates to pharmacy recommendations and providing appropriate rationale if recommendation is denied by the treating practitioner this will be completed by 9.23.22<br>· Nursing administration will review pharmacy recommendations monthly with the treating practitioner and document the outcome of the recommendation on the Pharmacy Document.<br>· The Facility Pharmacist will provide the facility a monthly report to address pending recommendations and those recommendations will be addressed with the treating physician and/or nurse practitioner.<br>4. Pharmacy reports will be forwarded to QAPI for review. Results of those reports will be presented by the Director of Nursing monthly and the Pharmacist quarterly. Results of those reports will be reviewed monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | prescriber document as assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g. uncontrollable movements).<br><br>The Pharmacy Consultation Report was signed by and RN with no other documentation and dated 11/8/2021.<br><br>A Pharmacy Consultation Report, dated December 6, 2021, indicated: REPEATED RECOMMENDATION FROM 11/2/2021: Please respond promptly to assure facility compliance with Federal regulations. Resident 36 receives Aaripiprazole which may cause involuntary movements including tardive dyskinesia (TD), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the past 6 months. Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol. If this therapy is to continue, it is recommended that a) the prescriber document as assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g. uncontrollable movements).<br><br>The Pharmacy Consultation Report was signed by and RN, dated 12/8/2021 and written on the form was AIMS done on 12/9/2021.<br><br>A Pharmacy Recommendation Report, dated 4/7/2022, recommended to decrease the Venlafaxine from 200 mg daily to 150 mg a day. | | | |

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| | During an interview, on 8/18/2022 at 12:38 P.M., the Director of Nursing indicated the pharmacy recommendations did not get addressed timely, the AIMS was done in December, and the Venlafaxine was not decreased and should have been.<br><br>2. A clinical record review was completed on 8/18/2022 at 9:29 A.M. Resident 40's diagnoses included, but were not limited to: depression, anxiety, Parkinson's disease and dementia.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 12/21/2021, and a Quarterly MDS assessment, dated 6/14/2022, indicated Resident 40 received antipsychotic and anti depressant medications. No GDR's documented.<br><br>A Pharmacy Consultation Report, dated May 5, 2022, indicated the resident has received an antidepressant, Citalopram 20 mg (milligram) every day since 124/2021 for managment of depressive symptoms. The recommendation was please attempt a gradual dose reduction to 15 mg every day. The Physician's response was to decline the recommendation above because GDR is clinically contraindicated for this indivudual as indicated below.<br>(Note: Please check option #1 or #2 AND provide patient -specific rationale on the lines below.) The form lacked the checks of either option 1 or 2, and under the section: Please provide CMS REQUIRED patient-specific rationale describingh why a GDR attempt is likely to impair function or cause psychiatric innstability in this individual: The documentation was Resident with Hospice services. The form was signed by an RN and dated 5/10/2022. | | | |

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| | During an interview, on 8/18/22 at 11:48 A.M., the Director of Nursing indicated the pharmacy recommendation had not been addressed timely and should have been and the reason of Hospice was not appropriate.<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled,"Pharmacy Services Policies and Procedures- Medication Regime Review", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated... 6. For non-Urgetn recommendations, the Facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident. Upon receipt of the written Consultant Pharmacy Report of non-urgent recommendations, the DON or the facility designee shall provide the report to the attending physician(s) or their designee during their next regularly scheduled facility visit or within 5 business days, whichever should comwe first. A. Attending physician or designee should respond to the resommendation within 14 days of the pharmacist's review date, but not later then teh Consultant Pharmacist's next monthly MRR. ...9. If th Attending Physician or theri agent fails to address a recommendation or document a reationale ffor declining a recomemendation: A. The Director of Nursing or facility designee will alert the Medical Director where MRR's are not addressed timely or completely by the attending physician. B. The DON, Medical Director, or facility designee will review trhe incomplete recommendation with the Attending Physician or their designee...."<br><br>3.1-25(i) | | | |
| F 0758 SS=D | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN | | | |

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| Bldg. 00 | Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's | | | |

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| | medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>Based on record review, interview and observation, the facility failed to complete a GDR (gradual dose reduction) on antipsychotic medications and failed to complete an AIMS assessment timely for 2 of 5 residents reviewed for unnecessary medications. (Residents 36 and 40)<br><br>Findings include:<br><br>1. A clinical record review was completed on 8/15/2022 at 2:49 P.M. Resident 36's diagnoses included, but were not limited to: dementia, depression, and psychotic disorder.<br><br>An Annual MDS (Minimom Data Set) assessment, dated 6/12/2022, indicated Resident 36 received an antipsychotic and an antidepressant medication.<br><br>Resident 36 current physician orders, dated 8/2022, indicated she had received Venlafaxine (anti depressant) 200 mg (milligrams) daily since 10/14/2021, Aripiprazole (antipsychotic) 7.5 mg daily, Melatonin (hormone) 5 mg daily and Wellbutrin(antidepressant) 300 mg daily. A GDR (gradual dose reduction) indicated clinically contraindicated by the physician on 7/8/2021.<br><br>A Pharmacy Recomendation Report, dated 4/7/2022, recommended to decrease the Venlafaxine to 150 mg daily. | F 0758 | 1. The AIMS assessment has been completed for resident 36 and the reduction of the Venlafaxine is being reviewed by the Medical Director. Resident 40's antidepressant is being reviewed by the Medical Director. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and with pharmacy recommendations in place have the potential to be affected by the alleged deficient practice.<br>· Current pharmacy recommendations will be provided to the medical director for review with recommendations either granted or denied pending appropriate rationale.<br><br>3. Licensed Nursing Staff along with the Medical Director/Nurse Practitioner will be educated by the Director of Clinical Education on the requirement as it relates to pharmacy recommendations and providing appropriate rationale if recommendation is denied by the treating practitioner this will be completed by 9.23.22 | 09/23/2022 |

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| | Resident 36's current MAR (Medication Administration Record), dated 8/1 through 8/30/2022, indicated Resident 36 was receiving 200 mg of Venlafaxine.<br><br>During an interview, on 8/18/2022 at 12:38 P.M., the Director of Nursing indicated the pharmacy recommendation did not get addressed, and the resident was still receiving the 200 mg.<br><br>2. A clinical record review was completed on 8/18/2022 at 9:29 A.M. Resident 40's diagnoses included, but were not limited to: depression, anxiety, Parkinson's disease and dementia.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 12/21/2021, and a Quarterly MDS assessment, dated 6/14/2022, indicated Resident 40 received antipsychotic and anti depressant medications. No GDR's documented.<br><br>A Pharmacy Consultation Report, dated May 5, 2022, indicated the resident has received an antidepressant, Citalopram 20 mg (milligram) every day since 124/2021 for managment of depressive symptoms. The recommendation was please attempt a gradual dose reduction to 15 mg every day. The Physician's response was to decline the recommendation above because GDR is clinically contraindicated for this indivudual as indicated below.<br>(Note: Please check option #1 or #2 AND provide patient -specific rationale on the lines below.) The form lacked the checks of either option 1 or 2, and under the section: Please provide CMS REQUIRED patient-specific rationale describingh why a GDR attempt is likely to impair function or cause psychiatric innstability in this individual: The documentation was Resident with Hospice services. The form was signed by an RN and | | • Nursing administration will review pharmacy recommendations monthly with the treating practitioner and document the outcome of the recommendation on the Pharmacy Document.<br>• The Facility Pharmacist will provide the facility a monthly report to address pending recommendations and those recommendations will be addressed with the treating physician and/or nurse practitioner.<br>4. Pharmacy reports will be forwarded to QAPI for review. Results of those reports will be presented by the Director of Nursing monthly and the Pharmacist quarterly. Results of those reports will be reviewed monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | dated 5/10/2022.<br><br>During an interview, on 8/18/22 at 11:48 A.M., the Director of Nursing indicated the pharmacy recommendation had not been addressed timely and should have been and the reason of Hospice was not appropriate.<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled," Medication Management: Unnecessary Drugs", dated 4/1/2022, and indicated the policy was the one the facility currently used. The policy indicated"... 1. The policy will ensure that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental. physical, and psychosocial wellbeing. ...3. Unnecessary drugs are defined as any drug when used: A. In excessive dose (including duplicate drug therapy.) B. For excessive duration. C. Without adequate monitoring. D. Without adequate indications for its use. E. In the presence of adverse consequences that indicated the dose should be reduced or discontinued. F. Or any combination of the reasons above. 2. The Consultant Pharmacist will address the use of unnecessary drugs during the medication regimen review...."<br><br>3.1-48(b)(2) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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. | | | |

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| | §483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation and interview, the facility failed to ensure medications/treatments were kept in a locked cabinet or cart when unattended, failed to ensure medication storage areas were free from loose medications; undated medications; appropriately separated; and a medication with no resident identifiers during medication storage reviews for 2 of 2 treatment carts observed, 1 of 1 medication rooms observed and 2 of 3 medication carts observed. (F hall treatment cart, D hall treatment cart, Long Term medication room, and E & F hall medication carts)<br><br>Findings include:<br><br>1. During an observation, on 8/15/2022 from 6:55 A.M. to 7:28 A.M., the F hall treatment cart was observed unlocked and unattended.<br><br>During an interview, on 8/15/2022 at 7:29 A.M., | F 0761 | 1. The Medication/Treatment Carts are required to be locked and since the identification of this which has since surpassed therefore corrections could not be made. The Medication carts have been checked and any loose pills removed and/or items stored improperly. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.<br>3. Licensed Nursing Staff and Qualified Medication Aids have been educated by the Director of Clinical Education on the requirement as it relates to | 09/23/2022 |

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| | LPN 8 indicated the cart should not be left unlocked.<br><br>2. During an observation, on 8/15/2022 at 7:05 A.M., the D hall treatment cart was unattended, unlocked and had an opened box of Diclofenac gel (anti inflammatory) for Resident 7.<br><br>During an interview, on 8/15/2022 at 7:06 A.M., LPN 8 indicated the cart should not be unlocked and the medication should not be left out on the cart.<br><br>3. During a random observation, on 8/15/2022 at 3:20 P.M., the F hall treatment cart was unattended and unlocked.<br><br>During an interview, on 8/15/2022 at 3:21 P.M., LPN 7 indicated the treatment cart should not be left unlocked.<br><br>4. During a medication storage observation on 8/16/2022 at 2:03 P.M., the following was observed: 1 opened bottle of women's day multi vitamins with only a name on the bottle; 3 loose pills in 2 drawers.<br><br>During an interview, on 8/16/2022 at 2:06 P.M. LPN 7 indicated the bottle should have had the resident's name, room number and instructions of how many to take.<br><br>During an interview, on 8/16/2022 at 2:07 P.M., QMA 18 indicated the loose pills should not be in the cart.<br><br>5. On 8/18/2022 at 11:03 A.M., the Long Term Medication Room was observed to have the following: an opened unlabeled bottle of women's daily multi vitamins for Resident 32, and 2 | | Medication Storage, Locked Medication/Treatment Carts along with proper storage of items within the mediation cart by 9.23.22.<br>· Nursing Administration will perform random rounds daily to check medication/treatment carts to ensure they are locked at all times when not in use. Medication Carts will be checked weekly to ensure items are stored properly and in the proper location.<br>4. Medication Observation audits will be forwarded to QAPI for review. Results of those audits will be presented by the Director of Nursing and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | packages of Bisacodyl suppositories for two residents who had since died on 7/13 and 7/20/2022.<br><br>During an interview, on 8/18/2022 at 11:04 A.M., QMA 18 indicated the multi vitamins were not listed on Resident 32's medication list and should have been sent back to the pharmacy or given to the family along with the suppositories for the other 2 residents.<br><br>6. On 8/18/2022 at 11:12 A.M., the E hall medication cart was observed to have the following: the top drawer had an unopened bottle of nitroglycerine tablets, a bottle of Acidophilus, and a spray bottle of sure prep (protective spray for skin) in the same compartment with oral medications.<br><br>During an interview, on 8/18/2022 at 11:13 A.M., QMA 19 indicated the spray should not be in the medication cart like that.<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled, " Medications Management Program", dated 7/13/2021, and indicated the policy was the one currently used by the physician. The policy indicated "...1. A. Medications carts are organized in a consistent manner. ... 3. The medication cart is locked when not in use and in direct line in sight. ...5. No medications, chemicals or other dangerous articles are left on top of the cart...."<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled," Medication Management 6.4 Medication Labeling", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. Ensure that all drugs and | | | |

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| | biological's used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions. ...4. Any item that is improperly labeled, damaged, soiled or appearing to be tampered with or received in an unsealed condition should be replaced. ...11. Strip labeling may be added to the original label of an OTC product to identify the name of the resident(s) the container intended for...."<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled, " Medication Disposal and Returns", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...1. It is the responsibility of the nursing staff to dispose of any discontinued and/or expired medications that are NOT returnable to the LTC Provider Pharmacy. ...4. Licensed nursing staff is responsible for removing all discontinued medications (e.g. Liquids, creams, patches, ophthalmic solutions, inhalers, etc.) at the time of discontinuation from the cart and/or storage area. ...6. The nurse should place all discontinued or outdated medications in a designated, secure location which is solely designated for Pharmaceutical waste destruction. ...9. Facility should dispose of discontinued medication, out dated medication, or medications left in the facility after a resident has been discharged in a timely fashion utilizing the same process...."<br><br>3.1-25(j)<br>3.1-25(o)<br>3.1-25(m)<br>3.1-25(r) | | | |
| F 0812 SS=E | 483.60(i)(1)(2)<br>Food | | | |

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| Bldg. 00 | Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, record review and interviews, the facility failed to ensure food was stored, prepared and served in a sanitary manor in 1 of 1 kitchens and 2 of 3 nourishment pantries. This deficient practice potentially affected 78 of 81 residents in the facility who consumed food.<br><br>Finding includes:<br><br>During a sanitation tour of the kitchen, conducted on 8/11/2022 between 9:55 A.M. - 10:30 A.M., the following was noted:<br><br>There was a white plastic tubing draining water into a floor drain, from the ice machine. The tubing was noted to be touching the edge of the floor drain. There was no air gap between the end of | F 0812 | 1. The floor drain coming from the ice machine was immediately elevated at the time of the discovery. The splash guard was immediately cleaned at the time of the discovery. The employee noted that had the cell phone by the serving area was immediately educated with the phone removed at the time of the discovery. The spatula was placed into the trash at the time of the discovery. The convection oven has been cleaned and no longer has grime on it. The package of ham had just had been opened and the date written on it as required. The cook had been | 09/23/2022 |

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| | the drainage tubing and the floor drain to prevent potential bacterial contamination.<br><br>The splash guard to the large stand up mixer was noted to be heavily soled with multiple different colors of dried substances.<br><br>There was an employees phone, connected to a charging cable, lying on the stainless steel food preparation counter. The evening cook was noted to be placing various types of food items on the counter as she prepared to make tuna salad for the evening meal.<br><br>A small stand up mixer was stored, uncovered on a shelf underneath the toaster. During an interview with the cook and dietary aide, Employees 50 and 51, both staff indicated the mixer was not utilized very often.<br><br>One large spatula had a visibly burnt/melted handle and a chunk of rubber missing from the spatula end.<br><br>The bottom convection oven had a large accumulation of burnt debris build up on bottom and a heavy greasy build up on the doors.<br><br>There was a portion of ham, located in the walk in refrigerator that was opened and not dated when it had been opened.<br><br>During an observation of the meal service, conducted on 8/11/22 at 11:28 A.M., Cook 50 was observed wearing his mask under his mouth and nose while he prepared food<br><br>After preparing pureed Shepherd's pie meat mixture in the food processor, Employee 50 washed the container and them returned to the | | educated immediately around the mask use and the temping of the food items at the time of the discovery. The Nursing Pantry refrigerators have been cleaned and unauthorized items removed from refrigerators. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.<br>3. The Dietary Department has been educated by the Administrator on the requirement as it relates to a clean sanitary environment within the kitchen by 9.23.22.<br>· The Administrator and/or designee will perform the weekly sanitation checklist and forward any abnormal findings to the Dietary Supervisor for immediate correction.<br>4. Sanitation Audits will be forwarded to QAPI for review. Results of those audits will be presented by the Administrator and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | food preparation area without washing his hands and continued to prepare food.<br><br>Cook 50 did not clean the food thermometer after taking the temperature of mechanical prepared chicken meat. The chicken meat had measured 111 degrees Fahrenheit. The cook then placed the unsanitized thermometer into the cooked rice, cooked carrots and cooked chicken pieces. He did not sanitize the thermometer at any point during the food temperature process.<br><br>During an observation of the meal preparation, conducted on 8/15/2022 at 11:10 A.M., the Food Service Supervisor was noted have placed 6 pieces of cooked ham into the food processor. Next he poured an unmeasured amount of ham glaze from a metal steam table pan, into the food processor with the ham. He then, with his bare hands, opened a plastic bag of bread and reached into the bag, obtained two pieces of bread and placed the bread into the food processor with the ham and glaze.<br><br>During an interview with the Food Service Supervisor, on 8/15/2022 at 2:55 P.M., he confirmed Employee 50 should have sanitized the thermometer before and during obtaining food temperatures.<br><br>During an observation of the nourishment pantries, conducted on 8/16/22 at 2:12 P.M. with RN 14, the following was noted:<br>The refrigerator in the Rehabilitation unit pantry had dried drips of food and liquids noted in both the freezer and refrigerator sides. In addition, there were beverages, unlabeled and undated, identified by RN 14 as staff beverages. There were unlabeled drinks and cookies stored in a visibly soiled plastic bag. The plastic bag was noted to | | | |

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| | be very sticky to the touch on he outside.<br>The refrigerator in the long term care pantry had an unlabeled, opened pitcher of a red colored liquid and a carton of expired almond milk. In addition, there was a plastic bag with soiled plastic containers. The plastic container had an unidentified brown liquid in the bottom. There was also a dried brown liquid underneath the refrigerator drawers. There was also brown splatters in the freezer close to the ice maker.<br><br>A policy regarding the maintenance and cleaning of refrigerators in nourishment pantries was requested on 8/17/2022 at 3:00 P.M., and was not provided.<br><br>Review of the facility policy and procedure, titled "Nutrition Policies and Procedures", provided on 8/16/2022 at 3:12 P.M. by the Corporate Regulatory Specialist nurse the following was included: "...Guidelines for checking food temperatures: 1. Make sure the thermometer is clean and has been sanitized with an appropriate sanitizer....Safe Food Handling: ...6. Food is served with clean, sanitized utensils. 7. The food preparation area and utensils used to prepare food are cleaned and sanitized prior to your use, using approved washing and sanitizing technique....."<br><br>3.1-21(i)(3) | | | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of | | | |

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| | communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. | | | |

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| | (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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on record review, observation and interview, the facility failed to ensure proper infection control practices were implemented related to not handling medications with an ungloved hand in 1 of 3 medication observations; failed to complete hand washing during catheter care for 1 of 1 residents observed for catheter care; failed to change gloves/wash hands during wound care for 1 of 1 residents observed for wound care and failed to ensure oxygen tubing and nasal cannula were stored in a sanitary manner for 1 of 1 residents reviewed for oxygen use. ( RN 16, CNA 10 and LPN 11 )<br><br>Findings include: | F 0880 | 1. The Nurse administering the medications has been educated on the proper handling of medications during a medication pass. Nursing staff has been educated on handwashing during catheter care, wound care and ensuring oxygen tubing is stored in a sanitary manner. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing at the facility and who are dependent for medication administration, catheter care, wound care and oxygen use has the potential to be | 09/23/2022 |

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| | 1. During an medication observation on 8/15/2022 at 8:36 A.M., RN 16 was observed to pull the morning medication cards from the medication cart on the B hall for Resident 42. RN 16 reviewed the order on the computer screen then on the medication card and with an ungloved hand, she punched put out the potassium pill into her hand, then placed the pill into a plastic medicine cup. RN 16 continued to repeat the same sequence for 6 other pills.<br><br>During an interview, on 8/15/2022 at 8:29 A.M., RN 16 indicated her hands were clean, but probably should have worn gloves.<br><br>2. A clinical record review was completed on, 8/15/2022 at 3:27 P.M. Resident B's diagnoses included, but were not limited to: chronic venous hypertension, lymphedema, anxiety, indwelling urethral catheter and retention of urine.<br><br>On 8/17/2022 at 11:46 A.M., CNA 10 was observed along with CNA 17 to provide catheter and peri care to Resident B. CNA 10 obtained a basin with water and washcloths and placed them on the over the bed side table. CNA 10 washed the residents front area with soap and water and with one hand held the catheter and then wiped starting in the vaginal/peri area out towards the end of the catheter. The aide then rinsed the front area by ringing water across the area then wiped it again with another wash cloth. CNA 17 repositioned the resident on the left side and supported the residents position. CNA 10 washed the residents buttocks and in between the upper thighs. She then applied water to rinse the area and patted the buttocks dry. CNA 10 with the same gloves on, removed the dirty linens from the bed and then applied clean linens. | | affected by the alleged deficient practice.<br>3. Nursing staff has been educated by the Director of Clinical Education on Medication Pass, Handwashing for catheter use, handwashing prior and following wound care with return demonstration and proper oxygen storage by 9.23.22.<br>· Nursing administration will perform random rounds weekly to observe catheter/wound care and validate handwashing occurs as required.<br>· Nursing administration will round weekly to validate proper oxygen storage and labeling occur any violation found will be immediately corrected.<br>4. Infection Control Audits will be forwarded to QAPI for review. Results of these audits will be presented by the Infection Control Nurse and/or designee monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | CNA 10, then placed a Hoyer pad under the resident, still with the same gloves that were used for washing her Foley catheter and her buttocks. CNA 10 moved the resident and repositioned the pad underneath the resident. CNA 10 then removed her gloves and washed her hands.<br><br>During an interview, on 8/17/2022 at 12:01 P.M., CNA 10 indicated she should have removed her gloves and washed her hands after washing the resident. 3. During an observation of wound care, conducted on 8/18/22 at 8:50 A.M. for Resident 39 and on 8/18/2022 at 8:55 A.M. for Resident 48., LPN 11, the facility wound nurse was noted to have donned a pair of gloves, washed each resident's wounds with normal saline, utilizing a 4 inch by 4 inch gauze pad, then, without washing her hands and/or changing her gloves, proceeded to apply clean dressings to each resident's wounds.<br><br>On 8/18/2022 at 3:15 P.M., the Director of Nursing provided the policy titled," Medication Management Program", dated 7/13/2021, and indicated the policy was the one currently used by the facility. The policy indicated ... L Disposable gloves are available. ...8. B. Do not touch the medication when opening a bottle or a unit dose package...."<br><br>On 8/17/2022 at 2:30 P.M., the Director of Nursing provided the policy titled," Hand Hygiene/ Handwashing", dated 11/27/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...1. Hand hygiene/hand washing is done: After: A. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. After patient/resident contact. C. After contact with a contaminated object or source where there | | | |

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|---|---|---|---|
| | 155850 | A. BUILDING 00<br>B. WING | 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BELLTOWER HEALTH & REHABILITATION CENTER | 5805 NORTH FIR ROAD<br>GRANGER, IN 46530 |

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| | is a concentration of microorganisms, such as mucous membranes, non- intact skin, body fluids or wounds. D. After toileting or assisting others with toileting, or after personal grooming. ...H. After removal of medical/surgical or utility gloves...."<br><br>On 8/18/2022 at 2:00 P.M., the Director of Nursing provided the policy titled, "Indications for Glove Use", dated 11/27/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...1. A. Gloves are changed between patients/residents. B. Gloves are changed if contaminated with blood or body fluids before touching other parts of the same patient/resident...."<br><br>3.1-18(a) | | | |
| F 0921 SS=E Bldg. 00 | 483.90(i) Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation, record review and interviews, the facility failed to ensure the environment on the dementia unit was free of hazardous hygiene items and chemicals. This potentially affected 15 of 15 cognitively impaired residents residing on the dementia unit.<br><br>Finding includes:<br><br>During the initial tour of the facility, conducted on 8/11/2022 between 12:00 P.M. - 12:30 P.M., with the Dementia Unit Manager, RN 25, packaged denture tablets were noted in open plastic containers in 2 of 10 residents rooms. There were 15 ambulatory cognitively impaired residents | F 0921 | 1. The denture tabs were immediately removed from the area at the time of the discovery. The cleaning chemicals were placed in a secure area upon notification of the discovery. There was no negative outcome related to the alleged deficient practice.<br>2. Residents residing on the secure dementia unit have the potential to be affected by the alleged deficient practice.<br>3. Memory Care staff has been educated by the Director of Memory Care on the requirement | 09/23/2022 |

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| | observed on the unit.<br><br>On 8/12/2022 at 10:10 A.M., a packaged denture cleanser tablet was noted in an open plastic container in 1 of 10 residents rooms.<br><br>Review of the warning label from the brand of denture tablets included the following: "...Do not take internally. Do not breathe dust. Keep out of contact with eyes and avoid extended contact with skin...In exposed or concerned, get medical attention...if swallowed, contact Poison Control or doctor/physician...."<br><br>During an observation of the nourishment pantry area on the secured dementia unit, conducted on 8/16/22 at 2:12 P.M., with RN 16, an almost full plastic container of Dawn dishsoap and Kaboom bathroom foaming cleanser were located in an unlocked cupboard underneath the sink.<br><br>During an interview during the tour, with QMA 27, she indicated the cleaners should not be stored in an unlocked cupboard.<br><br>The warning label on the Kaboom cleanser included the following: "...Ingestion: Rinse mouth. Do NOT induce vomiting. Immediately call a Poison Center or doctor/physician...."<br><br>The warning label on the Dawn dish soap included the following: "...Keep out of reach of children. If in eyes, may cause discomfort...."<br><br>Review of the facility policy and procedure, titled "Medication Storage, "provided by the Director of Nursing on 8/18/2022 at 3:30 P.M., included the following: "...2. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff | | as it relates to keeping hazardous items locked and secure by 9.23.22<br>· Locking mechanisms has been installed on the night stands in each resident room to ensure items are locked and secure.<br>· The Memory Care Director will perform random checks to ensure all items are secured and locked.<br>4. Room Round audits will be forwarded to QAPI for review. Results of those audits will be presented by the Memory Care Unit Director Monthly for a period of 6-months or until compliance is achieved.<br>5. Date of Compliance 9.23.22 | |

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| | members...." There was no policy provided at the time of exit regarding storage of hazardous cleaning supplies.<br><br>3.1-19(e) | | | |