

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2023
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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 20, 21, 22, 23, 24 & 27, 2023</p> <p>Facility number: 002668 Provider number: 155745 AIM number: 200325990</p> <p>Census Bed Type: SNF/NF: 31 SNF: 6 Residential: 39 Total: 76</p> <p>Census Payor Type: Medicare: 3 Medicaid: 12 Other: 61 Total: 76</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/1/23.</p>	F 0000	<p><i>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</i></p> <p>Holy Cross Village requests consideration for the desk review for all citations.</p>	
F 0550 SS=D Bldg. 00	<p>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. 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.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jen Armendariz	TITLE DON	(X6) DATE 03/17/2023
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>§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.</p> <p>§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.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§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.</p> <p>§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.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate clothing for 1 of 2 residents reviewed for dignity. (Resident 32)</p> <p>Finding includes:</p>	F 0550	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 32 was ensured to be</p>	03/19/2023

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	<p>During an observation on 2/20/2023, CNA 1 was observed leaving Resident 32's room. Resident 32 was sitting in his recliner chair with his pants not fully pulled up and his shirt not pulled down over his torso.</p> <p>A clinical record review for Resident 32 was completed on 2/22/2023 at 11:05 A.M. Diagnoses included, but were not limited to: pulmonary embolism, dementia, diabetes mellitus type 2, and chronic kidney disease.</p> <p>An Admission Minimum Data Set (MDS) Assessment was completed on 12/22/2022. The assessment indicated Resident 32 has severe cognitive impairment. He required extensive assistance one staff member for dressing.</p> <p>A Care Plan initiated on 12/24/2022, indicated Resident 32 required assistance with activities of daily living (ADL's). The Care Plan Indicated Resident 32 required extensive assistance of staff to dress.</p> <p>On 2/22/2023 at 3:31 P.M., Resident 32 was observed sitting in a titled wheelchair wearing only a shirt and disposable brief. Resident 32 was visible from the hallway.</p> <p>During an interview on 2/22/2023 at 3:33 P.M., CNA 5 indicated, it was inappropriate to be dressed this manner when others can see him.</p> <p>On 2/23/2023 at 11:19 A.M., Resident 32 was observed lying in bed with a facility gown in place. The facility gown was twisted into the left arm hole exposing a disposable brief. The blankets only covered the lower body.</p>		<p>properly dressed.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents have the potential to be affected</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff were re-educated on Resident Rights with a focus on dignity.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? DON or designee will visually observe 5 residents a week x4 then monthly x5 to ensure residents dignity is maintained at all times. Observations may continue an additional 6 months if ongoing concerns are noted. Results will be reviewed during QAPI</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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F 0561 SS=D Bldg. 00	<p>On 2/24/2023 at 7:48 A.M., Resident 32 was observed lying in bed with a shirt and disposable brief in place. He was uncovered and exposed.</p> <p>A policy was provided on 2/24/2023 at 1:55 P.M., by the Assistant Director of Nursing (ADON) titled, "Resident Rights". The policy indicated, "...4. Respect and dignity. The resident has the right to be treated with respect and dignity ...b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless it would infringe upon the rights or health and safety of other residents"</p> <p>3.1-3(p)(4)</p> <p>483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and</p>			

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	<p>participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>Based on interview and medical record review, the facility failed to provide showers per the resident's choice for 1 of 1 resident reviewed for preferences. (Resident 6)</p> <p>Finding includes:</p> <p>During an interview, on 2/20/2023 at 10:42 A.M., Resident 6 indicated she only receives a shower on Fridays.</p> <p>A clinical record review for Resident 6 was completed on 2/21/2023 at 1:26 P.M. Diagnoses included, but were not limited to: hemiplegia affecting non-dominant side, psychotic disorder, epilepsy, anxiety disorder, and depressive disorder.</p> <p>An Admission Minimum Data Set (MDS) Assessment on 9/9/2022 indicated it was very important to Resident 6 to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>A Quarterly MDS Assessment on 12/7/2022 indicated Resident 6 was cognitively intact. She required total assistance with one staff member for bathing.</p> <p>A review of Resident 6's shower records, including electronic charting and shower sheet documentation, indicated she received the following showers for the past 30 days:</p>	F 0561	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 continues to be offered showers per care planned preference.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents have the potential to be affected</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff re-educated on the importance of honoring resident preferences. Staff were also educated on the importance of documenting all care provided to residents focusing on showers. Shower completion is being tracked by CNA team lead. A formal action plan will be developed for showers and documentation.</p> <p>4. How will the corrective actions be monitored to ensure</p>	03/19/2023

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F 0657 SS=D Bldg. 00	<p>2/3/2023 2/14/2023 2/12/2023 2/17/2023 2/20/2023 2/21/2023</p> <p>A Care Plan initiated on 9/10/2022, indicated Resident 6 required assistance with activities of daily living (ADL's). The Care Plan Indicated Resident was totally dependent on staff to provide a shower, and she preferred to have a shower in the evening three times a week.</p> <p>During an interview on 2/23/2023 at 1:55 P.M., CNA 5 indicated the facility provided a list that indicated a resident's shower day. She indicated Resident 6 received a shower three times a week.</p> <p>On 2/23/2023 at 2:19 P.M., the Assistant Director of Nursing (ADON) indicated that the facility does not have proof that Resident 6's showers are being completed three times a week, and that Resident 6 should have received showers three times a week.</p> <p>On 2/24/2023 at 1:55 P.M., the ADON provided a policy titled, "Resident Self-Determination; Promoting & Maintaining". The policy indicated, "...It is the practice of this facility to protect and promote resident rights by promoting and facilitating resident self-determination through support of resident choice"</p> <p>3.1-3(u)(3)</p> <p>483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan</p>		<p>the deficient practice will not recur? DON or designee will audit 3 residents a week x4 then monthly x5 to showers are being completed and documented per resident preference. Audits may continue for an additional 6 months if ongoing concerns are noted. Results will be reviewed during QAPI.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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	<p>must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>Based on observation, interview and record review, the facility failed to update the plan of care for 2 of 17 residents reviewed for care planning. (Residents 32 & 24)</p> <p>Findings include:</p> <p>1. A clinical record review for Resident 32 was completed on 2/22/2023 at 11:05 A.M. Diagnoses included, but were not limited to: pulmonary embolism, dementia, diabetes mellitus type 2, and chronic kidney disease.</p>	F 0657	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The care plans for residents 24 and 32 were updated accordingly.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken?</p> <p>All residents have the potential to</p>	03/19/2023
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	<p>An End of Medicare A Stay Minimum Data Set (MDS) Assessment on 1/20/2023 indicated Resident 32 had one fall with injury and one fall without injury.</p> <p>A Nurse's Note on 1/13/2023 at 2:00 A.M., indicated " ...Resident fell out of bed while having brief change and bed linen change. Fall was witnessed by CNA (Certified Nursing Assistant). He had rolled onto his side while receiving peri-care. Resident then fell from bed onto the floor, face down. Resident has an abrasion/hematoma to Rt/mid [right/middle] forehead with possible bruising noted on upper right orbital near eyebrow ...Left Front tooth has scant amount of bleeding near gums and does seem to be slightly loose. Very superficial abrasion to bridge of nose with no active bleeding ...Floor mat placed at bedside. Ice pack applied to resident's hematoma on forehead"</p> <p>On 1/23/2023 at 2:10 P.M., a Nurse's Note indicated, " ...This nurse heard someone yelling for help. When this nurse entered the room, resident was on his back on the floor fall mat ...Resident admitted to turning over in bed and fell off the side onto the floor"</p> <p>On 1/24/2023 at 9:45 A.M., a Nurse's Note indicated a bariatric bed was placed in the room.</p> <p>A Care Plan initiated on 6/7/2022 and revised on 12/24/2022 indicated Resident 32 had an increased risk for falls during basic activities of daily living. The last intervention placed was on 6/7/2022.</p> <p>A Care Plan initiated on 8/31/2022 indicated Resident 32 was at risk for falls due to poor safety awareness. The last intervention placed was on 8/31/2022.</p>		<p>be affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff who are responsible for updating care plans will be in-serviced on the Care Plan Policy. Falls and Psyche med changes will continue to be reviewed in IDT meetings.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The DON or designee will review care plans for residents who fall or have care-planned medication changes. To ensure appropriate updates are made in accordance with Care Plan Policy Audit results will be reviewed during QAPI for a minimum of 6 months.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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	<p>On 11/20/2022, a care plan indicated Resident 32 was a fall risk related to history of multiple falls, decreased mobility, balance, strength, endurance, and safety awareness; cognitive deficits; alteration in cardiac, endocrine, and prostate function; use of high-risk medications; frequent pain; shortness of breath; and bowel and bladder incontinence. An intervention included keeping the bed in the lowest position. The last intervention placed was on 12/23/2022.</p> <p>An observation on 2/23/2023 at 11:17 A.M., Resident 32 was observed to be in a bariatric bed with a mat to the left of bed. The bed was not placed in the lowest position.</p> <p>During an interview on 2/23/2023 at 2:03 P.M., the Assistant Director of Nursing (ADON) indicated she could not find an intervention placed on 1/13/2023 to prevent Resident 32 from falling out of the bed.</p> <p>An Admission Minimum Data Set (MDS) Assessment on 12/22/2022, indicated Resident 32 had severe cognitive impairment. He did not have any significant weight loss or gain. He required supervision with set up help for eating.</p> <p>A review of Resident 32's weights indicated the following: 2/3/2023 159.9 pounds 1/3/2023 175.6 pounds 12/2/2022 197.0 pounds 11/1/2022 195.0 pounds 10/4/2022 195.4 pounds</p> <p>A Dietary Note on 1/5/2023 at 12:58 P.M., indicated Resident 32 triggered for a significant weight loss for the past month and six months.</p>			

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	<p>Resident 32 had lost 11.1 percent of his body weight in one month. The note indicated, " ...He has had a significant decline in the past 1 month with Covid-19 outbreak, having Covid himself and taking meals in his room for several weeks because of required Covid isolation. He is on a regular diet with lower sugar options for his diabetes if he chooses" New interventions were placed for Carnation Instant Breakfast powder with 8 ounces of whole milk three times daily, fortified cereal at breakfast, fortified pudding at lunch, and fortified mashed potatoes with gravy at dinner.</p> <p>A Dietary Note on 2/7/2023 at 2:57 P.M., indicated Resident 32 had lost more weight this past month. Resident 32's weight was down 8.6 percent in one month and lost 18.8 percent in less than three months. The note indicated, " ...Therapy has order for feeding assistance at meals. He eats ok when fed/prompted"</p> <p>A Care Plan initiated on 2/15/2022 and revised on 12/24/2022 indicated for Resident 32 to have adequate intake of oral foods and beverages and to maintain adequate weight and fluid intake. The Care Plan did not address weight loss, or any interventions placed to assist in weight loss reduction.</p> <p>During an interview on 2/23/2023 at 3:19 P.M., the Registered Dietician indicated Resident 32 was placed on the Nutritionally at Risk reviews. She indicated she should have updated the care plan when the supplements were added.</p> <p>2. A clinical review for Resident 24 was completed on 2/22/2023 at 10:05 A.M. The diagnoses included, but not limited to: dementia with severe agitation, and severe protein-calorie malnutrition.</p>			

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	<p>A Physician Order, dated 10/20/2022, indicated "mirtazapine tablet 7.5 MG (milligram), give 1 tablet by mouth one time a day for Appetite Stimulant related to unspecified severe protein-caloric malnutrition."</p> <p>A Care Plan, dated 8/24/2022, indicated "[Name of Resident] is utilizing Marinol R/T appetite stimulation."</p> <p>During an interview on 2/22/2023 at 2:45 P.M., the Social Worker indicated the care plans are revised with every assessment period, quarterly, annual, significant change and any new behavioral changes. The Interdisciplinary team is responsible for the revisions. She is not on Marinol currently but on mirtazapine and the care plan was not updated and should have been.</p> <p>On 2/23/2023 at 1:45 P.M., the Assistant Director of Nursing (ADON) provided a policy titled, "Comprehensive Care Planning", revised 12/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Explanation and Compliance Guidelines: 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment...."</p> <p>On 1/24/2023 at 1:55 P.M., the ADON provided the policy titled, "Care Plan Revisions Upon Status Change". The policy indicated, "...The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change ...d. The care plan will be updated with the new or modified interventions"</p> <p>3.1-35(d)(2)(B)</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0677 SS=D Bldg. 00	<p>483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>Based on observation, interview, and record review the facility failed to ensure residents received showers/bathing twice a week and fingernails were cleaned for dependent Residents for 2 out of 3 Residents reviewed for activities of daily living. (Resident 9 &19)</p> <p>Findings include:</p> <p>1. A clinical record review for Resident 9 was conducted on 2/21/2023 at 1:28 P.M. The diagnoses included, but not limited to: Alzheimer's disease, major depressive disorder, and anxiety.</p> <p>The Resident 9's showers were scheduled for Monday and Thursday evening.</p> <p>The shower documentation in the electronic medical record indicated that he had a shower on 1/30/2023 and 2/16/2023, a bed bath on 1/26/2023, 2/6/2023 and 2/20/2023. There was no documentation for 1/23/2023, 2/2/2023, 2/9/2023 and 2/13/2023 of a shower or bed bath given.</p> <p>A Care Plan, dated 9/14/2022, indicated "I have an ADL Self Care Performance Deficit and require assistance with ADL's", with an intervention of "BATHING: Bro. Berg usually requires physical assistance of one staff member for bathing."</p> <p>During an interview on 2/22/2023 at 1:54 P.M., Certified Nurse Aide 11 (CNA) who works the day</p>	F 0677	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 9 and 19 were promptly provided with ADL assistance.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents have the potential to be affected</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff were re-educated on shower and nail care policies.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? DON or designee will audit 5 residents a week x4 then monthly x5 for completed hygiene and documentation in accordance with residents preferred shower schedule per careplan. Audits may continue for an additional 6 months if ongoing concerns are</p>	03/19/2023	

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	<p>shift indicated that each resident gets two showers a week unless they request more. When she gives a resident a shower if it is a male she shaves them, washes hair, trims toe and fingernails, checks the skin for open areas or bruises. The charting is done on the computer on the wall and the only place they chart. If a resident refuses, you would check refused in the charting.</p> <p>During an interview on 2/22/2023 at 2:21 P.M., Certified Nurse Aide 12 (CNA) who works second shift indicated that each resident gets two showers a week but depends on if heavily soiled they will shower. She charts in the computer when she gives a shower and is the only place showers are charted. She washes under arms, back, legs, feet, peri-area, face, hair and trims toe and fingernails, take a stick and cleans under the nails. If the person is diabetic, she does not trim nails. If a resident refuses she tells the nurse or asks a coworker to try, if refused then it is charted refused in the computer.</p> <p>During an interview on 2/23/2023 at 1:50 P.M., the Memory Care Manager indicated the residents are given 2 showers a week unless they want more. The CNA's document in Point Click Care (PCC) wall mount or the computer and do not document anywhere else. She would expect the CNA to give showers, if refused a bed bath would be done and documented. If the resident refused, she would expect the CNA to select refusal and the nurse to document the refusal in the progress notes. She indicated it was not documented on 1/23/2023, 2/2/2023, 2/9/2023, or 2/13/2023 that a shower was given in CNA charting or the progress notes and should have been.</p> <p>2. A clinical record review for Resident 19 was</p>		<p>noted. Results will be reviewed during QAPI</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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	<p>conducted on 2/21/2023 at 3:30 P.M. The diagnoses included, but not limited to: Alzheimer's disease, and dementia, severe, with agitation.</p> <p>During an observation on 2/20/2023 at 10:30 A.M., resident was sitting in a bedside chair looking at a magazine and noted a brown substance under his fingernails.</p> <p>During an observation on 2/21/2023 at 9:32 A.M., resident was sitting in a bedside chair looking at a paper and noted brown substance under his fingernails.</p> <p>During an observation on 2/22/2023 at 9:19 A.M., resident was sitting at the dining room table eating breakfast and noted a brown substance was under his fingernails.</p> <p>A Care Plan, dated 4/24/2022, indicated "I have an ADL Self Care Performance Deficit and require assistance with ADL's", with an intervention of BATHING: Mr. Barger usually requires total assist of one staff member for bathing.</p> <p>Showers were documented in electronic medical record on 1/25/2023, 1/28/2023, 2/8/2023, 2/11/2023 on day shift.</p> <p>Bed baths were documented on 1/24/2023, 1/27/2023, 1/29/2023, 1/30/2023, 2/2/2023, 2/3/2023, 2/6/2023, 2/7/2023, 2/10/2023, 2/12/2023, 2/13/2023, 2/14/2023, 2/16/2023, 2/17/2023, 2/20/2023, 2/21/2023, & 2/22/2023. No refusals of showers were documented.</p> <p>During an interview on 2/22/2023 at 1:54 P.M., the Certified Nurse Aide 11 (CNA) who works the day shift indicated when she gives a resident a shower</p>			

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F 0689 SS=D Bldg. 00	<p>if it is a male she shaves them, washes hair, trims toe and fingernails, checks the skin for open areas or bruises.</p> <p>During an interview on 2/22/2023 at 2:21 P.M., Certified Nurse Aide 12 (CNA) who works second shift indicated that she washes under arms, back, legs, feet, peri-area, face, hair and trims toe and fingernails, takes a stick and cleans under the fingernails.</p> <p>On 2/23/2023 at 2:30 P.M., the Memory Care Manager provided a policy titled, "Showering Residents", dated 3/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Explanation and Compliance Guidelines: 1. Residents will be provided showers per request and based upon resident safety. Showers are generally scheduled twice weekly or as preferred by residents. 2. Bed baths may be given on regular shower days if resident refuses showers...."</p> <p>On 2/23/2023 at 2:36 P.M., the Assistant Director of Nursing (ADON) provided a policy titled, "Nail Care", dated 11/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule generally in accordance with shower schedules. Nail care will be provided between scheduled occasions as the need arises...."</p> <p>3.1-38(3)(E)(2)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p>			

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	<p>§483.25(d) Accidents. The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review the facility failed to ensure safety measures were followed for a resident receiving a hair cut in the beauty shop while wearing oxygen for 2 out of 3 residents reviewed for accidents. Resident 9 & 32)</p> <p>Findings include:</p> <p>1. A clinical review for Resident 9 was completed on 2/21/2023 at 1:28 P.M. The diagnoses included, but not limited to: Alzheimer's disease, major depressive disorder, and anxiety.</p> <p>During an observation on 2/22/2023 at 10:15 A.M., Resident 9 was sitting in the beauty shop with his oxygen on and another female resident went in, and the door was closed. At 10:25 A.M. heard a device in use knock on the door and asked the beautician what device she was operating, and she indicated the portable electric clippers then she proceeded to pick up the portable hair dryer cleaning hair from the resident. Requested the beautician to stop. Observed the oxygen was running at 2.5 liters per nasal cannula.</p> <p>During an interview on 2/22/2023 at 10:27 A.M., the beautician indicated that she can run a hair dryer but only if the resident was not on a portable green tank.</p>	F 0689	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 9 and 32 returned to the unit no adverse effects noted. The beautician was advised that no oxygen can be worn while hair dryers are being used.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents utilizing oxygen therapy or in the salon while someone with oxygen is also receiving services have the potential to be affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? It was identified that the beautician was unaware of the difference between compressed air and liquid oxygen. The beautician was educated on the oxygen tanks used in this facility and the policy</p>	03/19/2023

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	<p>During an interview on 2/22/2023 at 10:30 A.M., the Administrator indicated that they do not allow a hairdryer to be utilized when a Resident is on oxygen.</p> <p>On 2/23/2023 at 8:35 A.M., the Administrator provided a policy titled, "Salon Services", revised 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... 8. Be sure that hair salon staff and other pertinent staff are trained/oriented on the following issues: a. Keeping hair dryer settings on low heat and monitoring to ensure the air does not become too warm. b. Keeping the oxygen tank at least 5 feet from the dryer unit as the tubing will allow without creating another hazard for individuals walking in the area. f. When possible, consider taking the oxygen off while the resident is under the dryer. This will require a nursing assessment...."</p>		<p>for oxygen use during salon services.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? DON or designee will observe salon services weekly to ensure oxygen is not in use in conjunction with any heat source used in the salon for a minimum of 6 months. In the event of ongoing concern observations may continue for an additional 6 months.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-039

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	<p>2. A clinical record review for Resident 32 was completed on 2/22/2023 at 11:05 A.M. Diagnoses included, but were not limited to: pulmonary embolism, dementia, diabetes mellitus type 2, and chronic kidney disease.</p> <p>An End of Medicare A Stay Minimum Data Set (MDS) Assessment on 1/20/2023 indicated Resident 32 had one fall with injury and one fall without injury.</p> <p>A Nurse's Note on 1/13/2023 at 2:00 A.M., indicated " ...Resident fell out of bed while having brief change and bed linen change. Fall was witnessed by CNA (Certified Nursing Assistant). He had rolled onto his side while receiving peri-care. Resident then fell from bed onto the floor, face down. Resident has an abrasion/hematoma to Rt/mid [right/middle] forehead with possible bruising noted on upper right orbital near eyebrow ...Left Front tooth has scant amount of bleeding near gums and does seem to be slightly loose. Very superficial abrasion to bridge of nose with no active bleeding ...Floor mat placed at bedside. Ice pack applied to resident's hematoma on forehead"</p> <p>On 1/23/2023 at 2:10 P.M., a Nurse's Note indicated, " ...This nurse heard someone yelling for help. When this nurse entered the room, resident was on his back on the floor fall mat ...Resident admitted to turning over in bed and fell off the side onto the floor"</p> <p>On 1/24/2023 at 9:45 A.M., a Nurse's Note indicated a bariatric bed was placed in the room.</p>			

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	<p>A Care Plan initiated on 6/7/2022 and revised on 12/24/2022 indicated Resident 32 had an increased risk for falls during basic activities of daily living.</p> <p>A Care Plan initiated on 8/31/2022 indicated Resident 32 was at risk for falls due to poor safety awareness.</p> <p>On 11/20/2022, a care plan indicated Resident 32 was a fall risk related to history of multiple falls, decreased mobility, balance, strength, endurance, and safety awareness; cognitive deficits; alteration in cardiac, endocrine, and prostate function; use of high-risk medications; frequent pain; shortness of breath; and bowel and bladder incontinence. An intervention included keeping the bed in the lowest position.</p> <p>An observation on 2/23/2023 at 11:17 A.M., Resident 32 was observed to be in a bariatric bed with a mat to the left of bed. The bed was not placed in the lowest position.</p> <p>During an interview on 2/23/2023 at 2:03 P.M., the Assistant Director of Nursing (ADON) indicated she could not find an intervention placed on 1/13/2023 to prevent Resident 32 from falling out of the bed.</p> <p>On 1/24/2023 at 1:55 P.M., the ADON provided the policy titled, "Fall Prevention Policy". The policy indicated, "...Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls"</p> <p>On 2/23/2023 at 8:35 A.M., the Administrator provided a policy titled, "Salon Services", revised 2/2023, and indicated the policy was the one</p>			

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F 0695 SS=D Bldg. 00	<p>currently used by the facility. The policy indicated "... 8. Be sure that hair salon staff and other pertinent staff are trained/oriented on the following issues: a. Keeping hair dryer settings on low heat and monitoring to ensure the air does not become too warm. b. Keeping the oxygen tank at least 5 feet from the dryer unit as the tubing will allow without creating another hazard for individuals walking in the area. f. When possible, consider taking the oxygen off while the resident is under the dryer. This will require a nursing assessment..."</p> <p>3.1-45(a)(1)(2)</p> <p>483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>Based on observation, interview, and record review the facility failed to ensure proper storage of nasal cannula tubing and CPAP mask when not in use for 2 out of 4 residents reviewed for respiratory care. (Resident 9 & 28)</p> <p>Findings include:</p> <p>1. A clinical review for Resident 9 was completed on 2/21/2023 at 1:28 P.M. The diagnoses included, but not limited to: Alzheimer's disease, major depressive disorder, and anxiety.</p>	F 0695	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents #9 and #28 were provided with new, dated respiratory supplies.</p> <p>2. How will other residents who have the potential to be affected be identified and what</p>	03/19/2023

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	<p>A Physician Order, dated 2/18/2023, indicated Oxygen at 2-5 liters per nasal cannula, titrate for BIOX above 90% every 24 hours as needed for oxygenation.</p> <p>During an observation, on 2/20/2023 at 11:57 A.M., Resident 9 was wearing nasal cannula attached to portable tank with tubing undated.</p> <p>During an observation, on 2/21/2023 at 9:26 A.M., nasal cannula was sitting on the wheelchair cushion and dated 2/19/23.</p> <p>During an observation, on 2/21/2023 at 12:55 P.M., there is a bag hanging on the back of the wheelchair dated 2/21 and the oxygen tubing was wrapped around the right handle of the wheelchair.</p> <p>During an observation, on 2/22/2023 at 9:20 A.M., a storage bag was hanging from the left handle of the wheelchair dated 2/21 and the tubing was wrapped around the right handle of the wheelchair.</p> <p>During an interview, on 2/22/2023 at 9:21 A.M., the Licensed Practical Nurse 16 (LPN) indicated that the oxygen tubing should have been placed in the bag when not in use.</p> <p>On 2/22/2023 at 2:15 P.M., the Assistant Director of Nursing provided a policy titled, "Oxygen Administration", revised 11/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use...." 2. During an observation on 2/20/2023 at</p>		<p>corrective action will be taken? All residents receiving oxygen therapy, nebulizer treatments, and/or utilizing C/BiPAPs have the potential to be affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All residents who receive oxygen therapy, nebulizer treatments, or utilize a CPAP/BiPAP were ensured to have supplies that were appropriately dated. Clinical staff were re-educated on what to do if respiratory supplies are noted to not have a date or if tubing is found to create an infection control concern. Staff were re-educated on respiratory supply storage when not in use.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The Infection Preventionist or designee will audit 3 residents weekly x4 then monthly x 5 to ensure proper labeling and storage of respiratory supplies is in accordance with facility policy. Audit results will be reviewed during QAPI. Audits may continue for an additional 6 months if ongoing concerns are noted.</p> <p>5. By what date will the systemic changes for each deficiency be completed?</p>	

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	<p>10:25 A.M., Resident 35's C-PAP mask was observed to be lying on the bed.</p> <p>On 2/21/2023 at 32:39 A.M., Resident 35's C-PAP mask and oxygen nasal cannula were lying on the bed.</p> <p>A clinical record review for Resident 35 was completed on 2/22/2023 at 10:00 A.M. Diagnoses included, but were not limited to: dementia, atrial fibrillation, and diabetes mellitus type 2.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment on 2/1/2023 indicated Resident 35 received oxygen therapy.</p> <p>A Care Plan initiated on 5/12/2022 indicated Resident 35 had altered respiratory status related to sleep apnea and reports of shortness of breath.</p> <p>On 2/22/2023 at 10:26 A.M., the C-PAP mask was observed to be lying on the bed, and the portable oxygen nasal cannula was lying in the seat of the wheelchair.</p> <p>On 2/23/2023 at 9:47 A.M., the C-PAP mask was observed lying on the bed, and the portable oxygen nasal cannula was lying on the bathroom floor.</p> <p>On 2/23/2023 at 9:49 A.M., CNA 6 was brought to Resident 35's room. CNA 6 indicated the portable oxygen nasal cannula should be in a respiratory bag, and the nasal cannula must have fallen out of the respiratory bag. CNA 6 picked the oxygen nasal cannula up from the bathroom floor and placed the nasal cannula in the respiratory bag attached to the wheelchair. CNA 6 indicated C-PAP masks are not stored in any particular way, and there was not a protocol for C-PAP mask storage.</p>		3/19/23	

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F 0812 SS=D Bldg. 00	<p>On 2/24/2023 at 1:55 P.M., the Assistant Director of Nursing provided the policy titled, "C-Pap, BiPap". The policy did not address storage of the C-PAP mask when not in use.</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to provide sanitary food service in 1 of 2 dining rooms residents observed for food delivery service. (main dining room)</p> <p>Findings include:</p> <p>1. On 2/20/2022 at 12:09 P.M. through 12:30 P.M., dining room food service was observed in the main dining room. Certified Nurse Aide (CNA) 1</p>	F 0812	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Clinical Staff will be reeducated on food delivery service to ensure infection control is maintained.</p> <p>2. How will other residents</p>	03/19/2023

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R 0000	<p>and 2 was observed having their thumb beyond the rim of the plate when serving the residents' salad, dessert and main plate.</p> <p>2. On 2/22/2023 at 8:22 A.M. through 8:31 A.M., breakfast was observed in the main dining room. Certified Nurse Aide 3 and 4 was observed having their thumb beyond the rim of the plate when serving the resident's main plate and served the bowl with the hand over the top.</p> <p>During an interview, on 2/22/2023 at 8:33 A.M., CNA 3 indicated that thumbs should not be on the plate and the bowls should be handled from the bottom and not over the top.</p> <p>On 2/27/2023 at 9:35 A.M., the Dietary Supervisor 15 provided a policy titled, " Dining Room/Retail Service Table Service", undated, and indicated the policy was the one currently used by the facility. The policy indicated, " Policy: The server will ensure proper service of all food and beverages, and proper removal of all courses and beverages. Procedure; Utilize The Service Experience training program located on the Seniors Resource page on Sodexonet for proper table service for all levels of dining. "The Service Experience Trainer Guide", addressed "serving meal tips with trainees". Hair and fingers should Never come in contact with food and/or any eating surface of the utensils or dinnerware...."</p> <p>3.1-21(3)</p>		<p>who have the potential to be affected be identified and what corrective action will be taken? All residents attending meals in the dining room have the potential to be affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Food delivery service education will be provided upon hire, annually, and as needed to promote infection prevention practices in accordance with facility policies.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The DON or designee will perform a minimum of 3 documented food delivery observations weekly x4 then monthly x5. Observations may continue for an additional 6 months if ongoing concern is noted. Observation results will be reviewed during QAPI.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and Licensure Survey.</p> <p>Survey dates: February 20, 21, 22, 23, 24, and 27, 2023</p> <p>Facility number: 002668</p> <p>Residential Census: 39</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p><i>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</i></p> <p>Holy Cross Village requests consideration for the desk review for all citations.</p>	
R 0148 Bldg. 00	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p>			

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	<p>(4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to ensure a yearly inspection was performed on the heating and ventilation system. This has the potential to affect 39 residents that reside at the facility.</p> <p>Finding includes:</p> <p>During an interview on 2/27/2023 at 10:30 A.M., the Director of Plant Operations indicated they change the filters quarterly and if there is a problem, they call Dynamic Mechanical. They do not come out to do a yearly inspection.</p> <p>On 2/27/2023 at 10:48A.M., the Director of Plant Operations provided a policy titled, " HVAC System Policy", dated 4/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Only qualified personnel shall service the HVAC system. a. The Administrator maintains a contract with a qualified service agency for routine servicing and maintenance of the HVAC system. b. The Maintenance Director is responsible for notifying the service agency of needed repairs, servicing, or maintenance. 6. Documentation of all inspections, test, and maintenance shall be maintained by the Maintenance Director...."</p>	R 0148	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dynamic Mechanical is scheduled to do an inspection of HVAC system 3/17/23.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents are potentially affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Annual inspections will be scheduled and logged.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Inspection and service information will be documented and stored in the office of the Director of Maintenance. Results of inspection will be reported during QAPI</p> <p>5. By what date will the systemic changes for each</p>	03/19/2023

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R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to provide sanitary food service to 8 of 8 residents observed for food delivery service in the residential main dining room.</p> <p>Finding includes:</p> <p>On 2/23/2023 at 12:10 P.M., through 12:35 P.M., a dietary assistant was observed in the residential main dining room. Employee 13 was observed to have her thumb beyond the rim of the plate when serving the residents' main plate.</p> <p>During an interview on 2/23/2023 at 12:40 P.M., Employee 13 indicated she was unaware her thumbs were over the rims of the plates and they should not be over the edge of the plate when serving residents.</p> <p>On 2/27/2023 at 11:38 A.M., Dietary Supervisor 15 provided a policy/ brochure currently being used entitled,"The Service Experience Trainer Guide." The policy/brochure addressed "serving meal tips with trainees". Hair and fingers should Never come in contact with food and/or any eating surface of the utensils or dinnerware.</p>	R 0273	<p>deficiency be completed? 3/19/23</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dietary staff will be reeducated on food delivery service to ensure infection control is maintained.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All Assisted Living residents attending meals in the dining room have the potential to be affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Food delivery service education will be provided upon hire, annually, and as needed to promote infection prevention practices in accordance with facility policies.</p>	03/19/2023

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R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the		<p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The dietary manager or designee will perform a minimum of 3 documented food delivery observations weekly x4 then monthly x5. Observations may continue for an additional 6 months if ongoing concern is noted. Observation results will be reviewed during QAPI.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>	

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	<p>resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>A. Based on record review and interview, the facility failed to provide the required documentation of photographs for 3 of 5 residents and advanced directive for 1 of 5 residents in the emergency file. (Residents C, D, G, & F)</p> <p>Finding include:</p> <p>1. A record review of Resident C was completed on 2/24/2023 at 10:14 A.M. Diagnoses included, but were not limited to: coronary artery disease, heart failure, and diabetes.</p> <p>A review of the emergency file binder indicated a photograph was not available.</p> <p>2. A record review of Resident D was completed on 2/24/2023 at 10:44 A.M. Diagnoses included, but were not limited to: anxiety, depression, and osteoporosis.</p> <p>A review of the emergency file binder indicated a photograph was not available.</p> <p>3. A record review of Resident F was completed on 2/24/2023 at 11:34 A.M. Diagnoses included, but were not limited to: congestive heart failure, anxiety, and small bowel obstruction.</p> <p>A review of the emergency file binder indicated an advanced directive was not available.</p> <p>4. A review of Resident G was completed on 2/24/2023 at 11:10 A.M., Diagnoses included, but were not limited to: Hypertension.</p> <p>A review of the emergency file binder indicated a photograph was not available.</p>	R 0356	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents C, D, and G pictures were updated in EMR and placed in ICE packet. The AL Manager located the advanced directive for resident G in the ICE packet at the time it was questioned.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents have the potential to have been affected.</p> <p>A.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? IT provided education to the AL Manager on using the new camera to upload resident photos into EMR. AL Manager will ensure ICE Packets are complete within 24-72 hours of admission.</p> <p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? AI Manager will document ICE Packet completion for all new Residential admissions for the</p>	03/19/2023

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	<p>During an interview on 2/24/2023 at 1:28 P.M., the Nurse Supervisor indicated the facility did not have a camera for a while and photographs were not obtained. She indicated many photographs were not obtained during periods of Covid-19 outbreaks. She indicated a camera had been purchased from Amazon, and needs to catch up on the photographs. The Nurse Supervisor indicated that advanced directives should be a part of the emergency file.</p> <p>On 2/27/2023 at 10:29 A.M., the Nurse Supervisor provided the policy titled, "Emergency Preparedness-Evacuation". The policy indicated, "...Resident Emergency Packets e. The emergency information packet will include: v. Power of Attorney and/or advanced directives...." The policy did not indicate the need for a photograph.</p> <p>B. Based on record review and interview, the facility failed to ensure a Certified First Aid employee was working every shift.</p> <p>Finding includes:</p> <p>A nursing schedule dated 2/19/2023 through 2/28/2023 indicated there were no certified first aid employees working on first, second or third shift.</p> <p>During and interview on 2/27/2023 at 10:11 A.M., the Director of Nursing indicated there should have been qualified staff in the Assisted Living building that are certified in First Aid.</p> <p>On 2/27/2023 at 10:15 A.M., the Director of Nursing provided a policy titled, "Nursing CPR (Cardiopulmonary Resuscitation) and First Aid", dated 2/23 and indicated the policy was the one currently used by the facility. "...It is the policy of this facility CPR certified staff will be available at</p>		<p>next 6 months. Documentation will be reviewed during QAPI</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p> <p>B.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were directly affected by the clinical staff not having first aid certification.</p> <p>2. How will other residents who have the potential to be affected be identified and what corrective action will be taken? All residents have the potential to have been affected.</p> <p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? HR Manager contacted CPR provider to ensure going forward the CPR class provided includes BLS and First Aid. Employees who obtain CPR certification elsewhere will be required to provide proof of First Aid Certification in accordance with facility CPR policy.</p>	

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	all times...Staff working in Assisted Living will maintain a "first aid certification" in addition to CPR...."		<p>4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Employee CPR/First Aid certification status will be reviewed monthly during QAPI to ensure staff are up to date on certifications.</p> <p>5. By what date will the systemic changes for each deficiency be completed? 3/19/23</p>		