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	155850	A. BUILDING 00 B. WING	08/14/2023

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00411784. This visit was in conjunction with the Investigation of Complaint IN00414532. Complaint IN00411784 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00414532 - No deficiencies related to the allegations are cited. Survey dates: August 7, 8, 9, 10, 11, 12, 13, & 14, 2023 Facility number: 013644 Provider number: 155850 AIM number: 22136441 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 17 Medicaid: 53 Other: 12 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/22/2023.	F 0000		
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marti Carmean	Administrator	09/15/2023

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

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Bldg. 00	Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such			

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	information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure the Physician Orders for Scope of Treatment (POST) form matched the Physician order for 1 of 82 residents whose Advanced Directives were reviewed (Resident 232). Finding includes: A record review was completed on 8/8/2023 at 1:16 P.M. Resident 232's POST form was signed by the resident on 7/21/2023 indicating to attempt CPR (Cardiopulmonary Resuscitation), and full interventions to meet medical needs. The POST form was signed by the physician on 7/21/2023. A Physician order, dated 7/22/2023, indicated Resident 232's code status was a DNR (Do Not Resuscitate). A Care Plan, with a start date of 7/27/2023, indicated that Resident 232 had elected a full code status with a goal of directing medical care to make values and treatments known in which stated desires would be honored. Approaches to support Resident 232's code status included, but were not limited to, notifying the physician of resident's desires and any needed physician's order obtained. During an interview, on 8/8/2023 at 2:50 P.M., Employee 12 reviewed Resident 232's chart and indicated that orders stated that Resident 232 was a DNR and that the signed POST form was for a Full Code status. During an interview on, 8/14/23 at 2:18 P.M., Employee 10 indicated the code status for	F 0578	1.Resident 232 physician order was immediately changed upon notification. There was no negative outcome related to the alleged deficient practice. 2.Residents residing at the facility have the potential to be affected by the alleged deficient practice 3.Facility wide audit completed to ensure all code status's match the physician order. Facility nursing staff has been educated on the requirement as it relates to Advanced Directives with an emphasis on Physician Orders by 9.13.23 · Code status audits will be conducted for new admissions and on a monthly basis any discrepancies will be immediately corrected. 1.The audit findings will be presented to the Quality Assurance and Performance Improvement Committee for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery. 2.Date of Compliance 9.18.23	09/18/2023

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	residents would be found on the face sheet of the residents' chart, and in physician orders. On 8/8/2023 at 2:45 P.M., the DON provided a current policy titled "Advanced Directives" with no initiation or revision date. The policy indicated " ...Physician Orders for Life Sustaining Treatment: A form designed to improve patient care by creating a portable medical order form that records patient treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency ...." 3.1-4(I)(7)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this			

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	section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with			

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	intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure that transfer and discharge paperwork was completed and given to a resident	F 0623	1.The ombudsman was notified for resident 76 on August 14th. Resident 76 did not return to	09/18/2023

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	or family members and failed to notify the ombudsman in a timely manner of resident's discharge from the facility for 1 of 1 residents reviewed for notification of discharge. (Resident 76) Finding Includes: A record review was conducted on 8/14/23 at 2:49 P.M., for Resident 76. Diagnoses included, but were not limited to: urinary tract infection, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, malignant neoplasm of uterus, inflammatory disease of uterus. An Admission MDS (Minimum Data Set) assessment, date 5/8/2023, indicated the resident was cognitively intact. A Discharge MDS assessment, dated 7/11/2023, indicated the resident had been discharged with an anticipated return to facility. A Progress Note, dated 7/11/2023 at 4:15 A.M., indicated Resident 76 had a significant change in condition and was sent to the ER (Emergency Room). No documentation was available that indicated transfer forms were completed and sent with Resident 76 to the hospital. A Discharge report and email, dated 8/7/2023 at 1:48 P.M., was provided by the Social Services Director on 8/14/2023 at 3:30 P.M., and did not include Resident 76 on the monthly discharge report to the Ombudsman. A Discharge report and email sent to the		facility from hospital 2.Residents residing at the facility that are transferred out and/or discharged to home have the potential to be affected by deficient practice. Discharge packets have been updated that includes validation with signatures of the Discharge notice, bed hold policy and ombudsman notification. 3.Licensed Nursing staff will be educated by the Staff Development Nurse on the discharge notices and the bed hold policy by 9.13.23. · Transfer & Discharge audits will be conducted on a weekly basis to ensure Transfer Paperwork is sent with the resident for hospital and home discharges. 1.The audit findings will be presented to the Quality Assurance and Performance Improvement Committee for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery. 2.Date of Compliance 9.18.23	

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	Ombudsman, dated 8/14/2023 at 3:54 P.M., was provided by the Executive Director which included Resident 76 as being discharged to the hospital. During an interview, on 8/14/2023 at 2:26 P.M., the MDS coordinator indicated that the resident was sent out to the hospital on 7/11/2023. It was unknown if transfer paperwork was sent with Resident 76 as there was nothing in the computer and the resident did not return to the facility. During an interview, on 8/14/2023 at 2:45 P.M., Employee 9 indicated that all transfer and discharge paperwork, including the bed hold paperwork, should be in the computer system, and if not in the computer, it was probably not done as staff has not been consistently completing paperwork. During an interview, on 8/14/2023 at 4:10 P.M., with the Administrator and Director of Nursing indicated there was no copy of transfer paperwork in the chart as paperwork is not duplicated and is sent with a resident when the resident transfers out. The facility would get the packet back when resident returned to the facility. (This resident did not return from the hospital). The Administrator indicated that the Ombudsman was sent a more comprehensive list of discharges for the month of July 2023 which was different from the Social Service Director's list. A current policy was provided by the Regional Nurse, on 8/9/2023 at 11:30 A.M., titled "Discharge Notification" with a revision date of 10/1/2020. The policy indicated " ...To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate, transfer or discharge of a resident, the documentation that			

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	must be included in the medical record, and who is responsible for making the documentation ...the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State long-Term Care Ombudsman and documentation to reflect in the resident's medical record. Document the reasons for transfer or discharge in the resident's medical record ...a copy of the transfer/discharge notice must be included in the resident's medical record ... Information provided to the receiving provider must include a minimum of the following: contact information of the practitioner responsible for the care of the resident, resident representative information, all special instructions or precautions for ongoing care, comprehensive care plans, diagnoses and allergies, medications and most relevant labs ...when a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident representative as soon as practicable ...Copies of emergency transfers must also be sent to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis ...They facility will keep evidence of monthly notification of Emergent Discharges to the Ombudsman ...." 3.1-12(a)(6)(A)			
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.			

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	§483.20(b) Comprehensive Assessments §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: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (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. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this			

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	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. (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.) (iii)Not less than once every 12 months. Based on observation, record review and interviews, the facility failed to ensure the comprehensive assessment was accurate and completed for 2 residents reviewed for dental status and bowel and bladder continence . (Resident 1 &51) Findings include: 1. The record for Resident 1, reviewed on 8/10/2023 at 2:54 P.M., indicated the resident was admitted to the facility with diagnosis, including but not limited to: multiple sclerosis, dry mouth and limitation of activities due to disability. The most recent Quarterly Minimum Data Set (MDS) assessment, completed on 6/29/2023, indicated the resident was alert and oriented and there was no indication, under the Oral/Dental Status section of the resident being edentulous (without teeth). Resident 1 was identified as requiring extensive to total staff assistance for activities of daily living, including personal hygiene, transfers and wheelchair locomotion.	F 0636	1. Resident 1 has been referred to the facility dentist to address resident's loose-fitting dentures. Resident 51's continence status has been added to the most current MDS. There was no negative outcome related to the alleged deficient practice. 2. Residents residing at the facility and have ill-fitting dentures and current bowel and bladder continence status has the potential to be affected by the alleged deficient practice. 3. MDS Nurse as well as licensed nursing staff has been educated by the Staff Development Nurse by 9.13.23 on the notification of dental needs of residents as well as of accurate bowel and bladder status. · Care Plan audits will be conducted weekly for 30 days and then monthly in conjunction with the MDS schedule.	09/18/2023

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	The significant change MDS assessment, completed 11/2/2022, did not assess the resident as being edentulous. During an interview with Resident 1, on 8/8/2023 at 9:01 A.M., she indicated her dentures were "fitting sloppy" and she indicated no one was offering to assist her with cleaning her dentures. During an interview with the MDS assessment coordinator, on 8/14/2023 between 8:00 A.M., and 5:00 P.M., she confirmed the MDS assessments were incorrect for Resident 1 regarding her oral status/teeth. 2. The record for Resident 51 was reviewed on 8/9/2023 at 1:51 P.M. Resident 51 was admitted to the facility with diagnosis, including but not limited to: urinary tract infection, type 2 diabetes mellitus with diabetic polyneuropathy, moderate, dementia without behavioral disturbance, lack of coordination, muscle wasting and atrophy multiple sites and muscle weakness. The Quarterly MDS assessment, dated 7/8/2023, indicated the resident was severely cognitively impaired, required the extensive assistance of two staff for transfers, bed mobility and toileting and required the extensive assistance of one staff for w/c locomotion, personal hygiene and dressing needs. The resident's incontinence needs section was not completed on the quarterly review. The Admission MDS assessment, completed on 6/23/2023 for Resident 51, indicated the resident required extensive assistance of two staff for toileting needs and was always continent of her bowels and bladder. There was no bowel or bladder incontinence		4. Resident assessment audits will be presented to the quality assurance and performance improvement committed, this tracking will be for monthly for three months and quarterly thereafter or until compliance is achieved. 5. Date of Compliance 9.18.23	

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	assessment completed for Resident 51 in the clinical record. The baseline care plan for Resident 51, contained a plan to address the resident's incontinence of bowel and bladder with interventions to assist the resident as needed. During an interview with CNA 13, on 8/10/2023 at 10:04 A.M., she indicated Resident 51 was both continent and incontinent of her bowels and bladder. She indicated the resident was usually aware of her need to void but did not always make it to the bathroom and was often incontinent. During an interview with the MDS coordinator, on 8/14/2023 at 10:04 A.M., she indicated the resident's Admission and Quarterly MDS assessments regarding the bowel and bladder continence section were incorrectly coded and should have reflected "Always incontinent" not "Always Continent." The MDS coordinator confirmed a bowel and bladder incontinence assessment had not been completed. 3.1-31(d)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure that the MDS (Minimum Data Set) assessment accurately reflected the resident's status as of the Assessment Reference Date for 1 out of 21 residents reviewed for MDS assessments. (Resident 68)	F 0641	1. Resident 68 has had the oxygen use added to the most current MDS. There was no negative outcome related to the alleged deficient practice. 2. Residents residing at the facility and have current oxygen orders has the potential to be	09/18/2023

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	Finding includes: The record for Resident 68 was reviewed on 8/11/2023 at 9:42 A.M. The diagnoses included, but were not limited to: chronic obstructive pulmonary disease and emphysema. A Physician's Order, dated 1/5/2023, indicated O2 (oxygen) at 2 liters per minute via nasal cannula every shift. During an interview, on 8/14/2023 at 11:13 A.M., the MDS coordinator indicated he was on oxygen during the assessment period for the Quarterly MDS assessments on 4/13/2023 and 6/9/2023 and Section O should have been marked for oxygen. She follows the Resident Assessment Instrument. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019. "...Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs...Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula...."		affected by the alleged deficient practice. 3. MDS Nurse as well as licensed nursing staff has been educated by the Staff Development Nurse by 9.13.23 on the requirement as it relates to oxygen use · Care Plan/MDS audits will be conducted weekly for 30 days and then monthly in conjunction with the MDS schedule. 4. Resident assessment audits will be presented to the quality assurance and performance improvement committed, this tracking will be for monthly for three months and quarterly thereafter or until compliance is achieved. 5. Date of Compliance 9.18.23	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and			

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	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 - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of			

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	this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interviews, the facility failed to ensure care plans were developed for 2 of 19 residents reviewed for care planning. (Residents 1 for dental care and Resident 15 Diabetes, Diuretic, anithypertensive and Vitamin D medication use) Findings include: 1. The record for Resident 1, reviewed on 8/10/2023 at 2:54 P.M., indicated the resident was admitted to the facility with diagnoses, included but not limited to: multiple sclerosis, dry mouth and limitation of activities due to disability. The Quarterly Minimum Data Set (MDS) assessment, completed on 6/29/2023, indicated the resident was alert and oriented and there was no indication, under the Oral/Dental Status section of the resident being edentulous (without teeth). The Significant Change MDS assessment, completed 11/2/2022, did not assess the resident as being edentulous. The current health care plans for Resident 1 included a plan to assist the resident with activities of daily living but the plan was not specific to what kinds of oral/dental assistance the resident needed. During an interview with Resident 1, on 8/8/2023 at 9:01 A.M., she indicated her dentures were "fitting sloppy" and she indicated no one was	F 0656	1. Resident 1 care plan has been updated to reflect current dental status, Resident 15 care plan has been updated to include diabetes, diuretic use, antihypertensives and vitamin D use. There was no negative outcome related to the alleged deficient practice. 2. Resident residing at facility and with edentulous status as well as diabetes, antihypertensive use, diuretic use and vitamin D use have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated by the staff development nurse on the requirement as it relates to comprehensive care plans by 9.13.23. Care plans will be reviewed and updated in conjunction with the MDS scheduled. · Care plan audits will be conducted weekly for 30 days and then monthly in conjunction with the MDS scheduled. 4. Care plan audits will be forwarded to quality assurance and performance committee for a period of monthly for 6- months or until compliance is achieved. 5. Date of Compliance 9.18.23	09/18/2023

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	offering to assist her with cleaning her dentures. The most recent dental exam for Resident 1, completed on 3/11/2020, recommended the resident use adhesive to ensure her dentures were fitting properly During an observation and interview with CNA 14, on 8/11/23 at 9:58 A.M., she thought the resident had dentures but when she was asked if she had assisted the resident with denture care, she changed her mind and said "maybe she has her own teeth." When asked to show where the resident's dental care equipment was located, CNA 14 walked into the resident's bathroom and could not locate any dental care equipment. CNA 14 then looked around room and could not locate any dental care supplies. Finally, Resident 1 indicated she thought she had some denture cleansing tablets she had purchased in a three drawer plastic cabinet. CNA 14 opened the top drawer of the cabinet and and there was a box of denture cleansing tablets shoved to the back of the drawer. Resident 1 was interview on 8/8, 8/9, 8/10 and 8/11 after she had received morning care regarding dental care and she indicated she had not been offered and/or assisted with denture care. During an interview with the MDS assessment coordinator, on 8/14/2023 between 8:00 A.M. and 5:00 P.M., she confirmed the MDS assessments were incorrect for Resident 1 regarding her oral status/teeth and she confirmed there was no care plan regarding denture care needs for Resident 1. 2. The record for Resident 15 was completed on 8/8/2023 at 11:45 A.M. Resident 15 was admitted to the facility with diagnoses, included but not			

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	limited to: nontraumatic subarachnoid hemorrhage, arteriosclerotic heart disease, chronic atrial fibrillation, type 2 diabetes mellitus, hypertension, and dysfunction of the bladder. The Quarterly MDS (minimum data set) assessment, completed on 6/20/2023 ,indicated Resident 15 was alert and oriented, required extensive assist of two staff for bed mobility, dressing and extensive assist of one for personal hygiene and toileting needs and was totally dependent for bathing needs, had not transferred out of bed, had two stage 3 unhealed pressure ulcers, and an indwelling urinary catheter The current Physician's Orders for medications, included, but were not limited to: a vitamin D supplement, Lantus insulin (a diabetic medication), Lasix (a diuretic medication) , Lisinopril (a medication to treat high blood pressure) Metaprolol Tartrate (a medication to treat high blood pressure, and Trajenta (a diabetic medication). There was no care plan to address the resident's diabetes, vitamin D deficiency, hypertension or diuretic medication use. During an interview with Employee 16, an OT1 on 8/10/2023 at 9:39 A.M., he indicated he had been working with the resident for approximately two weeks in May and when he was ready to work on transfers and chair positioning in the Broda reclining chair, the Hospice staff had removed the chair from the resident's room. He indicated he had requested multiple times for nursing to contact the Hospice staff in regards to the chair, but the chair had not been returned. There was no plan regarding the resident's need for a Broda chair.			

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	During an interview with the MDS coordinator, on 8/14/2023 at 9:45 A.M., she confirmed there was no care plan regarding hypertensive, vitamin D and diuretic medication use, no care plan regarding diabetes and no care plan addressing the resident's Broda chair needs. 3.1-35(a) 3.1-35(b)(1)			
F 0657 SS=E Bldg. 00	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 must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment,			

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	including both the comprehensive and quarterly review assessments. Based on observation, record review and interviews, the facility failed to ensure a care plan meeting was conducted timely and care plans revised timely for 4 of 19 residents reviewed for careplanning. (Resident 15, 39, 58 and179) Finding includes: 1. The record for Resident 15 was reviewed on 8/14/2023 at 12:30 P.M. Resident 15 was admitted to the facility with diagnoses included, but not limited to: nontraumatic subarachnoid hemorrhage, atherlosclerotic heart disease, chronic atrial fibrillation, hyperlipidemia, type 2 diabetes mellitus, mild cognitive impairment of uncertain or unknown etiology, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and insominia. The Quarterly, MDS (minimum data set) assessment, completed on 6/20/2023, indicated Resident 15 was alert and oriented, required extensive assist of two staff for bed mobility, dressing and extensive assist of one for personal hygiene and toileting needs and was totally dependent for bathing needs, had not transferred out of bed, had two stage 3 unhealed pressure ulcers, and an indwelling urinary catheter. During an interview with a representative from Resident 15's Hospice provider, conducted on 8/10/2023 at 11:43 A.M., she indicated Hospice usually attended the care plan meetings with the facility but she could not determine the date of the last coordinated care plan meeting. The care plan documentation from Resident 15's clinicial record indicated the last care plan meeting	F 0657	1.Resident 58,15,39 &179 has been provided an invitation to a care plan meeting 2.Residents residing at the facility have the potential to me affected by the alleged deficient practice. For existing residents, a care conference audit was performed and care plans scheduled if identified for the need. 3.Social service staff have been educated on the requirement as it relates to scheduling care plan meetings in conjunction with the MDS quarterly schedule. · Care Conference audits will take placed monthly in conjunction with the MDS schedule and any identified as being not complete will have an invitation sent. 1.Care Conference invitations and/or care conference schedules will be reviewed monthly at QAPI for a period of 6-months. The audit findings will be presented to the Quality Assurance and Performance Improvement Committee for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery. 2.Date of Compliance 9.18.23	09/18/2023

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	was conducted in January 2023. During an interview with the Social Service Director, on 8/14/2023 at 11:40 A.M., she indicated the resident was supposed to have had a care plan meeting on 6/30/2023 but she was on vacation and the meeting was not conducted. 2. During an interview, on 8/11/2023 at 11:55 A.M., the Assistant Director of Nurses (ADON) indicated Resident 39 had a non - pressure area to the right buttocks, and a deep tissue injury to the left heel. During an observation, on 8/11/2023 at 11:57 A.M., the following was observed on the left heel: a dark purple area approximately 1" x 1/2". The ADON indicated at times the aides would put a pillow under the legs. The area was measured on Wednesday 8/9/2023, and measured 2.2 cm x 2.5 cm. During an interview, on 8/11/2023 at 11:58 A.M., Resident 39 indicated "when I asked them (aides) to put the pillow under my legs they have an attitude and feel like they don't have time". The resident indicated she did not have the area before she fell and fractured her hip. A record review was completed on 8/11/2023 at 2:29 P.M. Resident 39's diagnoses included, but were not limited to: hypertension, fractured hip, anxiety, depression, chronic pain, fibromyalgia and rheumatoid arthritis. A 5-day MDS (Minimum Data Set) assessment, dated 7/19/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use and limited assist for eating.			

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	A Nurse's Note, dated 7/13/2023 at 6:30 A.M., indicated Resident 39 complained of pain to the left heel this AM. "...The resident continues to rest in her recliner with lower extremity on hard surface of leg rest. Redness blanchable noted to the left heel. The physician was notified with new orders for skin prep, heel protector and elevating the left lower extremity. Heel protector applied, left lower leg elevated with pillows and resident encouraged to keep it elevated. Resident stated pain relief after treatment started...." Current Physician Orders included the following: Order date of 7/13/2023 to elevate/float heels while in bed. Order date of 7/17/2023 for a Heel cup to the left heel and to change weekly. Order date of 7/26/2023 to cleanse with normal saline and apply betadine daily to the left heel. A current Care Plan, dated 7/26/2023, indicated the resident has a DTI (deep tissue injury) to her left heel. Interventions included, but were not limited to: Assess and record the condition of the skin surrounding the pressure. Assess the pressure ulcer for location, stage, size length, width, and depth, presence/absence of granulation tissue and epithelization weekly. Conduct a systematic skin inspection weekly. Report any signs of further skin breakdown Keep clean and dry as possible. Minimize skin exposure to moisture. Keep linens clean, dry, and wrinkle free. A Nurse's Note, dated 7/17/2023 at 3:36 P.M., indicated "...a skin assessment was completed, noted DTI (deep tissue injury) to the left heel. MD notified and new orders noted for Sure prep (protective barrier) and heel cup, change weekly...." During an interview, on 8/11/2023 at 3:31 P.M., the			

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	Director of Nursing indicated there should have been new interventions put into place when she came back after her surgery and the care plan was not updated and should have been.3. A record review for Resident 58 was completed on 8/8/2023 at 9:15 A.M. Diagnoses included, but not limited to: type 2 diabetes, hypertension, difficulty walking and muscle weakness. During an interview, on 8/8/2023 at 9:42 A.M., Resident 58 indicated she does not have care plan meetings. The electronic medical record under the care conference section indicated that she had a care plan meeting on 3/16/2023 and 6/20/2022. During an interview, on 8/9/2023 at 10:22 A.M., the Social Service Director indicated she did not have a care conference in June of 2023 or December of 2022, and she should have. They follow the Minimum Data Set Assessment schedule. There was no documentation in the medical record that they met as a team to review her plan of care. 4. A record review for Resident 179 was conducted on 8/10/2023 at 9:30 A.M. Diagnoses included, but were not limited to: unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, quadriplegia, persistent vegetative state, dysphagia following nontraumatic intracranial hemorrhage, gastrostomy status, and contracture of muscle sites-Bilattwrist (bilateral wrist), hip, knee, ankle. A Care Plan, dated 8/28/2018, indicated, " [Resident name] has a history of UTI and is at risk for future infections r/t [related to] incontinence."			

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	During an interview, on 8/10/2023 at 2:30 P.M., the MDS coordinator indicated she should have revised/resolved the urinary incontinence care plan when he received the foley catheter. On 8/9/2023 at 10:57 A.M., the Social Service Director provided a policy titled, "Person Centered Care Plan", dated 10/19/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...8. Social Service staff notifies patient/resident and his/her legal representative prior to each care plan meeting and invites them to attend the meeting in order to solicit his/her input. If the patient/resident or their legal representative is unable to attend, the care plan will be reviewed with the patient/resident or their legal representative and their responses will be promptly documented...." 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interviews, the facility failed to ensure nail care was provided for 1 of 6 residents reviewed for Activities of Daily Living (ADL) needs. (Resident 20) Finding includes: A record review was completed for Resident 20 on 8/8/2023 at 3:09 P.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis	F 0677	1. Resident 20 had her nails clipped and cleaned there was no negative outcome related to the alleged deficient practice. 2. Resident residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility Nursing staff has been educated by nursing administration regarding clipping	09/18/2023

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	following cerebral infarction affecting right dominant side, aphasia and dementia without behavioral disturbances. A Quarterly Minimum Data Set assessment, dated 5/15/2023, indicated she was totally dependent for bathing and extensive assist of one with grooming and personal hygiene. A Care Plan, dated 11/15/2023, indicated Resident 20 required assistance with activities of daily living (ADL's) due to cerebral vascular accident with right side hemiplegia. Interventions included: bathing dependent of one staff and dressing extensive assist of one. During an observation, on 8/7/2023 at 11:58 A.M., Resident 20's last 3 fingers on her right-hand curled under, her nails were long and jagged with a brown substance under them and her toe nails were long. During an observation, on 8/9/2023 at 9:34 A.M., Resident 20's last 3 fingers on her right-hand curled under, her nails were long and jagged and both hands had a brown substance under them. During an observation, on 8/11/2023 at 11:00 A.M., Resident 20's last 3 fingers were curled under, her nails were long, jagged and hand brown substance under them. During an interview, on 8/10/2023 at 3:39 P.M., CNA 7 indicated when she gave a shower, she gathered the supplies together then washed the resident's hair and continued down the body, dried the resident off, conducted a skin check, applied lotion, and dressed them. During an interview, on 8/11/2023 at 9:48 A.M.,		residents nails during weekly showers · Guardian angels will monitor residents' nails during room rounds 5 x per week any identified residents will have their nails clipped when needed. 4. Shower audits will be reviewed monthly during QAPI this review will occur monthly for a period of 3 months or until compliance is achieved. 5. Date of compliance 9.18.23	

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	CNA 4 indicated she gathered her linens, informed the resident, she assisted them with washing, hair, nails, shaving, applied lotion then dressing. During an interview, on 8/11/2023 at 9:56 A.M., CNA 8 indicated she gathered linen, informed the resident, and assisted with washing as needed, then dried them off. She charted in the charting system and filled out a shower sheet. On 8/11/2023 at 11:18 A.M., the Regional Nurse indicated they did not have a policy on nail care. 3.1-38(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for Hospice services, received coordinated care between Hospice and the facility. (Resident 15) Finding includes: Resident 15 was admitted to the facility with diagnoses included, but not limited to: nontraumatic subarachnoid hemorrhage, arteriosclerotic heart disease, chronic atrial fibrillation, hyperlipidemia, type 2 diabetes	F 0684	1. The Hospice company has been contacted and has provided the facility with the 5 months of required documentation. Resident 51 has a Baroda chair on order and will be implemented upon arrival to facility, Hospice has been notified of therapy services for resident 51 and this treatment is not related to his current hospice diagnosis. There was no negative outcome related to the alleged deficient practice.	09/18/2023

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	mellitus, mild cognitive impairment of uncertain or unknown etiology, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, HTN, morbid obesity, neuromuscular dysfunction of the bladder, dysphasia, post COVID 19, depression, constipation, insomnia. On 1/24/2023, major depressive disorder, recurrent, mild was added to his diagnosis list. The Quarterly MDS (minimum data set) assessment, completed on 6/20/2023, indicated Resident 15 was alert and oriented, required extensive assist of two staff for bed mobility, dressing and extensive assist of one for personal hygiene and toileting needs and was totally dependent for bathing needs, had not transferred out of bed during the assessment period, had two stage 3 unhealed pressure ulcers, and an indwelling urinary catheter. During an interview with Resident 15, on 8/8/2023 at 9:50 A.M., he indicated he could not get out of bed because Hospice had taken his Broda chair. He explained he did not feel safe in the high back wheelchair in his room currently, because he just slid out of the chair. He indicated he was working with therapy and when the therapist was ready to work on transfers to the Broda chair, he discovered Hospice had removed the chair from the room. The resident indicated he was looking forward to being able to get out of his bed/room and possibly attend some activities and go outside when his family visited. The current Physician's Orders and Care Plan indicated the resident was receiving Hospice services. A labeled binder at the Nurses' desk, which had		2. Residents residing at the facility and on hospice services have the potential to be affected by the alleged deficient practice. 3. Facility staff has been educated on the requirement as it relates to coordination of care with hospice services. This education will be completed by 9.13.23 · * Hospice companies will be invited to attend future care plan meetings. Care conference audits will be conducted weekly for 30 days and then monthly in conjunction with the MDS scheduled. 4. Care plan attendance with hospice providers will be forwarded to QAPI monthly for 12 months 5. Date of Compliance 9.18.23	

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	the resident's name and Hospice provider on the front, had not been updated since March 2023. During an interview with the Nursing Unit Manager, on 8/10/2023 at 9:30 A.M., the unit manager indicates she did not realize the documentation in the Hospice binder was from February and March 2023 upon review. During an interview with a representative from Resident 15's Hospice provider, on 8/10/2023 at 11:43 A.M.. it was determined the Hospice provider should have been bringing current clinical notes into the facility every two weeks. She indicated facility's choose whether to have electronic communication or printed documents and this facility was supposed to have been receiving updated , printed notes in the Hospice binder every two weeks. The Hospice representative was unaware the binder had not been updated since March 2023. When queried regarding therapy recommendations and recent services, the representative indicated she was not aware of any approved therapy service for Resident 15. The Hospice provider usually sent their own therapy consultants. The representative did confirm the Broda chair had been removed by Hospice because the resident was not utilizing the chair. She was unaware of any attempts made to request the chair be brought back for the resident's use. When asked if Hospice participated in any care plan meetings with the facility and the resident, they indicated they did but could located or give the most recent care plan meeting they had attended for Resident 15. During an interview with the SSD, on 8/14/2023 at 11:40 A.M., she indicated the resident was supposed to have had a care plan meeting on			

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	6/30/2023 but she was on vacation and the meeting was not completed. Review of facility documentation indicated Resident 15 had a care plan meeting with Hospice participation in January 2023 and had not had a care plan meeting since January. The facility contract with the Hospice provider for Resident 15 indicated the following service to be provided by the Hospice company: "...2.3 Information/Documentation provided to Facility on admission and on-going, including:...Most recent POC (plan of care)...Copies of clinical notes after each visit; ...2.4 IDT (Interdisciplinary team) Designate a member of each IDT that is responsible for a patient who is a resident of the Facility.. the designated member is responsible for providing overall coordination of the Hospice care of the patient with the facility reprentative and communicating with Facility representatives and other Hospice to ensure quality of care for the patients/family;...." 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, observation and interview, the facility failed to ensure a resident had interventions in place to prevent the development of a DTI (deep tissue injury) skin area for 1 of 4 residents reviewed for pressure ulcers. (Resident 39) Finding includes: During an interview, on 8/11/2023 at 11:55 A.M., the Assistant Director of Nurses (ADON) indicated Resident 39 had a non- pressure area to the right buttocks, and a deep tissue injury to the left heel. During an observation, on 8/11/2023 at 11:57 A.M., the following was observed on the left heel: a dark purple area approximately 1" x 1/2". The ADON indicated at times the aides would put a pillow under the legs. The ADON indicated the area was measured on Wednesday 8/9/2023, and measured 2.2 cm (centimeter) x 2.5 cm. During an interview, on 8/11/2023 at 11:58 A.M., Resident 39 indicated "when I asked them (aides) to put the pillow under my legs they have an attitude and feel like they don't have time". The resident indicated she did not have the area before she fell and fractured her hip. A record review was completed on 8/11/2023 at 2:29 P.M. Resident 39's diagnoses included, but were not limited to: hypertension, fractured hip, anxiety, depression, chronic pain, fibromyalgia and rheumatoid arthritis.	F 0686	1.Resident 39 has had a new treatment put into place. Resident 39 has been assessed by the wound physician and care plan implemented addressing the affected area. 2.Residents residing at the facility that have a need for new treatment will have treatments initiated as needed. · Nursing administration will perform a facility wide skin sweep to ensure no other areas are identified. 1.Licensed Nursing has been educated by nursing administration the requirement as it relates to preventing deep tissue injuries by 9.13.23 · Treatment audits will be performed weekly for 30 days and then monthly thereafter with preventative measures put into place. 1.Weekly skin observation reports will be reviewed by Nursing Admin weekly x6 weeks. Results of those audits will be forwarded to QAPI for review for 6 months or until compliance is achieved. 2.Date of Compliance 9.18.23	09/18/2023

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	A 5-day MDS (Minimum Data Set) assessment, dated 7/19/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use and limited assist for eating. A Nurses' Note, dated 7/10/2023 at 6:17 P.M., indicated the resident arrived via ground ambulance, transferred to chair by EMS (emergency medical services). "...Resident returned from [name of hospital] after surgery-fixation left hip IM nailing. Resident is alert and oriented and able to make her needs known, up with walker and 2 assist to pivot to bedside commode. Resident resting with eyes closed in recliner. No signs or symptoms of pain noted at this time...." A Nurse's Note, dated 7/11/2023 at 5:15 P.M., indicated a follow up skin assessment was completed."... Left Hip fracture. Upper surgical area 4 sutures noted, lower left hip 3 sutures noted both surgical areas well approximated. No drainage noted...." The Note lacked documentation of any assessment of the left heel. An Admission assessment, dated 7/11/2023, indicated a surgical site to the left hip. The Assessment lacked the documentation of a skin assessment being completed on the left heel. A Nurse's Note, dated 7/12/2023 at 5:39 A.M., indicated Resident 39 was in the recliner resting with eyes closed. A Nurse's Note, dated 7/13/2023 at 6:30 A.M., indicated Resident 39 complained of pain to the left heel this AM. The resident continues to rest in her recliner with lower extremity on hard surface of leg rest. Redness blanchable noted to the left			

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	heel. The physician was notified with new orders for skin prep, heel protector and elevating the left lower extremity. Heel protector applied, left lower leg elevated with pillows and resident encouraged to keep it elevated. Resident stated pain relief after treatment started. A Nurses's Note, dated 7/15/2023 at 12:36 A.M., indicated BLE (bilateral lower extremities) elevated and heel protector to left heel in place. Compliant with med's and care and is resting quietly in bed at this time. A Nurse's Note, dated 7/17/2023 at 3:36 P.M., indicated: Skin assessment completed, noted DTI (deep tissue injury) to the left heel, 2 cm (centimeter) x 1 cm. Physician was notified and new orders received for Sure Prep (protective barrier), heel cup (heel protector) and change weekly. A Wound Evaluation and Management Summary, dated 7/19/2023, indicated the resident had an unstageable area to the left heel partial thickness measuring 1.5 x 1.0 cm (centimeters)."... Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater depth today. Discussed pain and pain management stratigies with the patient, family, and/or care providing staff. Patient not following recommendations to elevate legs. Patient not following repositioning or off loading recommendations. Reviewed off - loading surfaces and discussed care plan. Discussed wound healing trajectory and expectations with patient and/or family...." The clinical record lacked the documentation to show that Resident 39 was refusing and being			

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	non-compliant with the interventions of not off loading her heels. A Nursing Weekly Wound measurement, Date/Time Observed 7/17/2023 at 3:26 P.M. Length - head to toe direction was 2 cm (centimeters). Width - hip to hip direction 1cm Wound healing status: Declining Comments: DTI A Nursing Weekly Wound measurement: Date/Time Observed 7/19/2023 at 7:38 A.M. Length - head to toe direction (centimeters) 1.5 Width - hip to hip direction (centimeters) 1 Comments: unstageable A Nursing Weekly Wound measurement: Date/Time Observed 7/26/2023 at 10:43 A.M. Length - head to toe direction (centimeters) 2 Width - hip to hip direction (centimeters) 2 Wound healing: status Declining Comments: non compliant A current Care Plan, dated 5/19/2023 and revised on 8/8/2023, indicated the resident was at risk for skin breakdown related moisture, and sitting for extended periods of time. Preferred to sleep in a recliner causing additional risk.Interventions included, but were not limited to: "...Apply house skin barrier cream as needed. Daily skin inspection by CNA. Weekly skin assessment by nurse. Pressure reducing mattress and labs and diagnostics as ordered. Medications/Supplements as ordered. Notify MD/NP of any new areas. Perform treatment as ordered. Report any decline to wound nurse and wound physician...." A current Care Plan, dated 7/26/2023, indicated "... the resident has a DTI (deep tissue injury) to her			

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	left heel. Interventions included, but were not limited to: Assess and record the condition of the skin surrounding the pressure. Assess the pressure ulcer for location, stage, size length, width, and depth, presence/absence of granulation tissue and epithelization weekly Conduct a systematic skin inspection weekly. Report any signs of further skin breakdown Keep clean and dry as possible. Minimize skin exposure to moisture. Keep linens clean, dry, and wrinkle free...." A current Care Plan, dated 1/28/2018 and revised on 8/8/2023, indicated the resident was at risk for pain/discomfort related to: Fibromyalgia, rheumatoid arthritis, osteoarthritis, history of hip pain, chronic pain, lower back pain. Interventions included, but were not limited to: sleept in recliner for comfort, position for comfort with physical support as necessary. During an interview, on 8/11/2023 at 2:57 P.M., the ADON indicated there were no interventions put into place prior to the resident obtaining the area to the heel. During an interview, on 8/11/2023 at 3:31 P.M., the Director of Nursing indicated there should have been new interventions put into place when she came back after her surgery. On 8/14/2023, a policy for Pressure Ulcer Prevention was requested, but one was not provided prior to the survey exit. This Federal tag relates to complaint IN00411784. 3.1-40			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate care of a nephrostomy tube	F 0690	1.The care plan for resident 179 has been modified to include the nephrostomy tube, catheter and	09/18/2023

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	and foley catheter and Physician Orders for treatment for 1 of 1 residents reviewed for urinary and nephrostomy catheter. (Resident 179) Finding includes: A record review for Resident 179 was conducted on 8/10/2023 at 9:30 A.M. Diagnoses included, but not limited to: unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, quadriplegia, persistent vegetative state, dysphagia following nontraumatic intracranial hemorrhage, gastrostomy status, and contracture of muscle sites-Bilattwrist (bilateral wrist), hip, knee, ankle. A Care Plan, dated 7/30/2023, indicated "(Resident' first name) requires an indwelling urinary catheter and nephrostomy tube r/t obstructive uropathy." The goal was the following: "Resident will have catheter care managed appropriately, as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma." The interventions included: "Assess the drainage every shift. Record the amount, type, color, odor. Observe for leakages, Keep catheter system a closed system as much as possible, Nephrostomy and Catheter per MD order, Provide assistance with catheter care, Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine)." During an interview, on 8/10/2023 at 9:44 A.M., LPN 3 indicated Resident 179 should have had an order for the foley catheter with size, catheter care, to change monthly, and to irrigate as needed, and she did not see any orders.		incontinent care 2.Residents residing at the facility with active nephrostomy tubes, catheters and incontinence status will have care plans developed as indicated. 3.Licensed Staff have been educated on the regulations as it relates to Care plan implementation by Nursing Administration on implementation of care plans by 9.13.23 · New Physician Orders will be reviewed 5 times a week by nursing administration with care plans being updated for acute changes. 1.Care plan audits will be conducted monthly for a period of 6-months or until compliance is achieved. Results of those audits will be forwarded to QAPI for review for 6-months. 2.Date of Compliance 9.18.23	

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	During an interview, on 8/10/2023 at 9:49 A.M., LPN 3 indicated Resident 179 also did not have a daily dressing change order for his nephrostomy tube. During an observation, on 8/10/2023 at 9:51 A.M., LPN 3 indicated the date on the dressing at the nephrostomy site was dated 8/4 with initials. There was a large clear dressing with visible yellow colored gauze with yellow drainage and a scant amount of blood-tinged drainage. The skin around the ostomy insertion site was noted to be red with blood. A foul odor was noted in the room when she was cleansing the site. During an interview, on 8/10/2023 at 11:04 A.M., LPN 3 indicated Resident 179 was sent out to Emergency Room (ER) the nephrostomy tube was put in on 6/23/2023 at the hospital they found out he had hydroneprosis and he returned on 6/30/2023 with the nephrostomy tube. A Progress Note, dated 7/22/2023 at 10:00 A.M., indicated he was moaning and facial grimace and a temperature of 100.4, his right nephrostomy tube draining amber urine with visible pus. Physician was notified and was sent to ER. A Progress Note, dated 7/30/2023 at 5:57 P.M., indicated resident returned from the hospital. A Patient Transfer Assessment Form, dated 7/30/2023, indicated he had a urethral catheter. On 8/10/2023 at 10:59 A.M., the MDS Nurse provided a policy titled, "Nephrostomy and Cystostomy tube dressing changes", from Lippincott book, dated 2023 and indicated the policy was the one currently used by the facility.			

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	The policy indicated " ...Special considerations: Change the dressings daily and as needed....." And a policy titled, Indwelling Urinary Catheter Care and Removal, from Lippincott book, dated 2023 and indicated the policy was the one currently used by the facility. The policy indicated "...Provide routine hygiene for meatal care...." On 8/14/2023 at 9:37 A.M., the Director of Nursing provided a policy titled, " Nursing Policies and Procedures SUBJECT: Physician Orders", dated 5/5/2023, and indicated the policy was the once currently used by the facility. The policy indicated "...1. The qualified licensed nurse completes an admission medication regiment review from the transfer record form an acute care hospital, home, or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed, 3.1-41			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was stored and maintained per professional standards and signage was on the	F 0695	1. The O2 signage for resident 68 was immediately put into place at the time of discovery, the O2 bags were replaced with the dates	09/18/2023

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	door for 2 of 2 residents reviewed for respiratory care. (Resident 68) Finding includes: A record review was completed for Resident 68 on 8/11/2023 at 9:42 A.M. Diagnoses included. but were not limited to: chronic obstructive pulmonary disease and emphysema. During an observation, on 8/7/2023 at 11:34 A.M., Resident 68 respiratory storage bag was dated 7/28/2023 and oxygen humidifier was very low on water with the same date. During an observation, on 8/8/2023 at 9:35 A.M. the respiratory equipment was still dated 7/28/2023. During an observation, on 8/9/2023 at 9:14 A.M., the respiratory equipment was still dated 7/28/2023. During and observation, on 8/11/2023 at 9:11 A.M. CNA 4 entered the resident's room with a portable oxygen tank, placed the tubing on the machine then wrapped the nasal cannula around the two handles of the wheelchair. During an interview, on 8/11/2023 at 9:19 A.M., CNA 4 indicated she should not have wrapped the tubing around the handles, instead she should have placed it in the bag due to germs. During an observation, on 8/11/2023 at 9:39 A.M., there was no signage on the door that oxygen was in use. During an observation, on 8/12/2023 at 5:15 P.M., there was no signage on the door that oxygen was		corrected. The C.NA was not identified as whom wrapped the O2 tubing around the w/c 2. There was no negative outcome related to the alleged deficient practice. 3. Facility Nursing staff have been educated by nursing administration of proper dating, signage and O2 tubing placement/transporting residents requiring oxygen. This education will be completed by 9.13.23 · Nursing administration will audit O2 storage weekly for 30 days and monthly thereafter. 4. Oxygen audits will be forwarded to QAPI monthly for a period of 6-months or until compliance is achieved. 5. Date of Compliance 9.18.23	

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	in use. During an interview, on 8/9/2023 at 9:15 A.M., the Unit Manager 14 indicated that it should have be changed weekly, it was missed. During an interview, on 8/12/2023 at 5:23 P.M., the Unit Manager 15 indicated that a sign should have been on the door that oxygen is in use. A Physician Order, dated 1/5/2023, indicated to change oxygen equipment, tubing/nasal cannula/mask/humidification system weekly. A Physician Order, dated 1/5/2023, indicated to keep oxygen cannula/mask/tubing/and or nebulizer bagged when not in use, every shift. On 8/14/2023 at 2:04 P.M., the Director of Nursing provided a policy titled, "Respiratory Policies and Procedures Equipment Change Schedule", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Nasal Cannula: Change on an as needed basis or per State regulations. Bubbler: change with circuit...." The policy did not address the storage of oxygen tubing when not in use. 3.1-47(a)(6)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.			

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	§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. (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. (ii) Any irregularities noted by the pharmacist 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. (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. §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 initiate physician signed pharmacy recommendations to decrease a pain medication in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident 39)	F 0756	1.Resident 39's physician has reviewed the current medication regimen and the dose has been changed as recommended. 2.Residents residing at the	09/18/2023

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	Finding includes: A record review was completed on 8/11/2023 at 2:29 P.M. Resident 39's diagnoses included, but were not limited to: hypertension, fractured hip, anxiety, depression, chronic pain, fibromyalgia and rheumatoid arthritis. A 5-day MDS (Minimum Data Set) assessment, dated 7/19/2023, indicated Resident 39 required extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use and limited assist for eating. A Pharmacy Consultation Report, dated 1/5/2023, indicated Resident 39 received three or more CNS (central nervous system) medications which can cause an increase risk for fall and fractures. The recommendation was to reevaluate this combination and reduce the dose of Pregabalin (nerve pain medication) to 200 mg (milligrams) BID (twice a day) with the end goal of discontinuation. A Pharmacy Consultation Report, dated 3/6/2023, indicated Resident 39 received three or more CNS medications which can cause an increase risk for fall and fractures. The recommendation was to reevaluate this combination and reduce the dose of Pregabalin to 200 mg BID with the end goal of discontinuation. A Pharmacy Consultation Report, dated 5/7/2023, indicated Resident 39 received three or more CNS medications which can cause an increase risk for fall and fractures. The recommendation was to reevaluate this combination and reduce the dose of Pregabalin to 200 mg BID with the end goal of discontinuation.		facility have the potential to be affected. 3.Licensed Nurses and Social Services has been educated on the regulation as it relates to Gradual Dose Reductions by Nursing Administration this education will be completed by 9.13.23 · Nursing Administration and/or designee will perform monthly audits and identify any medication recommendations and implement the orders as signed by physician. 1.Psychotropic Medication audits will be conducted monthly for a period of 6 months, results of those audits will be forwarded to QAPI for review 2.Date of Compliance 9.18.23	

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	A Pharmacy Consultation Report, dated 6/7/2023, indicated Resident 39's physician had accepted the pharmacies recommendation to decrease the Pregabalin to 200 mg twice a day on 5/18/2023, but the order has not yet been processed. The recommendation was to please process the accepted pharmacy recommendation and update the medical record accordingly. A Medication Administration Record (MAR), dated May 2023, indicated Resident 39 had received the Pregabalin medication 200 mg three times a day from 5/1/2023 to 5/31/2023. A MAR, dated June 2023, indicated Resident 39 had received the Pregabalin 200 mg three times a day from 6/1/2023 to 6/30/2023. A MAR, dated July 2023, indicated Resident 39 had received the Pregabalin 200 mg three times a day from 7/1/2023 to 7/7/2023. During an interview, on 8/14/2023 at 10:55 A.M., the Director of Nursing indicated the pharmacy recommendation was not followed up timely and should have been. On 8/14/2023 at 4:21 P.M., the Director of Nursing provided the policy titled," Pharmacy Services Policies and Procedures: 1.2 Medication regimen Review", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...6. For non-Urgent 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 Pharmacist Report of non-urgent recommendations, the DON or facility designee shall provide the report to the attending			

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	physician(s) or their designee during the next regularly scheduled visit or within 5 business days, whichever should come first. A. Attending physician or designee should respond to the recommendation within 14 days of the pharmacist's review date, but not later than the Consultant Pharmacist's next monthly MRR (Medical Record Review)...." 3.1-25(i)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, record review and interviews, the facility failed to ensure the medication regimen was free from unnecessary	F 0757	1.Resident 51's physician has been contacted and informed of the second round of antibiotics	09/18/2023

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	medication for 2 of 5 residents reviewed for medication use. (Resident 15 regarding monitoring of medications and 51 regarding antibiotic use) Findings include: 1. The record for Resident 15 was reviewed on 8/9/2023 at 9:52 A.M.. Resident 15 was admitted to the facility with diagnoses included, but not limited to: nontraumatic subarachnoid hemorrhage, atherlosclerotic heart disease, chronic atrial fibrillation, type 2 diabetes mellitus, , hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertension, morbid obesity, neuromuscular dysfunction of the bladder, dysphasia. The Quarterly MDS (Minimum Data Set) assessment, completed on 6/20/2023 indicated Resident 15 was alert and oriented, required extensive assist of two staff for bed mobility, dressing and extensive assist of one for personal hygiene and toileting needs and was totally dependent for bathing needs, had not transferred out of bed, had two stage 3 unhealed pressure ulcers, and an indwelling urinary catheter The current medications for Resident 15 included Lantus insulin and Tradjenta, medication to treat type 2 diabetes mellitus. There was a Physician's Order indicating a hemoglobin A1C (a laboratory test to determine the effectiveness of the resident's medication and diet in respect to the diabetes disease process) was to have been completed annually but the order had been discontinued and rewritten and there was no Hemoglobin A1C completed in the past 12 months for Resident 15.		given, Resident 15 has had a current A1C and has been reviewed by the MD. There was no harm related to the alleged deficient practice. 2.Residents receiving antibiotics and diabetic residents residing at the facility have the potential to be affected. 3.Licensed Nurses have been educated on the requirement as it relates to unnecessary medication with an emphasis on antibiotic use and ordered A1C laboratory results. · Nursing Administration will audit pharmacy recommendations monthly and forward to MD for review with orders implemented. 1.The audit findings will be presented to the Quality Assurance and Performance Improvement Committee for tracking and trending monthly for three months and quarterly thereafter, or until deemed no longer necessary. Any areas of concern will be addressed at the time of discovery. 2.Date of Compliance 9.13.23	

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	There was no plan to address the resident's current medication use of Lisinopril and Metoprolol Tartrate, both given to treat hypertension. The last recorded blood pressure for Resident 15 was documented May 28, 2023. The unit manager brought the resident's Hospice binder into the conference room on 8/10/2023 but then realized the most recent note in the binder for Resident 15 was from March 2023. During an interview with the MDS coordinator, on 8/14/2023 at 9:40 A.M. she confirmed there had been no hemoglobin A1C level completed in the past 12 months. 2. The record for Resident 51 was reviewed on 8/8/2023 at 1:51 P.M. Resident 51 was admitted to the facility on with diagnoses included. but not limited to: urinary tract infection, Type 2 diabetes mellitus with diabetic polyneuropathy and moderate, dementia without behavioral disturbance. The Quarterly MDS assessment, dated 7/8/2023, indicated the resident was severely cognitively impaired, required the extensive assistance of two staff for transfers, bed mobility and toileting needs and required the extensive assistance of one staff for w/c locomotion, personal hygiene and dressing needs. The resident's incontinence needs section was not completed on the quarterly review. The current medication regimen for Resident 51 included the antibiotic medication, Macrobid, ordered to start on 8/3/2023 and end on 8/10/2023 to treat a urinary tract infection. A Nursing Progress Note, dated 7/10/2023 at 5:15 A.M., indicated the resident's son had visited the			

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	night before and noticed Resident 51's increased confusion and forgetfulness and requested the resident be assessed for a possible urinary tract infection. The note indicated the physician was notified, an order received for a urinalysis with culture and sensitivity if indicated. The sample was collected and the laboratory was notified of the need to pick up the collected sample. The urinalysis was completed and results reported to the facility on 7/12/2023. The Nurse Practitioner indicated she wanted to wait (to treat) until the culture and sensitivity results were completed. The physician ordered the antibiotic, Levofloxacin, on 7/19/2023 to be given for 8 days to address the resident's urinary tract infection. A Nursing Progress Note, dated 8/3/2023 at 7:17 P.M., indicated the Nurse Practitioner was notified of the resident's urinalysis results and ordered the antibiotic, Macrobid, to be given for 7 days. There was no documentation of a second urinalysis being obtained and no documentation of continued signs and/or symptoms of an urinary tract infection. During an interview with a representative of the laboratory company, on 8/9/2023 at 4:00 P.M., she indicated there was only one urinalysis test ran for Resident 51. The test was received on 7/10/2023 and the culture and sensitivity results were reported to the physician and facility on 7/14/2023. During an interview with the Infectious Preventionist, on 8/14/2023 at 10:19 A..M., she indicated the floor nurse thought the fax date on a copy of the urinalysis culture and sensitivity results faxed to the facility, notified the MD and			

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	obtained a new antibiotic order in error. The policy and procedure regarding antibiotic orders was requested and not received. An original document regarding the McGreer's system to documenting an infection was presented but the form was completed for the second antibiotic use but utilized the documentation from the 7/10/2023 urinalysis results. 3.1-48(a)(1) 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §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 §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 medical record and indicate the duration for the PRN order. §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. Based on record review and interview, the facility failed to ensure a Pharmacy Recommendation and Physician's Order, to gradually reduce an antipsychotic medication, was implemented timely for 1 of 5 residents reviewed for medication use. (Resident 15) Finding includes: The record for Resident 15 was reviewed on 8/9/2023 at 9:52 A.M. Resident 15 was admitted to the facility with diagnoses included, but not limited to: nontraumatic subarachnoid hemorrhage, mild cognitive impairment of uncertain or unknown etiology, depression and insomnia. On 1/24/2023 , a diagnoses of major depressive disorder, recurrent, mild was added.	F 0758	1 Resident 15's physician has reviewed the current medication regimen and the gradual dose reduction has been changed as recommended. There was no negative outcome related to the alleged deficient practice 2 Residents residing at the facility and on antipsychotic mediations has the potential to be affected by the alleged deficient practice. 3 Licensed Nurses and Social Services has been educated on the regulation as it relates to Gradual Dose Reductions by Nursing Administration this	09/18/2023

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	155850	A. BUILDING 00 B. WING	08/14/2023

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	The Quarterly MDS (minimum data set) assessment, completed on 6/20/2023 indicated Resident 15 was alert and oriented, required extensive assist of two staff for bed mobility, dressing and extensive assist of one for personal hygiene and toileting needs and was totally dependent for bathing needs, had not transferred out of bed, had two stage 3 unhealed pressure ulcers, and an indwelling urinary catheter. The current medication regimen for Resident 15 included the antipsychotic medication, Risperdone 0.5 mg to be given twice a day. A Pharmacy Recommendation, dated 1/4/2023 was made for A.M. dose of Risperdone to be reduced from 0.5 mg to 0.25 mg. The recommendation was accepted by the physician on 1/12/2023. Review of the Physician's Order history indicated there was no Physician's Order documented and the dose of 0.5 mg twice a day was continued until August 10, 2023. A Pharmacy Recommendation to again attempt a gradual dose reduction was requested in April 2023 but contraindicated by the physician. The pharmacy recommendation on 5/7/2023 was again made to request a reduction in the Risperdone from 0.5 mg twice a day to 0.25 mg in the AM and 0.5 mg in the PM. The request was approved by the physician on 8/10/2023 and a new order to reflect the changes was implemented. During an interview with the Social Services Director, on 8/14/2023 at 3:08 P.M., she indicated she does not put Physician Orders into the computer system. She indicated she collects the pharmacy recommendations and the physician responses and gives the signed recommendations		education will be completed by 9.13.23 · Nursing Administration and Social Services will audit monthly pharmacy recommendations and forward to physical for review, Nursing administration will implement orders as directed by treating physician. 4 Psychotropic Medication audits will be conducted monthly for a period of 6 months, results of those audits will be forwarded to QAPI for review 5 Date of Compliance 9.18.23	

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	to the Director of Nursing. The SSD indicated she does not check the physician orders to ensure the medication changes for gradual dose reductions are implemented timely. On 8/14/2023 at 4:21 P.M., the Director of Nursing provided the policy titled," Pharmacy Services Policies and Procedures: 1.2 Medication regimen Review", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...6. For non-Urgent 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 Pharmacist Report of non-urgent recommendations, the DON or facility designee shall provide the report to the attending physician(s) or their designee during the next regularly scheduled visit or within 5 business days, whichever should come first. A. Attending physician or designee should respond to the recommendation within 14 days of the pharmacist's review date, but not later than the Consultant Pharmacist's next monthly MRR (Medical Record Review)...." A policy regarding Physician Orders was provided on 8/14/2023 at 9:47A.M., by the Director of Nursing but there were no timeframes or specific procedures described related to transferring written physician orders from the bottom of the pharmacy recommendation form into the electronic charting system to ennsure the order was implemented timely. 3.1-48(b)(2)			
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were dated when opened, failed to store wound cleanser away from medications, failed to ensure medication carts were free of loose pills and failed to ensure residents alcohol bottles were labeled with resident identifiers in 3 of 3 medication carts and 1 of 1 medication rooms observed. (F/D Medication cart, B Medication cart, Memory Care Medication cart and the Long Term Medication room) Findings include:	F 0761	1.The medications were cleaned from the med cart upon discovery, the liquid in the drawer were removed to the proper drawer. The liquor and perfume were discarded immediately. There was no negative outcome related to the alleged deficient practice. 2.Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3.Nursing staff has been	09/18/2023

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	1. On 8/11/2023 at 9:13 A.M., a medication storage observation was completed with QMA 5 on the F/D Hall cart, the following was observed: An opened and undated bottle of Robitussin cough syrup. Three (3) opened and undated bottles of Mira-lax (stool softener). An opened and undated bottle of ant-acid tablets. During an interview, on 8/11/2023 at 9:15 A.M., QMA 5 indicated the medications should have had a date opened. 2. On 8/11/2023 at 9:24 A.M., a medication storage observation was completed with LPN 2 on the B Hall medication cart, the following was observed: Six (6) loose pills and pieces of tablets in 2 drawers. An opened and undated bottle of Robitussin cough syrup. An opened and undated bottle of MOM (Milk of Magnesium) Two (2) bottles of Dyna 4 hex (antiseptic) in the drawer with liquid medications. During an interview, on 8/11/2023 at 9:28 A.M., LPN 2 indicated the medications should have had a date opened on them and the cleanser should not be in the medication cart. 3. On 8/11/2023 at 9:39 A.M., a medication storage observation was completed with QMA 6 on the memory care medication cart, the following was observed: Two (2) loose pills in cart. An opened, undated bottle of Magnesium Citrate with no resident identifiers.		educated on the requirement as it relates to medication storage, this education will be completed by 9.13.23 · Nursing managers will perform random rounds Monday thru Friday to check medication cart storage and correct any areas out of compliance. 1.Medication cart audits will be forwarded to QAPI monthly for a period of 12 months or until compliance is achieved. 2.Date of Compliance 9.18.23	

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	During an interview, on 8/11/2023 at 9:45 A.M., QMA 6 indicated there should be no loose pills in the cart and the Magnesium Citrate should have had a date opened and a resident name on it. 4. On 8/12/2023 at 9:50 A.M., a medication storage observation was completed with QMA 5 on the Long Term Care medication room, the following was observed: The medication refrigerator had a red sticky substance along the bottom of the drawers. Under the sink the following was observed: An opened 1/2 empty bottled of Absolute vodka with no resident identifier. An opened bottle of Tanqueray Gin 1/4 full with no resident identifier. An opened bottle of Cabernet Sauvignon wine 3/4 full, with no resident identifier. A bottle of perfume with no resident identifier. During an interview, on 8/11/2023 at 9:50 A.M., QMA, 5 indicated the fridge should have been cleaned and the bottles of liqueur should have a resident's name on them. On 8/11/2023 at 11:20 A.M., the Corporate Nurse provided the policy titled, Pharmacy Services Policies and Procedures: Section 8- Medication Storage", dated 4/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...7. Once multi-dose packaged medication or biological is opened, nursing will mark multi-dose products (e.g. inhalers, insulin, ophthalmic, optics, and the like) with the date opened and follow manufactures/supplier guidelines with respect to expiration dates. 8. Potentially harmful substances (e.g. urine test reagent tablets, household poisons, cleaning supplies, and disinfectants) are clearly identified and stored away from medications...."			

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	3.1-25(j)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with professional standards for food safety. This deficient practice had the potential to affect the 80 of 82 residents who received food from the kitchen. Findings include: 1.During a tour of the kitchen, conducted on 8/7/2023 at 7:29 A.M. to 7:44 A.M., with the Dietary Manager, the following was observed:	F 0812	1.The juices identified during the survey was immediately discarded upon discovery. There was no negative outcome related to the alleged deficient practice. The temp logs in the nutrition pantry were removed and new logs placed. 2.Residents residing at the facility have the potential to be affected by the alleged deficient practice.	09/18/2023

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	- In the dry storage there was an open bag of heath toffee candy pieces and bag of nachos undated. -The freezer had a bag of hash browns and jalapeno poppers not sealed. - The reach in refrigerator had 2 open gallons all items without an open date. During an interview, on 8/7/2023 at 7:43 A.M., the Dietary Manager indicated that all items should have an open date and the 2 items in the freezer should have been sealed properly. 2. During a tour of the nourishment rooms on 8/14/2023 between 10:04 A.M. to 10:13 A.M., with the Dietary Manager, the following was observed: -The long term care room had a container with vegetables/salad in a plastic shopping bag without a name or date, and a bottle of prune juice and 2 pitchers of juice without an open date. - The refrigerator temperatures posted on the appliance was missing entries for 8/12/2023 and 8/13/2023. During an interview, on 8/14/2023 at 10:06 A.M., the Dietary Manager indicated that the food could have been a staff members lunch and the juice should have bend dated. And that his staff oversees checking the refrigerator temperatures twice a day and they did not this past weekend. 3. During an observation, on 8/14/2023 at 10:08 A.M. of the Rehab nourishment room the following was observed: - The refrigerator had an open bottle of prune juice, 2 pitchers of juice and 2 cartons of thicken liquids without open dates.		3.Dietary staff have been educated on the requirement as it relates to dating food items to include a use by date. This education will be completed by 9.13.23 · Weekly sanitation audit will be completed weekly and any identified areas of improvement will be forwarded to Dietary manager. 1.Sanitation audits will be forwarded to QAPI monthly for a period of 12 months. 2.Date of compliance 9.18.23	

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	-Temperature monitoring submissions for the following dates: 8/5/2023, 8/6/2023, 8/12/2023 and 8/13/2023. During an interview, on 8/14/2023 at 10:13 A.M., the Dietary Manager indicated the liquids should have been dated when open/made and his staff oversaw monitoring the refrigerator temperatures twice a day and they did not 8/5/2023, 8/6/2023, 8/12/2023 and 8/13/2023. On 8/9/2023 at 1:39 P.M., the Director of Nursing provided a policy titled, " Nutrition Policies and Procedures", SUBJECT: Food Safety In Receiving And Storage, revised 6/20/2023, and indicated the policy was the one currently used by the facility. The policy did not address the labeling of an item when it is open. On 8/14/2023 at 2:25 P.M., the Dietary Manager provided a policy titled, "Nutrition Policies And Procedures", SUBJECT: Nourishment/Snacks", revised 6/20/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Store bulk nourishments in a separate refrigerator from medications. Temperature control is monitored at least twice daily for all nourishment room refrigerators and/or freezers. Anything in the nourishment room that is not properly labeled and dated will be discarded...." 3.1-21(i)(3)			