

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2023
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey</p> <p>Survey dates: February 27, 28 2023; and March 1, 2 and 3, 2023.</p> <p>Facility number: 000240 Provider number: 155349 AIM number: 100274960</p> <p>Census Bed Type: SNF/NF: 90 SNF: 11 Total: 101</p> <p>Census Payor Type: Medicare: 11 Medicaid: 55 Other: 35 Total: 101</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed March 8, 2023</p>	F 0000		
F 0550 SS=D Bldg. 00	<p>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling urinary catheter bag was covered to maintain the resident's dignity for 1 of 8 residents reviewed for dignity (Resident 29)."</p> <p>Findings include: On 02/29/23 at 3:35 PM, Resident</p>	F 0550	<p>What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>All residents mentioned in survey as being affected have</p>	03/25/2023

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	<p>29's record was reviewed. Diagnoses included neuromuscular dysfunction of the bladder, cerebral infarction, mellitus type 2 with diabetic neuropathy, hemiplegia and hemiparesis affecting left non-dominant side.</p> <p>Resident 29's comprehensive Minimum Data Sheet (MDS) assessment, dated 2/20/23, indicated the resident's Brief Interview for Mental Status (BIMS) score was 8, she was alert but not interviewable. The MDS indicated she received hospice and had an indwelling catheter.</p> <p>A review of the resident's order, dated 11/25/2022, indicated Resident 29 had an indwelling foley catheter. An order for Resident 29, dated 11/23/22, indicated to ensure the drainage bag was covered.</p> <p>A review of Resident 29's care plan, last revised 1/10/23, indicated the resident had a foley catheter related to a neuromuscular dysfunction of the bladder.</p> <p>During an observation on 02/29/23 at 9:10 AM, Resident 19 was observed laying in bed with her catheter bag hung along the lower right side of the bed facing the door; no privacy bag was covering the catheter bag.</p> <p>In an interview on 2/29/23 at 9:20 AM, the Infection Preventionist indicated Resident 29's catheter bag should be covered for privacy and it was not.</p> <p>On 3/1/23 at 2:10 PM, a current policy titled "Catheter Care", updated 9/20, provided by the Executive Director, indicated the bag connected to the catheter should be covered to ensure the dignity of the resident.</p>		<p>been interviewed to ensure resident well-being. Residents were reminded at resident council to please communicate with management if they are feeling frightened or in any way unpleasant or mistreated. Resident with reluctance to change clothes will be audited to ensure clothes are changed every 2 days and that documentation is completed when resident refuses. New catheter bags have been purchased that will ensure the cover of the bag is of a thicker material than previous fig catheter bags used to ensure cover is not ripped and that urine within the catheter bag remains unseen. Residents' food will be removed from tray and placed in front of them.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>Resident interviews with social services will continue to ensure resident's well-being and mental health is cared for. Resident's struggling with depression, crying, etc. will be interviewed by social services and or administrator to learn reason's of depression, crying, etc. and investigate where appropriate. 5 Residents will be audited weekly to ensure clothes are not worn more than 2 days.</p>	

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	3.1-3(a)		<p>Resident's with catheters will be audited weekly to ensure a fig bag is in place and urine is not visible. Meal times will be audited weekly to ensure food is placed on the table.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Resident in question for frequent crying will be audited 3 X weekly to ensure her mental health is cared for. Five residents will be audited weekly to ensure clothes are not worn more than 2 days. Residents with catheters will be audited weekly to ensure a fig bag is in place and urine is not visible. Dining rooms will be audited weekly to ensure food is placed on the table.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>All audits will be presented to the monthly QA committee until deficient free audits are presented for a consecutive 6 months. Following 6 consecutive months of no deficiencies audits will be completed monthly and reported to QA committee.</p> <p>By what date the systemic</p>	

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			<p>changes for each deficiency will be completed March 25, 2023</p> <p>Tag F550 IDR</p> <p>1) Resident 70 indicated to surveyors that she cries daily. Resident 70 has one documentation of crying whereas there is documentation for other residents who do cry and have behaviors. It is stated that Five other residents present during the council meeting indicated they had cried but their names were not shared with the administrator and facility team members so the items could be addressed and investigated. Resident made comments on time frames of waits for call lights which are not confirmed. Residents stated that staff will enter a room and turn off a call light. This has been brought to management previously and investigated. Video footage of times were reviewed and there was never a case of a staff member entering a room, call light being turned off, and the team member immediately exiting. This investigation was stated to the surveyors while administrator was in question. The 2567 states that "A social Services Progress note dated 1/9/23... There was no indication any investigation into Resident 70's increase in tearfulness was completed." Documentation of a full</p>	

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			<p>investigation spanning the time frame of 1/13/23 through 1/27/23 was provided for the surveyors and is attached to this IDR. Social Service personnel spent the following days with Janet: 1/13, 1/16, 1/17, 1/18, 1/19, 1/20, 1/24. Documentation for previous allegations by Resident 70 were offered to the surveyors for which they declined.</p> <p>The 2567 states the administrator indicated she was aware of the staff not wearing name tags, this was not the statement. The statement was that we had an issue with agency staff not wearing name tags. It is also stated that no notes had been made available for the surveyors by the time of survey exit which is not valid. Notes provided by Social Services, and the talk therapist/psychosocial, were all presented to the surveyors and are attached to this IDR as well.</p> <p>2) Resident 61 was in the same outfit from Monday through Wednesday but did have multiple attempts made by staff to change her clothes. Video footage of an attempt by the administrator on Wednesday 3/1 are available upon request. The resident's desire to not change clothes are visible in the video footage as the administrator discusses the resident's shirt and further prompts the resident by offering to</p>	

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			<p>braid her hair (an attempt that can at times promote the desire to change clothes for the resident). When the issue was brought to the attention of the administrator, administrator let surveyor know she herself attempted to change resident's clothes and resident was resistive.</p> <p>3) Resident 29 was in the privacy of her room and her catheter bag was visible while walking past her room. Resident fig bag was appropriately covered at all times in common areas.</p> <p>4) Our main kitchen is under a full renovation and closed. We are making all meals out of our Assisted Living Kitchen. Staff were advised that it is o.k. in this intermittent time to place food on a tray in front of a resident in an attempt to get them their food and out of their way quicker for food temperatures as the food was coming from a further distance. This was stated to the surveyor, that during this time of transition it has been approved for tray's to be on the table. The surveyor did not note this in the 2567 but noted conversations held with the dietician and activity aide. No resident's were asked if they felt undignified or their quality of life were diminished due to eating from a tray. Residents in question have stated to activity aide 6 that they like food remaining on a tray to help them better see the food.</p>	

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F 0583 SS=D Bldg. 00	<p>483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p>		The red tray assists in defining boundaries. The conclusion that a resident is undignified and their rights have been violated by eating off of a tray is solely based upon the opinion of the surveyor.	

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	<p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>Based on observation, interview and record review the facility failed to ensure privacy for 1 of 1 resident reviewed. (Resident 32)</p> <p>Findings include:</p> <p>In an observation on 03/01/23 at 12:58 PM, from the hallway across from the dining area, a door was observed wedged open with a yellow wet floor sign. Inside the bathroom, Resident 32 was sitting on the toilet with her clothing to her ankles in full view of a visitor. A noise came from behind the bathroom door, RN 12 (Registered Nurse) stated, "one minute (Resident 32's name), I will be right there".</p> <p>During an interview on 3/1/23 at 12:59 PM, Unit Manager 16 indicated Resident 32 frequently would go into the restroom without shutting the door. Unit Manager 16 indicated the wet floor sign was wedged there to indicate the floor was mopped. Unit Manager 16 indicated the floor was no longer wet. Unit Manager 16 did not indicate how she was aware the floor was not wet. Unit Manager 16 moved the wet floor sign from the doorway (shutting the door). Unit Manager 16 indicated no resident should be in the bathroom with the door open regardless of visitors in proximity.</p> <p>An observation and interview with Housekeeper 14 on 3/2/23 at 9:41AM, observed housekeeping putting a sign in the middle of the opening of a resident's door. The housekeeper indicated the middle of the open door was the place</p>	F 0583	<p>Tag F 583</p> <p>What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident has been reminded to close the door behind herself while using the restroom. Team has been in-serviced to assist residents in closing the bathroom door when appropriate for resident.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>All residents who use the restrooms independently have the potential to be effected. Team members have been in-serviced on closing a restroom door when in use by a resident and safe for resident.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Public restroom doors will be audited weekly to ensure they are not being used by a resident while</p>	03/25/2023

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	<p>housekeeping personnel were trained to put the sign on the inner most part of the door, next to hinges, to keep the floor wet sign from accidentally wedging the door open. Housekeeper 14 indicated they place a wet floor sign in the middle of the door opening in frequently used locations to best ensure visibility. Housekeeper 14 indicated she had not wedged a door open with a wet floor sign. Housekeeper 14 indicated the sign should be removed when the floor was dry.</p> <p>Resident 32's record review, began on 02/28/23 at 10:48 AM, indicated diagnosis included unsteadiness on feet, history of falls, dementia, need for assistance with personal care, overactive bladder, and Alzheimer's disease.</p> <p>Resident 32's current MDS (minimal data set), indicated the following:</p> <p>Section C for cognitive patterns indicated Resident 32 had minimal to no cognitive deficits with a BIMS (Brief Interview for Mental Status) of 14. Section E for behavior indicated Resident 32 did not have behaviors of disrobing in public, and public sexual acts. Section G for functioning status Resident 32's assessment indicated she requires limited physical assistance of one staff for toileting. Section GG for functional abilities Resident 32's assessment indicated she requires partial/moderate assistance with toileting hygiene. Section H for bowel and bladder Resident 32's assessment indicated she was frequently incontinent of urine and occasionally incontinent of bowel.</p> <p>Resident 32's current care plan indicated the following: The problem of functioning performance with an intervention listed as; Resident requires substantial or maximal</p>		<p>the door is open.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>Public restroom doors will be audited weekly to ensure they are not being used by a resident while the door is open. Audits will be presented to the monthly QA committee until 6 consecutive months have occurred with no deficiencies. Following 6 consecutive months with no deficiencies audits will be completed Quarterly.</p> <p>By what date the systemic changes for each deficiency will be completed</p> <p>March 25, 2023</p> <p>Tag F583 IDR</p> <p>Resident 32 has a BIMS of 13 and is competent to know that the bathroom door was not shut, nor did resident 32 mind the lack of privacy. Video Footage of the event is available upon request. In the video RN 12 is seen at the nurses cart in orange scrubs. Unit Manager 16 is at the cart with a black blazer and red scrub pants. The two surveyors exit the elevator and approach the med cart. The Surveyor in a blue shirt stands near the bathroom door and then approached Unit Manager 16. Unit</p>	

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	<p>assistance for toileting hygiene, and lower body dressing. The focus of bladder incontinence indicated interventions included assist to toilet upon rising, before and after meals, at bedtime, and as needed. Resident 32's care plan did not indicate a behavior of not ensuring her privacy or the ability for Resident 32 to toilet unassisted.</p> <p>Upon request for policy regarding privacy, on 2/27/23 at 1:39 PM, the Administrator provided a current procedure titled, "Abuse Prevention", revised 12/2022, this policy did not indicate a procedure for ensuring residents' privacy.</p> <p>No other policy was provided prior to exit.</p> <p>3.1-3(a)(t)</p>		<p>Manager 16 immediately goes to the bathroom, views and is seen speaking to the person in the bathroom and closes the door. In the 2567 the surveyor stated that RN 12 stated "one minute (Resident) I will be right there" In no where in the video footage is it seen that this occurred or that surveyor spoke to RN 12. RN12 stated to administrator that this conversation never occurred, which was verified in video footage. In the statement made in the 2567 pertaining to how Unit Manager 16 new the floor was not wet, that is known by visually viewing the floor. The 2567 states that the resident in the bathroom was in full view of a visitor. The person in question as the visitor was an assisted living resident visiting his wife. Regardless of his status as visitor or assisted living resident this gentleman's placement in the chair besides the med cart made a view inside the bathroom impossible. The 2567 states that a procedure titled, "Abuse prevention" was given to them and did not indicate a procedure for ensuring residents' privacy. The policy given to the surveyors for privacy was titled "Resident Rights: Dignity". Administrator gave this policy to surveyors and specifically pointed out that it discusses resident privacy on bullet point 10. Policy attached to IDR.</p>	

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F 0641 SS=D Bldg. 00	<p>483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure accurate assessment for 1 of 26 residents reviewed. (Resident 59).</p> <p>Findings include:</p> <p>On 3/1/23 at 10:29 AM, Resident 59's record was reviewed. Diagnoses included bipolar disorder, cirrhosis of the liver, dementia, major depressive disorder, cerebral infarct, and hemiplegia and hemiparesis following cerebral infarct affection right dominant side.</p> <p>Resident 59's Preadmission Screening and Resident Review (PASRR) I (federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 5/28/21, indicated the resident</p>	F 0641	<p>In conclusion Resident 32, assessed as a competent resident, entered a public restroom and did not shut the door. Once team members had knowledge of the door not shut they assisted the resident by shutting the door. The resident was not viewed by a visitor and resident's privacy was not compromised. The question remains as to what is privacy, if a competent person goes to the restroom in their home with the door open, is their privacy violated?</p> <p>FTAG 641</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All charts will be audited to ensure a completed PASSR has been completed and any level 2 follow ups completed as appropriate.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur All charts will be audited to ensure</p>	03/25/2023	

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	<p>had a current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses of bipolar disorder and alcohol abuse. The resident was referred for a PASRR Level II (a document to confirm the indicated diagnosis noted in the PASRR Level I screening and to determine whether placement or continued stay in a nursing facility is appropriate). Resident 59's PASRR II, dated 6/7/21, indicated he had DSM diagnoses of bipolar disorder and alcohol abuse.</p> <p>Resident 59's annual Minimum Data Set (MDS) assessment, dated 4/8/22, was reviewed. The MDS Section A1500 PASRR was marked "0" for "No" indicating the state level II PASRR does not consider the Resident 59 to have a serious mental illness and/or intellectual disability or a related condition. The MDS indicated the resident's health conditions included bipolar disorder.</p> <p>In an interview on 3/2/23 at 11:15 AM, Social Services 1 indicated he entered "0" for "No" on the MDS Section A1500 PASRR for Resident 59 because the resident had not been having issues. A "0" for "no" in this section indicated the state level II PASRR did not consider the resident to have a serious mental illness and/or intellectual disability or a related condition and did not trigger Section A1510 to be completed which should had been. MDS Section A1510 allowed the facility to identify if the PASRR II indicated the resident had a mental illness and/or intellectual disability or a related condition.</p> <p>On 3/2/23 at 1:17 PM, a current policy titled "RAI Policy", updated 12/22, provided by the Administrator, indicated the facility followed the Center for Medicare & Medicaid Services Long Term Care Facility Assessment Instrument (RAI) 33.0 User's Manual Version 1.15, 10/2017 (or</p>		<p>a completed PASSR has been completed, any level 2 follow ups completed as appropriate. Social services and MDS will audit each chart with every Medicaid change in payor, admission, annual or significant change in status MDS completed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>PASSR will be monitored by 2 staff members and completed as needed with every Medicaid change in payor, within 14 days of a significant change in condition, annual or significant change in status MDS completed as well as the consultant from Med-Rec Systems auditing random charts quarterly. The audits completed at these times will be presented to the monthly QA committee for 6 months until 6 months of deficiency free audits. At that point the audits will be presented to the QA Committee monthly for ongoing compliance. The percentage goal for compliance is 100%.</p> <p>By what date the systemic changes for each deficiency will be completed</p> <p>March 25, 2023</p> <p>F641 – IDR</p> <p>The PASSR process is waived</p>	

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F 0675 SS=D Bldg. 00	<p>current version) for RAI completion.</p> <p>No State Rule Applies</p> <p>483.24 Quality of Life § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light was responded to in a timely manner for 1 of 3 residents reviewed (Resident 68).</p> <p>During an observation on 3/1/23 at 9:22 AM, a call light was observed turned on outside room 316. A large monitor at the nurse's station was sounding a tone and displaying the room number where the call light was located.</p> <p>On 3/1/23, at 9:22 AM Licensed Practical Nurse (LPN) 10 was observed carrying bottles of nutritional supplements to the medication room. After exiting the medication room, she passed by the call light monitor and walked down the hall.</p> <p>On 3/1/23 at 9:31 AM, LPN 10 was observed walking into the medication room. The call light remained on in room 316.</p>	F 0675	<p>due to the national pandemic and does not resume until May 2023.</p> <p>F675 What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice. Team in-serviced on resident call light response times and appropriateness of activities while a call light is on.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected.</p> <p>What measures will be put into place and what systemic changes will be made to</p>	03/25/2023

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	<p>During an interview at 9:48 AM on 3/1/23, Resident 68 who resided in room 316, indicated she needed assistance transferring into her bed from her wheelchair. The call light remained on outside her room.</p> <p>At 9:52 AM on 3/1/23, two Certified Nursing Assistants (CNAs) were observed leaving another resident's room carrying plastic bags containing bed linens. LPN 10 was observed at that time wiping down a medication cart. The call light monitor was approximately 15 feet from where she was standing. Room 316 was displayed on the screen and the call light tone was sounding. After placing linen in a soiled linen location and performing hand hygiene, CNA 9 answered the call light in room 316.</p> <p>During an interview on 3/1/23 at 9:58 AM, CNA 9 indicated all staff are responsible for answering call lights. She indicated Nurses should answer call lights when CNAs are occupied with other residents.</p> <p>During an interview on 3/1/23 at 10:16 AM, LPN 10 indicated she did not know why she did not notice the call light going off. She indicated she had stepped into a break area at the time to have a bite to eat.</p> <p>A record review on 3/3/23 at 1:15 PM indicated Resident 68 had diagnoses including hypertension, Parkinson's disease, and depression. A Minimum Data Set (MDS) included a Basic Interview for Mental Status (BIMS) score of 14 out of 15 indicating she was alert, oriented and able to be interviewed.</p> <p>A document titled Tech- Care Report received on 3/2/23 indicated the call light in room 316 had been</p>		<p>ensure that the deficient practice does not recur Team in-serviced on resident call light response time and appropriateness of activities while a call light is on. Call light times will be audited in 1 (24 hour) increments per week.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place Call light times will be audited in 1(24 hour) increments per week. Audits will be reported to Monthly QA Committee until 6 consecutive months of deficiency free audits. Once 6 consecutive months of deficiency free audits is achieved audits will be completed monthly.</p> <p>By what date the systemic changes for each deficiency will be completed March 25, 2023</p>	

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F 0676 SS=D Bldg. 00	<p>activated on 3/1/23 at 9:20 AM and was on for 32 minutes.</p> <p>Resident Council Minutes dated 12/15/23 were reviewed. 2 residents indicated call light response times were too long.</p> <p>Resident Council Minutes dated 2/14/23 were reviewed with one resident indicating concern about call light wait times.</p> <p>During a resident council meeting held with surveyors on 3/1/23 at 2:00 PM, 8 residents indicated they had concerns about long waits for call lights to be answered.</p> <p>A policy titled Resident Call Lights, dated 8/22 indicated all staff members who see or hear an activated call light are responsible for responding.</p> <p>3.1-37(a)</p> <p>483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:</p> <p>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this</p>			

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	<p>section ...</p> <p>§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview, and record review the facility failed to ensure communication and hearing loss needs were addressed for 2 of 3 residents reviewed. (Resident 62 and Resident 22).</p> <p>Findings include:</p> <p>1) During an observation on 2/27/23 at 10:40 AM, Resident 62 did not have her hearing aids in her ears.</p> <p>During an observation and interview on 02/28/23 at 08:41 AM, RN 12 (Registered Nurse) was observed to ask Resident 62 about pain. Resident 62 did not turn to acknowledge RN 12 was talking to her. A peer at the table pointed to RN 12 and Resident 62 stated, "I don't know". Pain was documented by RN 12 as a zero. RN 12 indicated</p>	F 0676	<p>F Tag 676 What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice. All residents with hearing aides will use hearing aide order set to ensure placement. Care plans and Plan of Care will be updated to ensure correct order for hearing aide placement. Team in-services on importance of device placement for hearing impaired.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	03/25/2023
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	<p>Resident 62 did not complain of any pain when asked.</p> <p>Resident 62's chart review, began on 02/28/23 at 11:08 AM, indicated diagnosis included Alzheimer's disease, morbid obesity, anxiety, pain, and unspecified voice and resonance disorder. Resident 62's current MDS (Minimal Data Set) section I for Active Diagnosis did not list any diagnosis regarding hearing loss. Section of MDS regarding hearing loss was not provided. Resident 62's care plan mentioned hearing aids under the focus of ADLs (Activity of Daily Living) without any specific focus on hearing loss.</p> <p>Resident 62's orders included hearing aid placement was to be in the morning and removed at bedtime. This was scheduled and documented as completed at 8am throughout the survey.</p> <p>During an observation of Resident 62, on 2/28/23 at 11:33AM, she did not have her hearing aids in.</p> <p>In an interview on 2/28/23 at 11:36AM, the Unit Secretary indicated Resident 62 was extremely hard of hearing and required hearing aids in both ears for communication purposes.</p> <p>During an observation on 2/28/23 at 11:51 AM, two surveyors standing to the left of Resident 22 attempted to speak to him and received no response.</p> <p>During an observation on 2/28/23 at 12:10 PM, Resident 22 was observed having a conversation with his wife in the dining room. She was seated at his right. In an interview, Resident 22's indicated Resident 22 is completely deaf in his left ear and wears a hearing aide in his right ear.</p> <p>During an interview on 3/1/23 at 10:18 AM,</p>		<p>identified and what corrective action(s) will be taken</p> <p>Audit completed to ensure all residents with communicative devices are appropriately placed. Team in-serviced on importance of device placement for hearing impaired.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Audits will be completed 2 times weekly for residents with need for communicative devices to ensure the device in in place. Team in-serviced on importance of device placement for hearing impaired.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>Audits will be completed 2 times weekly for residents with need for communicative devices. The audits will be presented to the monthly QA meeting until 6 months have been completed with no deficiencies. Following 6 consecutive months of deficiency free audits the audits will be completed monthly and presented to the QA Committee.</p>	

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F 0686 SS=D Bldg. 00	<p>Certified Nursing Assistant 3 indicated she did not know if Resident 22 had better hearing in one ear or the other.</p> <p>During a record review on 3/1/23 at 1:45 PM, Resident 22 had diagnoses including unspecified dementia, major depressive disorder, recurrent, severe, with psychotic symptoms, and anxiety disorder. A Minimum Data Set (MDS) dated 2/9/23 included a Basic Interview for Mental Status score of 5 out of 15 indicating he was cognitively impaired and unable to be interviewed. The MDS also indicated he had difficulty hearing and used a hearing aid.</p> <p>In an interview on 3/1/23 at 2:20 PM, Minimum Data Set (MDS) Coordinator 4 indicated any hearing issues and strategies to communicate should be indicated on the care plan and communicated to the staff. No care plan discussing hearing or communication strategies was available for review.</p> <p>A policy dated titled Hearing Aid Care dated 8/22/23 indicated the facility should assist residents in using their hearing aides.</p> <p>A policy titled Effective Communication dated 1/22 indicated a resident's process for communication should be obtained upon admission. The policy also indicated plans and goals for communication should be individualized and in accordance with the resident's established routine.</p> <p>3.1-38(a)(2)(E)</p> <p>483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer</p>		<p>By what date the systemic changes for each deficiency will be completed March 25, 2023</p>		

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	<p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Based on observation, interview, and record review the facility failed to implement standard procedures for pressure ulcer treatment for 1 of 2 residents reviewed. (Resident 64).</p> <p>Findings include:</p> <p>During a continuous observation on 2/27/23 from 9:13 AM to 10:32 AM, Resident 64 was observed sitting in front of the nursing station in a wheelchair. Her feet were dangling. She had a wedge with padding between her legs. She was crying out "please help me please" and "Get me out of here" several times. At 10:32 AM Resident 64 was taken to shower room and did not return to common area by end of observation at 11:35 AM.</p> <p>Resident 64's record review, on 02/27/23 at 11:33 AM, indicated diagnosis included dementia, anxiety, irritable bowel, heart disease, and dysphagia. Resident 64's orders included active liquid protein four times a day for wound care, hospice, wash right buttock with soap and water, apply Medi honey alginate, and cover with dry dressing.</p>	F 0686	<p>F Tag 686</p> <p>What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Nurses will be in-serviced on wound treatments. Wound care dressings will be audited weekly.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>All residents with wound care have the potential to be affected. Wound care in-service will be completed. Wound care dressings will be audited weekly by the Director of Nursing or designee. Audits will take in to consideration time, date, treatment, and infection control processes.</p>	03/25/2023
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	<p>Resident 64's current quarterly MDS (Minimum Data Set) assessment included the following: Section C for Cognitive patterns was not assessed due to her inability to complete. Section G for functional status indicated she required extensive assistance of one staff for bed mobility, personal hygiene, transfers, and toilet use. Section GG for functional abilities indicated she is dependent on staff for hygiene, toileting, rolling, and transfers. Section H for bladder and bowel indicated she is always incontinent of urine and frequently incontinent of bowel. Section M for skin conditions indicated she had a pressure ulcer that was unstageable. This section also indicated she had pressure reduction device on bed, nutrition intervention, and pressure ulcer treatment. It did not indicate any pressure reduction device for chair, turning, or repositioning program in place.</p> <p>Resident 64's care plan included the focus of potential for skin impairment related to decreased mobility. The interventions were from December of 2021. There were no updated or new interventions after developing the pressure ulcer in January of 2023.</p> <p>Resident 64 was seen by the rounding wound care nurse practitioner on 2/28/23, 2/23/23, 2/16/23. The wound was identified as stage 3 pressure ulcer. On 2/7/23, 2/1/23 and 1/24/23, the wound was identified as unstageable. Unit Manager 16's progress notes indicated the wound was a stage 2 pressure ulcer on 2/28/23 and on 2/24/23. Unit Managers 16's progress notes indicated the wound was a stage 3 pressure ulcer on 2/7/23 and 2/1/23. Progress notes from the wound nurse</p>		<p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Wound care in-service will be completed and wound care dressings will be audited weekly.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place Audits will be presented to the monthly QA committee until 6 months of consecutive deficiency free. Following 6 consecutive months of deficiency free audits, the audits will be completed monthly and reported to the monthly QA committee.</p> <p>By what date the systemic changes for each deficiency will be completed March 25, 2023</p> <p>F 686 IDR The statement of "There were no updated or new interventions after developing the pressure ulcer in January of 2023" is incorrect. The interventions in the care plan are to follow current treatment orders. The Saint Anne's team was not made aware that surveyors could not find the new interventions, had Saint Anne's been knowledgeable</p>		

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	<p>practitioner and Unit Manager 16's assessments did not match in staging. Unit Manager 16 was the wound care nurse for the facility.</p> <p>An interview with Resident 64's emergency contact and POA (Power of Attorney), on 2/27/23 at 3:45 PM, indicated he was aware of the sore on her hip from friction.</p> <p>During an interview on 3/1/23, Unit Manager 16 indicated she was aware of monitoring of wound care that day and stated she would monitor the wound at 1pm. Unit Manager 16 indicated the wound was a twice a day dressing and they did not complete wound care in the AM so it could be observed.</p> <p>During an observation, on 3/1/23 at 12:58 PM, Unit Manager 16 and RN 12 (Registered Nurse) were at the medication cart. Neither of them indicated the dressing had been completed that day.</p> <p>Resident 64 was complaining of pain as she was being repositioned by RN 12 and Unit Manager 16. RN 12 indicated Resident 64 received pain medication prior to the dressing change.</p> <p>When Resident 64 was positioned and as comfortable as possible at the time, the dressing was removed. There was no lighting in the room. The light above Resident 64's bed was not able to be turned on although it was plugged in. The dressing was initialed by RN 12 and dated 3/1/23. Unit Manager 16 indicated RN 12 changed the dressing earlier that day.</p> <p>Unit Manager 16 washed her hands after removing the dressing. She did not dry her hands and commented on her hands still being wet while</p>		<p>of this at time of survey the explanation of where the orders were would have been explained and copies of orders given. Surveyors watched a wound treatment completed, which is evidence that interventions are in place. This is also acknowledged in the 2567 in the statement "Resident 64's orders included active liquid protein four times a day for wound care, hospice, wash right buttock with soap and water, apply Medi honey alginate, and cover with dry dressing." Again, this statement in the 2567 is contradictory to the previous statement that there were no updated or new interventions. The 2567 states that resident was left alone while calling out "please help me please" it is documented in the residents plan of care that she yells out and chants 'help'. This statement is not related to the associated tag, F686. The 2567 states that there are conflicts in the wound staging between the rounding wound nurse practitioner and unit manager. Physicians and nurse practitioners are often have discrepancies amongst themselves on the staging of a wound. This statement is not related to the associated tag, F686. The light in the room was not working at the time of the dressing change. Maintenance fixed this issue immediately upon their</p>	

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	<p>putting on her gloves. She then acquired 2 wash clothes and took them to the bathroom to apply warm water. She returned to the dresser where she had soap and a labeled dressing sitting on top of the dresser without a clean field. She put soap on a washcloth. Unit Manager 16 washed the area with her left hand, she used the soapy cloth, dropped the soapy cloth on the bed, then used the wet cloth. She did not wash hands or change gloves after washing the wound prior to applying the new treatment and covering. Unit Manager 16 used a small package prep adhesive around the area of the wound. The area was reddened with a darker edge about the size of a quarter. The area was on Resident 64's left gluteal and in the left inner quadrant. Unit Manager 16 then applied Medi honey alginate and a dressing pre labeled with date and initials which she had held in her right hand throughout the process. Resident 64 had stool present in her gluteal fold which was not cleaned prior to starting the dressing change. RN 12 cleaned Resident 64 after the dressing change and prior to repositioning.</p> <p>In an interview on 3/2/23 at 11:16 AM, Unit Manager 16 indicated she did not feel she had any difficulty with the dressing change. Unit Manager 16 indicated she washed her hands after removing the dressing and that was sufficient. Unit Manager 16 indicated stool was present during the dressing change. Unit Manager 16 indicated her clean field was on the dresser. She did not indicate what she used to create the clean field, simply repeated she had her soap on the dresser.</p> <p>In an interview on 3/2/23 at 12:32 PM, the Infection Control Nurse indicated it was important to do audits to ensure proper care, to ensure nursing confidence, and demonstration of skill. The Infection Control Nurse indicated it was</p>		<p>knowledge. This statement is not related to the associated tag, F686.</p> <p>Surveyor states in the 2567 that there was not a clean field. Unit Manager 16 cleaned the area where dressing equipment was kept previous to surveyor entering the room for the wound change. Unit manager 16 explained this to surveyor when questioned on if the field was clean with administrator present. The surveyor did not ask what was used to create the clean field and if it was known the specifics to that extent were wanted, would have been shared. In the 2567 observation of wound care the witnessed events by the surveyor conflict with the statements of the Unit Manager 16 and RN 12 who were present and completing the wound care. Following the observation and surveyor's statements of observations presented to the administrator, the administrator and unit manager 16 discussed discrepancies with the surveyor. During this conversation the surveyor at one point said unit manager 16 did not have a basin and wash cloths, when questioned further on this by unit manager 16 the surveyor then changed her statement and acknowledged the basin and wash cloths. Statements of the event as observed by unit manager 16 and RN 12 are. Unit manager 16 did</p>	

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F 0689 SS=D Bldg. 00	<p>important to keep the wound and surrounding area clean and to ensure no cross contamination happened throughout the process for wound healing and to decrease chance of infection.</p> <p>On 3/1/23 at 3:16PM, a current procedure titled, "Risk Factors for Pressure Ulcers" revised April 2020, indicated "3. general treatment goals for pressure ulcers. Stage 2 a) keep wound bed moist and peri wound tissue dry. Minimize trauma and pain. Prevent infection and further tissue destruction and damage. C. stage 3 and 4 a) keep wound bed moist b) absorb excessive exudate c) debride necrosis or devitalized tissue d) loosely pack dead space e) protect delicate granulation tissue and keep peri wound tissue dry. f) minimize pain."</p> <p>3.1-40</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to implement interventions to prevent falls for 2 of 7 residents</p>	F 0689	<p>wash her hands and surveyors remained in the room by the resident and did not follow unit manager to the bathroom to witness. 2567 states that resident was left with BM on her. Following wound care unit manager 16 and the surveyors exited the room and RN 12 remained in the room to complete further care. Surveyors were unaware and made assumption that care was not completed.</p> <p>The citation is on F Tag 686 is not validated as per the attached documents the resident's pressure ulcer is lessening. Resident is also on hospice with explained weight losses, nutritional, and medical device interventions. The pressure ulcer that is present is explainable with interventions and is improving.</p> <p>F Tag 689</p> <p>What Corrective Actions will be</p>	03/25/2023
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	<p>reviewed. (Resident 61 and Resident 39)</p> <p>Findings include:</p> <p>1) During an observation, on 2/27/23 at 12:11 PM, Resident 61 was observed walking backwards with her walker. There were 2 staff in room at the time. The staff did not redirect the resident from walking backward.</p> <p>Throughout the continuous observation on 2/27/23 from 9:33AM to 12:11PM, Resident 61 was pacing the halls without any supervision or staff cues to rest.</p> <p>Resident 61's record review on 2/28/23 at 11:01 AM indicated diagnosis included dementia, behavioral disturbance, heart disease, and anxiety.</p> <p>Resident 61's current care plan indicated she is at high risk for falls related to dementia and history of falling. An intervention was listed of asking resident to sit down and take a break when pacing and to cue Resident 61 to use walker appropriately.</p> <p>During an observation on 3/1/23 at 9:37 AM, Resident 61 and a peer were in a contact altercation. Resident 61 was attempting to sit in chair next to a peer. The chair was in a row of 4 chairs at the front of the dining room in the hallway and had the arms touching. When a peer began yelling and smacking at Resident 61, Resident 61 continued to pace and each time she passed the peer, the peer would make negative statements and glare at her. Resident 61 was verbally redirected several times to not sit there, but no other activity was offered to her. Resident 61 then attempted to go into the tv area and was bumping another peer's feet with her walker,</p>		<p>accomplished for those residents found to have been affected by the deficient practice.</p> <p>Environment rearranged for more appropriate spacing and parallel activities planned. The 30 to 60 minute checks for resident 39 have been removed as the order should have been discontinued. Resident 39 care plan updated that foot pedals may be in place while in wheelchair. Team members on 2nd floor educated on importance of furniture placement and appropriate spacing of residents. Signs placed to assist in reminding team members of the importance of spacing and placement.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>Resident fall interventions will be reviewed to ensure all are still active and appropriate. Those with outdated interventions have the potential to be affected. The environment on 2nd floor was rearranged for more appropriate spacing.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Environment rearranged for</p>	

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	<p>wheelchairs, and wheels on others' walkers. In the tv area there was an activity in progress with 17 people sitting in the room. Six wheelchairs were in the middle of the room with 11 others sitting off to the side. It was not possible for Resident 61 to walk through the room with a walker.</p> <p>During an observation on 3/1/23 at 10:56 AM the nurses and unit secretary were behind the desk. There were no CNAs (Certified Nursing Assistant) observed on the unit. The Unit Secretary indicated 3 CNAs of the 5 scheduled to work the unit were on break.</p> <p>During an observation and interview with the Administrator on 3/2/23 at 9:25 AM, 14 residents were observed in the tv room. There was no way to get through the room without bumping into something. The Administrator indicated space was an issue. The Administrator indicated the plan was to move some of the residents to the third floor. The Administrator indicated falls were not reported as happening in the tv room during the day.</p> <p>During an observation on 3/2/23 at 10:21 AM, 7 staff were observed behind the desk. There were no staff in the hallways, where Resident 61 continued to pace.</p> <p>In an interview on 03/02/23 at 11:38 AM, with Activities 15 indicated she was told to not use the activity room in the mornings. The activity room had 2 sections. One with tables and chairs the other with couches and chairs. Activities 15 indicated she had asked to do morning activities in the dining room due to lack of space and inability to spread out.</p> <p>In an interview on 3/1/ 23 at 9:56 AM, Unit</p>		<p>appropriate spacing. Resident fall interventions will be audited during the Monday – Friday Morning meeting to ensure that all interventions are appropriate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place Environmental rounding will be completed and audited weekly. Fall interventions will be audited during the Monday – Friday Morning meeting to ensure that all interventions are appropriate. Audits will be presented to the QA committee monthly. Once there has been 6 consecutive months of 100% compliance the audits will be completed monthly and presented to the monthly QA committee.</p> <p>By what date the systemic changes for each deficiency will be completed March 25, 2023</p>	

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	<p>Manager 16 indicated the a large number of residents go into tv room so they used that location. Unit Manager 16 indicated the unit was not an ideal set up for dementia unit. Unit Manager 16 indicated that there are at times 2 activities people on the unit and at those times they did parallel programming, so there was more room.</p> <p>2) On 2/28/23 at 11:41 AM Resident 39 was observed sitting in a wheelchair near a medication cart. The wheelchair had foot pedals in place.</p> <p>A record review on 3/1/23 at 9:29 AM indicated the resident's diagnoses included dementia, anxiety, and chronic pain syndrome.</p> <p>A quarterly Minimum Data SET (MDS) assessment dated 1/19/23 indicated the resident had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3 (not cognitively aware). The MDS indicated the resident had a history of falls.</p> <p>A physician order dated 7/30/22 indicated the resident was to have safety checks every 30 to 60 minutes. The physician order indicated the safety checks were to be performed by the nurse and or certified nursing assistant.</p> <p>A care plan focus dated 8/1/22 indicated the resident was at risk for falls due to decreased safety awareness, psychoactive drug use, and balance problems. A care plan intervention indicated the resident's wheelchair foot pedals should be on while in motion, and off at the point of transfer. The care plan did not indicate the resident was to have safety checks every 30 to 60 minutes.</p>			

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	<p>A post fall evaluation dated 2/26/23 indicated the resident was found on the floor in the common sitting area. The evaluation indicated prior to being found on the floor, the resident had been sitting at the table with her wheelchair in locked position and foot pedals in place.</p> <p>On 3/1/23 at 10:44 AM the resident was observed participating in activities with foot pedals in place on her wheelchair.</p> <p>During an interview with Certified Nursing Assistant (CNA) 22 on 3/1/23 at 10:50 AM she indicated she was not aware of the foot pedals being in place on the resident's wheelchair. She indicated she had not transferred the resident to the common sitting area. CNA 22 immediately removed the foot pedals.</p> <p>During an interview on 3/2/23 at 11:05 AM, Licensed Practical Nurse 20 indicated she was unaware of the physician order for safety checks every 30 to 60 minutes. She indicated the safety checks could possibly be included in the CNA task documentation.</p> <p>During an interview on 3/2/23 at 1:33 PM the Director of Nursing (DON) indicated she could not provide documentation of the resident's safety checks.</p> <p>A current policy titled "Fall Assessment" provided by the DON on 3/2/23 at 1:33 PM indicated interventions should be implemented to prevent recurrent falls. The policy indicated the interventions should be documented in the resident's care plan and communicated to resident care staff.</p>			

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F 0695 SS=D Bldg. 00	<p>483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>Based on observation, record review and interview, the facility failed to ensure oxygen tubing was properly labeled and stored when not in use for 2 of 3 residents reviewed. (Resident 29 and Resident 82).</p> <p>Findings include:</p> <p>1) During an observation on 2/27/23 at 11:39 AM, Resident 29's nasal cannula (NC) oxygen tubing (a lightweight tube split into two prongs on one end and placed in the nostrils used to deliver supplemental oxygen) attached to her oxygen condenser (a medical device that gives you extra oxygen) was laying on her bed, not in a bag, and was not labeled.</p> <p>On 2/29/23 at 3:35 PM, Resident 29's record was reviewed. Diagnoses included cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, contractures of multiple sites of muscles, diabetes mellitus type 2 with diabetic neuropathy, paroxysmal atrial fibrillation, hypothyroidism, essential hypertension, and body mass index.</p> <p>Resident 29's comprehensive Minimum Data Set</p>	F 0695	<p>F Tag 695 What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice. All residents with oxygen will be reviewed for adequate labeling and storage of their equipment. Team members educated through an in-service on appropriate oxygen tubing procedures. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents using oxygen have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur All residents with oxygen will be reviewed for adequate labeling and storage of their equipment. The</p>	03/25/2023
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	<p>(MDS) assessment, dated 2/20/23, indicated the resident's Brief Interview for Mental Status (BIMS) score was 8, she was alert but not interviewable. The MDS indicated she received oxygen while a resident at the facility.</p> <p>A review of the physician's order, dated 10/21/21, indicated her oxygen could be titrated between 1 liter per minute (LPM) and 6 LPM NC.</p> <p>A review of Resident 29's care plan, last revised 12/1/22, indicated the resident had altered cardiovascular status related to arrhythmia, hyperlipidemia, hypertension and heart disease and the goal was for the resident to be free from complications of cardiac problems. One intervention to maintain this goal indicated oxygen as ordered.</p> <p>2) During an observation on 2/27/23 at 9:41 AM, Resident 82's NC oxygen tubing attached to her oxygen condenser was laying on top of the condenser, not in a bag, and was not labeled.</p> <p>During an observation on 2/28/23 at 9:27 AM, Resident 82's NC oxygen tubing attached to her portable oxygen tank which she was wearing was not labeled. The resident's NC oxygen tubing attached to her condenser was laying on the floor of her room, not in a bag.</p> <p>On 3/1/23 at 1:25 PM, Resident 82's record was reviewed. Diagnoses included acute and chronic respiratory failure with hypercapnia, dyspnea, obstructive sleep apnea, chronic diastolic heart failure, and allergic rhinitis.</p> <p>The resident's comprehensive Minimum Data Set (MDS) assessment, dated 12/15/22, indicated the resident's Brief Interview for Mental Status</p>		<p>oxygen tubing will be audited to ensure adequate labeling and that a storage bag is present for storage while not in use.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>Oxygen tubing will be audited weekly to ensure adequate labeling and that a storage bag is present for storage while not in use. Audits will be presented to the monthly QA committee until there are 6 months of deficiency free audits. Upon 6 months of deficiency free audits the audits will be completed monthly.</p> <p>By what date the systemic changes for each deficiency will be completed</p> <p>March 25, 2023</p>	

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F 0697 SS=D Bldg. 00	<p>(BIMS) score was 15, she was alert, oriented and interviewable. The MDS assessment indicated she was on oxygen while a resident at the facility.</p> <p>A review of the resident's orders, dated 9/15/22, indicated she was to be on oxygen at 4 liters per minute (LPM) nasal cannula (NC).</p> <p>A review of Resident 82's care plan. Last revised 12/20/22, indicated the resident had an altered respiratory status with difficulty breathing related to acute respiratory failure with hypoxia secondary to congestive heart failure with a goal to maintain normal breathing patterns. One intervention to maintain this goal indicated oxygen by NC as ordered.</p> <p>In an interview on 2/27/23 at 11:39 AM, RN 2 indicated oxygen tubing should be labeled and in a bag when not in use.</p> <p>In an interview on 2/28/23 at 9:45 AM, the Infection Preventionist indicated oxygen tubing should be stored in a protective bag when not in use.</p> <p>On 2/29/23 at 4:00 PM, a current policy entitled "Clean Oxygen Supplies", updated 9/20, provided by the Administrator, indicated the purpose of the policy was to maintain clean and dust-free equipment so it works effectively and is free of contamination. The policy indicated all new tubing was to be initialed. No addition policies were provided by survey exit.</p> <p>3.1-47(a)(4)(5)(6)</p> <p>483.25(k) Pain Management §483.25(k) Pain Management.</p>			

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	<p>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review the facility failed to provide nonpharmacological interventions and assessment of pain for 1 of 1 resident reviewed for pain management. (Resident 39)</p> <p>On 2/28/23 at 11:41 AM Resident 39 was observed sitting in a wheelchair near a medication cart. The resident repeatedly referred to having a headache.</p> <p>A record review on 3/1/23 at 9:29 AM indicated the resident's diagnoses included chronic pain syndrome, anxiety, and unspecified dementia.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 1/19/23 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated a severe cognitive deficit. The MDS pain assessment was blank.</p> <p>A physician order dated 12/8/22 indicated the resident was to be administered morphine sulfate 15 milligrams (mg) 4 times daily for pain.</p> <p>A physician order dated 1/21/23 indicated the resident was to be administered morphine sulfate 15 mg every 2 hours as needed for pain.</p> <p>The resident's physician orders did not indicate the resident's pain was to be monitored or nonpharmacological interventions were to be utilized.</p> <p>A care plan focus dated 8/1/22 indicated the</p>	F 0697	<p>FTAG 697</p> <p>What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>All charts will be audited by team to ensure the pain care plan includes examples of appropriate non-pharmacological interventions for each resident receiving PRN pain medication. Follow up pain is currently being monitored. The Surveyors asked for the MAR & TAR, follow up pain levels are directly put in progress notes, not the MAR & TAR. Progress notes validating pain follow up on a numeric scale is attached.</p> <p>How other residents having the potential to be affected the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>All charts will be audited to ensure the pain care plan includes examples of appropriate non-pharmacological interventions for PRN pain medication for each resident with the admission, quarterly, annual or significant change in status MDS.</p>	03/25/2023
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	<p>resident was at risk for pain due to chronic pain syndrome. Interventions included administer medications, monitor for side effects and effectiveness of medications. The resident's care plan did not include the provision of nonpharmacological interventions to relieve pain.</p> <p>The resident's Medication Administration Record (MAR) for the months of January and February 2023 indicated the resident was administered morphine sulfate 15 mg 4 times daily for pain. The resident's pain level was indicated with a number at the time of administration. The MAR did not indicate the resident's pain was assessed after medication administration. The resident's MAR did not indicate nonpharmacological interventions were offered to relieve pain.</p> <p>The resident's MAR dated 1/21/23 through 3/2/23 indicated the resident was to be administered morphine sulfate 15 mg every 2 hours as needed for pain.</p> <p>On 2/22/23 at 11:15 AM the resident's MAR indicated the pain medication was not effective for a pain level of 8. The resident's pain level was not assessed on a numeric scale after the medication was administered. The resident's MAR did not indicate nonpharmacological interventions were offered to relieve pain.</p> <p>On 2/27/23 at 10:37 PM the resident's MAR indicated the pain medication was not effective for a pain level of 3. The resident's pain level was not assessed on a numeric scale after the medication was administered. The resident's MAR did not indicate nonpharmacological interventions were offered to relieve pain.</p> <p>During an interview on 3/2/23 at 11:05 AM LPN</p>		<p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur All charts will be audited to ensure the pain care plan includes examples of appropriate non-pharmacological interventions for PRN pain medication for each resident with the admission, quarterly, annual or significant change in status MDS completed as well as the consultant Med-Rec System auditing random charts quarterly. Team will be in-serviced on non-pharmacological interventions.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place All charts will be audited to ensure the pain care plan includes examples of appropriate non-pharmacological interventions for each resident with the admission, quarterly, annual or significant change in status MDS completed as well as the consultant Med-Rec System auditing random charts quarterly. The effectiveness of routine pain medication will be monitored monthly and quarterly. Pain medication adjustments will be addressed if applicable.</p>	

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	<p>20 indicated pain should be assessed before and after pain medication was administered. She indicated the pain assessment should be documented on the resident's MAR.</p> <p>A current policy titled "Pain Management" provided by the Executive Director on 3/2/23 at 1:17 PM indicated residents were to be assessed for acute or chronic pain upon admission and quarterly thereafter. The policy indicated if a resident was administered pain medication per required need (PRN) the pain level should be assessed before and after the medication was administered.</p> <p>3.1-37(a)</p>		<p>Audit will be presented at the monthly QA meeting. Once 6 months of consecutive 100% compliance is achieved the audits will be completed quarterly and presented to the quarterly QA committee ongoing.</p> <p>By what date the systemic changes for each deficiency will be completed March 25, 2023 FTAG 697 IDR</p> <p>The description in the 2567 does not support citation on tag 697. 697 states: "The facility must ensure that pain management is provided to residents who require such services" – Pain medication was administered to resident as ordered during resident times of pain. This is acknowledged in the 2567 but documenting times and dates pain medication is administered. "... who require such services, consistent with professional standards of practice..." – Physician orders did not indicate the resident's pain was to be monitored or nonpharmacological interventions were to be utilized. This is consistent with professional standards of practice as evidenced in the attached document "CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States 2022" Resident under question is a hospice resident receiving end of</p>	

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F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview and record review, the facility failed to identify triggers and	F 0699	life services, thus the clinical practice guidelines and recommendations do not apply per CDC guidance. The resident's comprehensive person-centered care plan and goals and preferences were met. Pain follow up was documented in progress notes. Facility was unaware that surveyors were unable to locate this information. Surveyors only looked in the MAR/TAR. Had facility known surveyors were looking for this information it would have been provided to them at time of survey. Documentation of numerical pain follow up is attached for the times in question. There is no substantial evidence that facility did not meet requirements of F 697 What Corrective Actions will be	03/25/2023

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	<p>initiate resident specific approaches in providing trauma informed care for 1 of 1 resident reviewed (Resident 92).</p> <p>During an interview on 2/27/23 at 3:26 PM, Resident 92 indicated she had recently moved to Indiana after spending the last 29 years in Florida. She indicated during her hospitalization in Florida her condominium received severe storm damage, developed mold and was uninhabitable. Resident 92 had a sad facial expression when discussing her move to Indiana. She discussed having difficulty transitioning into living in a small space and people coming into her room frequently.</p> <p>During a record review on 3/2/23 at 10:07 AM, Resident 92 had diagnoses including acute diastolic heart failure, left bundle-branch block, and post-traumatic stress disorder. A Minimum Data Set (MDS) dated 2/11/23 included a Basic Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was alert, oriented and interviewable. Section D of the MDS indicated Resident 92 indicated Resident 92 had indicators of mood concerns including trouble falling or staying asleep, feeling tired or having little energy, feeling bad about herself, trouble concentrating, and moving so slowly that others have noticed. The MDS indicated each of these symptoms occurred 2-6 times per week.</p> <p>In a progress note by Social Services Director 5 dated 2/13/23, Resident 92 indicated that she felt bad about herself at times because she spent 11 years of her life hearing negative comments from her ex-husband.</p> <p>In a progress note by Nurse Practitioner 50 dated 2/13/23, she indicated Resident 92 had been divorced and lived alone for 47 years after being</p>		<p>accomplished for those residents found to have been affected by the deficient practice.</p> <p>Every chart will be audited for a completed trauma informed care screening tool to ensure it has been completed appropriately and the results care planned as needed. Team members educated that information pertaining to a resident's past trauma is located in the resident care plan.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>A trauma informed care screening tool will be completed with every new admission</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>A trauma informed care screening tool will be completed with every new admission and the results will be care planned as needed. Quarterly MDS documentation will include any trauma related information and concerns including best approaches.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p>	

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	<p>married to a verbally abusive husband. Resident 92 had indicated in this visit she experienced "11 years of misery" and reported her husband had been mentally abusive.</p> <p>In a care plan dated 3/1/23, trauma was identified as a focus with a goal Resident 92 should receive culturally competent, trauma informed care within a safe environment through the next review. An intervention in this care plan indicated staff should identify the resident's history of trauma, cultural preferences and that triggers should be identified. Identified triggers and trigger-specific approaches were not available in the care plan for review. Specific approaches for mood concerns identified in section D of the MDS were not available in the care plan for review.</p> <p>During an interview on 3/3/23 at 8:51 AM Licensed Practical Nurse 10 indicated she was not aware of any specific triggers or approaches that should be used when interacting with Resident 92 as pertaining to any history of trauma.</p> <p>During an interview on 3/3/23 at 8:56 AM with MDS Coordinator 4, indicated that mood indicators identified in section d of the MDS should have prompted staff to generate a care plan addressing mood concerns.</p> <p>No policy regarding trauma- informed care was available for review.</p> <p>No state rule applies.</p>		<p>All new residents admitted will be reviewed monthly at the QA committee meeting. Audits will be presented until there have been 6 consecutive months with 100% compliance. At this point the audits will be completed quarterly and presented to the QA committee.</p> <p>By what date the systemic changes for each deficiency will be completed 3/25/2023</p> <p>FTAG 699 IDR Resident 92's completed trauma informed screening tool was completed and resident shared that she had past experiences that were stressful at the time, but not currently. Trauma informed care plan was completed in regards to past experiences including breast cancer and a verbally abusive husband. Approaches for mood concerns are addressed in the MDS, but surveyor stated in 2567 that "Specific approaches for mood concerns identified in Section D of the MDS were not available in the care plan for review." Specific is a general term which is subjective by definition. The approaches were present, but by the surveyors sole opinion were not specific. LPN 10 is a nurse which was floated to 3rd floor and would not be able to list off specific interventions without resident chart review.</p>	

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F 0761 SS=E Bldg. 00	<p>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>Based on observation, interview, and record review the facility failed to properly label and store medications for 5 of 6 residents in 1 of 3 medication storage rooms reviewed. (Resident 62, Resident 22, Resident 68, Resident 40, and Resident 87)</p> <p>Findings include:</p> <p>1) During a continuous observation on the dementia unit, on 02/28/23 at 8:41 AM, RN 12</p>	F 0761	<p>FTAG 761</p> <p>What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Team members have been in-serviced on appropriate labeling of medication including date open,</p>	03/25/2023

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	<p>(Registered Nurse) walked away from the medication cart without securing it to administered medication in another location not within sight of the medication cart. There were 8 Residents who came within arm's reach of the cart.</p> <p>RN 12 began preparing to administer medication to Resident 62. Resident 62 had several bottles of medications that were labeled with her preferred name and her last name. The medications were as follows: Acetaminophen 500mg; there was no open date, no room number, and no physician name amlodipine10-320; There was no open date A fiber supplement-1 fiber; There was no open date. no room number, and no physician name hydrochlorizaide 12.5mg; There was no open date Jardiance 25mg; There was no open date metopropol 50mg; There was no open date Preservation; There was no open date, no room number, and no physician name pantoprazoe 40mg; There was no open date Gemtesa 75mg; There was no open date CBD gummy (a controlled substance); There was no open date, no room number, no directions, and no physician name After getting all of Resident 62's medications together, crushed and floated in pudding, RN 12 began to walk away; leaving 11 bottles of pills, unsecured on top of the cart. RN 12 returned after turning her back to the cart, put the medications away then locked the cart.</p> <p>Resident 62's record review, began on 2/28/23 at 11:08AM, indicated diagnosis included Alzheimer's disease, difficulty swallowing, anxiety, depression, and hypertension.</p> <p>Resident 62 had physician orders for medications listed above and they were attempted to be</p>		<p>resident name, room number, & physician name. Medication carts reviewed and medication without an open date not at risk of spoiling prior to bottle expiration date.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Team members in-services on appropriate labeling of medication. Audits will occur weekly to ensure appropriate labeling of medication.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place Audits will occur weekly to ensure appropriate labeling of medication. Audits will be presented to monthly QA committee for 6 months until deficient free for 6 consecutive months. Following 6 months of consecutive deficiency free audits, audits will be completed monthly and presented to the monthly QA committee.</p> <p>By what date the systemic changes for each deficiency will be completed</p>	

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	<p>administered on 2/28/23.</p> <p>2) During an observation and interview on 2/28/23 at 9:36 AM with LPN 18 (Licensed Practical Nurse) at the Lakeside medication cart on the third floor, Resident 22's MiraLAX powder Bottle was without an open date. LPN 18 indicated the medication had been used by opening and noting the bottle was a quarter of the way full. LPN 18 indicated all medications are to have an open date when opened.</p> <p>Resident 22's record review on 3/1/23 at 8:06AM, indicated Resident 22 had an order for glycolax powder (MiraLAX) give 17 grams by mouth daily. The order was discontinued on 2/2/23.</p> <p>3) During an observation on 2/28/23 at 9:36 AM, the Lakeside medication cart was observed. Resident 68's aluminum-magnesium-simethicone (Milk of Magnesium) did not have an open date. LPN 18 verified that it had been opened.</p> <p>Resident 68's record review on 3/1/23 at 8:08AM, indicated Resident 68 had an order for aluminum-magnesium-simethicone give 5ml by mouth every 4 hours as needed. Resident 68's MAR documentation indicated they did not receive this medication in the month of February 2023.</p> <p>4) During an observation and interview, on 2/28/23 at 9:44AM the Tuscan cart on the first floor was observed. Resident 40's Mylanta double strength liquid was without an open date. LPN 19 verified the medication had been opened.</p> <p>Resident 40's record review began on 3/1/23 at 8:13AM indicated she had an order for Mylanta written in August of 2022. MAR documentation</p>		3/25/2023	

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	<p>indicated the medication was not given in the month of February 2023.</p> <p>5) During an observation on 2/28/23 at 10:03AM in the third floor medication storage room the refrigerator temperature log was observed. The log was labeled February 2023 it indicated the refrigerator was to be 36-46 degrees and the freezer temp was to be -4 to 14 degrees. The log had the following documented: 16 Refrigerator temp 32 freezer -10 (not within range) 17 Refrigerator temp 32 freezer -10 (not within range) 22 Refrigerator temp 34 and freezer -5 (not within range) 23 Refrigerator temp 34 and freezer -5 (not within range) 24 Refrigerator temp 36 and freezer -10 (not within range) There were no other temps recorded on the February log. Another refrigerator temp log available for review was dated December 2022. The temp log had the 15th documented as refrigerator 36 degrees and freezer at -10 degrees (not within range) There was no other documentation available for review.</p> <p>On 2/8/23 at 1:12 pm the Administrator provided the current policy titled "Medication Refrigeration and Freezer Temperatures" revised February 2023, indicated, "all refrigerators and freezers where medication is to be stored will be checked daily to ensure temperatures are appropriate for medication storage. The temperature should remain between 36 to 46 degrees Fahrenheit. The freezer temperature should be -4 to 14 degrees Fahrenheit."</p> <p>6) During an observation at on 2/27/23 at 10:46 AM, Resident 87 was lying in bed. A bottle of</p>			

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	<p>Tums chewable antacid tablets was on his bedside stand within his reach. In an interview conducted at that time, Resident 87 indicated he took 1 or two tablets when he felt like he needed them for a "sour stomach". Resident 87 indicated he did not know how long he should wait between doses or the maximum amount that could be taken in a day.</p> <p>A record review conducted on 3/1/23 at 8:49 AM, indicated Resident 87 had diagnoses including cerebral atherosclerosis, depression, hypertensive heart disease with heart failure and gastro-esophageal reflux disease without esophagitis. A Minimum Data Set (MDS) dated 2/10/23 included a Basic Interview for Memory Score of 15 out of 15, which indicated Resident 87 was alert, oriented and able to be interviewed.</p> <p>In an interview on 3/28/23 at 3:42 PM, the DON indicated residents with medications at bedside must pass a medication self-administration assessment, and any medications kept in the room should be locked in their bedside cabinet.</p> <p>A care plan dated 11/2/22 indicated medications should be given as ordered and monitored for side effects and effectiveness.</p> <p>During a review of physician's orders, no order for Tums was available for review.</p> <p>A self-administration of medication assessment was not available for review.</p> <p>A document titled Admission Information, undated, indicated all medications, both prescription and over the counter, must be ordered by the physician.</p>			

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F 0812 SS=F Bldg. 00	<p>A policy titled Medication Storage, last updated 9/22, indicated all medications should be stored in locked carts or medication storage rooms.</p> <p>3.1-25(j)(l)(m)(o)(r)</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>Based on observation, interview and record review, the facility failed to ensure kitchen sanitation was maintained. 101 of 101 residents residing in the facility were served food prepared in the kitchen.</p> <p>During an observation of the Health Center dish</p>	F 0812	<p>F TAG 812 What Corrective Actions will be accomplished for those residents found to have been affected by the deficient practice. Temperature Sheets for the refrigerators and freezers have been reviewed with team members</p>	03/25/2023

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	<p>room on 2/27/23 at 9:29 AM, water was observed dripping from ceiling approximately 3 feet from clean dishes just cleaned from the dishwasher. The floor surrounding the dishwasher area was wet.</p> <p>On 2/27/23 at 9:36 AM, during an observation, no internal thermometer was found in the walk-in cooler. Food particles and reddish quarter and dime sized spots were visible on the floor of the walk-in cooler and the walk-in freezer. Debris was also visible on the floor in the dry storage room.</p> <p>2 inch round brown spots were visible on the shelf beneath the coffee maker where cookware was stored.</p> <p>During an observation of the 2nd floor kitchenette on 2/28/23 at 8:32 AM,, debris was present on the floor of the food service area. The gasket lining the bottom of the refrigerator door was torn away and hanging from the door.</p> <p>During an observation on 2/28/23 at 8:46 AM, a temperature log was observed on the refrigerator with recordings for 2/15 and 2/28 and no other entries.</p> <p>During an interview on 2/27/23 at 9:36 AM, the Dietary Manager indicated temperatures should be recorded for two reach-in coolers and an ice cream freezer. She indicated the wrong form was used at the beginning of the month.</p> <p>A policy titled Refrigerator/Freezer Seal dated 2/23 was reviewed. The policy indicated the seals would be replaced annually and repaired as needed.</p> <p>A policy titled Refrigerator Freezer Walk in Floor</p>		<p>and will be audited. Cleaning audits have been reviewed with team members and will be audited. The routine replacement of gasket linings have an updated policy and maintenance personnel have been educated and the policy implementation will be audited. Team members educated on the importance of compliance with audits, cleaning, and temperatures sheets.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Temperature Sheets for the refrigerators and freezers have been reviewed and will be audited. Cleaning audits have been reviewed and will be audited. The routine replacement of gasket linings have an updated policy and will be audited.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place</p> <p>Audits will occur weekly. Audits will be presented to monthly QA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2023
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805
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	<p>Cleaning dated 2/23 indicated the refrigerator and freezer floors would be swept daily and mopped twice weekly.</p> <p>A policy titled Refrigerator/Freezer Temperatures dated 8/22 indicated temperatures of refrigerators and freezers should be monitored daily.</p> <p>3-1-21(i)(3)</p>		<p>committee for 6 months until deficient free for 6 consecutive months. Following 6 months of consecutive deficiency free audits, audits will be completed monthly.</p> <p>By what date the systemic changes for each deficiency will be completed</p> <p>3/25/2023</p> <p>F TAG 812 IDR</p> <p>We acknowledge that not all citations included in Tag 812 will be removed, however do feel there is sufficient evidence that the tag level should be minimized from an 'F' level tag. The observation of the health center dish room is valid in that the roof was leaking. It was raining as surveyors entered the building and the roof started leaking that morning. The roof cannot be fixed in the middle of the rain, however the roofing company was on site immediately upon the rain ceasing to patch the roof areas needing patched. The dishes in the dish room were all removed and taken to the assisted living kitchen where the dishes were ran through the dishwasher. The fact that the ceiling was leaking is a mute point in sanitation as no equipment in the room was used prior to being appropriately cleaned in the assisted living dish room. This topic was brought to the administrator on 2/27 and again later in the survey, however this was not discussed in the exit</p>	

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey</p> <p>Survey dates: February 27, 28 2023 and March 1-3 2023</p> <p>Facility number: 000240</p> <p>Residential Census: 75</p>	R 0000	<p>survey. The survey concluded with the statement that information not discussed in the exit survey will not be cited.</p> <p>The day of kitchen observations was our truck delivery day. Debris is present on these days as there are boxes of produce moved around. There was a coffee spot present on a shelf near a clean pan which was cleaned. The kitchen was in use during observations and coffee machines do have a splatter or a drip at times. The mess was not left unattended.</p> <p>The citation listed, Tag 812, only pertains to the discussions listed in the 2567 in regards to missing temperatures. Apart from that the "Store, prepare, distribute and serve food in accordance with professional standards for food service safety" are not validated by the listed concerns.</p>	

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

PRINTED: 04/28/2023
FORM APPROVED
OMB NO. 0938-039

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	Saint Anne Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed March 8, 2023				