STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155388	A. BUILDING 00 B. WING	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORE OF BEDFORD	514 E 16TH ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00372271. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00372271- Unsubstantiated due to lack of evidence. Survey dates: April 18, 19, 20, 21, and 22, 2022 Facility number: 000370 Provider number: 155388 AIM number: 100290790 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 1 Medicaid: 31 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 26, 2022.	F 0000	F-000 By submitting the enclosed material, Core Nursing and Rehabilitation of Bedford is not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Core Nursing and Rehabilitation of Bedford requests that the plan of correction be considered our allegation of compliance effective May 09, 2022 to the Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00372271 conducted on April 18, 19, 20, 21, and 22, of 2022. Core Nursing and Rehabilitation of Bedford will provide any additional information as requested. Survey Dates: April 18, 19, 20, 21, and 22, 2022 Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	§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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent a resident, with a history of smoking in the room, from smoking a cigarette in the residents' room with an operating oxygen concentrator. This resulted in a systemic failure which presented the potential for combustion of oxygen from a burning cigarette and could have caused harm to residents in the room, adjacent rooms, and hallways for 1 of 1 resident randomly observed for accidents (Resident 13) The Immediate Jeopardy began on 4/21/22 when the facility failed to ensure Resident 13 did not smoke a cigarette in the resident's room approximately 6 feet away from Resident 30's oxygen concentrator. The oxygen concentrator was in operation delivering 4 liters per minute of oxygen through oxygen tubing which was lying on Resident 30's bed. The Administrator was notified of the Immediate Jeopardy on 4/21/22 at 3:00 p.m. The Immediate Jeopardy was removed on April 22, 2022 at 2:50 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes:	F 0689	**F-689** **It is the practice of Core of Bedford Nursing and Rehabilitation to assure that all residents are free of accidents** §483.25(d). The facility must ensure that – §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** (Resident 13 and 30) were in the immediate area that could have been affected. The nurse immediately removed (Resident 13)'s lighter from his possession. (Resident 13) was re-accessed for safe smoking. (Resident 13) was found not to be a safe smoker and was placed on supervised smoking. (Resident 30) was offered a room change and stated that he was fine and is not currently exhibiting any mental anguish related to the event, per	05/09/2022

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	On 4/18/22 at 11:45 a.m., the Administrator provided a list of residents who smoke and the status of each resident's level of supervision. Resident 13 was listed as an independent smoker. The list indicated the designated area for resident smokers was the fenced-in outdoor space located at the rear of the facility. On 4/21/22 at 12:10 p.m., LPN 1 was observed to enter Resident 13's room, pull the privacy curtain between the residents, and perform a blood sugar test on Resident 30. A strong cigarette odor was immediately observed, cigarette smoke was observed in the room, Resident 13 was observed sitting up at the side of the bed while smoking a lit cigarette. Resident 30's oxygen concentrator was observer to be on, the oxygen tubing was not in use, and piled up in the bed. After approximately 5 minutes, the nurse was observed to pull back the curtain and had begun to exit the bedroom. At that time LPN 1 was asked about Resident 13 actively smoking a cigarette. The nurse indicated she did not notice the resident was smoking, and confirmed that Resident 30's oxygen concentrator was running. The nurse then told the resident he was not allowed to smoke in his room and threw the cigarette butt outside. The nurse indicated the resident was not allowed to have a cigarette lighter because he had a cognitive impairment and she was unsure how the resident obtained a lighter. The nurse further indicated the resident had been caught smoking in his bedroom prior to this day. The smoking resident was approximately 6 feet away from the running oxygen concentrator. On 4/21/22 at 12:15 p.m., Resident 30 indicated Resident 13 smoked in their shared bedroom all the time and he had asked him not smoke in the		follow up by nurse. **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. No residents were affected by the alleged deficient practice. Social Service interviewed residents. Residents were asked if they had any knowledge of anyone smoking in the facility. (Resident 30) was the only resident too admit too seeing someone smoking in the facility. Administrator called and spoke with Ombudsman about asking residents relinquish their lighters. All independent smokers were asked for their lighters until their smoking assessment could be reviewed. All independent smoker's assessments have been reviewed. Any independent smoker determined as unsafe will be placed on supervised smoking. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Facility has revised its **Resident Smoking policy and Resident Safe Smoking Assessment.** All staff will be in-serviced on resident smoking. All staff will be in-serviced on how and when to notify administration	

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	room because he did not want to 'explode' but he responded with profanities. During an interview on 4/21/22 at 12:20 p.m., LPN 1 indicated Resident 13 kept his pack of cigarettes with him at all times and was given a non-working cigarette lighter in order to manage negative behaviors related to smoking. On 4/21/22 at 12:30 p.m., Resident 13's clinical record was reviewed. The diagnoses included, but were not limited to: vascular dementia, Alzheimer's disease, Cerebrovascular Accident (stroke), and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 2/3/22, indicated the resident had moderate cognitive impairment. Resident 13's "Outdoor Court Yard [sic] / Smoking Assessment," dated 9/13/22, indicated the resident was cognitively impaired with poor decisions-making skills, the resident had a pertinent diagnoses of dementia, Alzheimer's, anxiety, and the resident was aware he could not have any matches or lighters on his person. The most recent review, dated 2/3/22, indicated the resident continued to smoke unsupervised. A smoking care plan, initiated on 9/21/21 and current through 5/3/22, indicated the resident was able and approved to go outdoors on his own and would become upset if he had to wait to smoke. The interventions included but were not limited to, smoking policy given to the resident, resident oriented to smoking area and procedures, may obtain 2 cigarettes from nurse. On 2/15/22, Resident 13 signed the facility's smoking policy which indicated they understood		about resident non- compliance when smoking. Independent smokers will be allowed to possess a lighter and cigarettes. All supervised smokers will have their smoking materials (lighter and cigarettes) maintained by nursing staff. All smoking residents will be informed of the new policy and procedures. **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:** Administrator, Social Service, DON or designee will monitor independent smokers for changes in behaviors that would require a new smoking assessment before their quarterly review. Administrator, Social Service, DON or designee will discuss new or worsening behaviors with Psych Consultant, Pharmacy and Medical Director for recommendations. Administrator, Social Service, DON or designee will bring new or worsening behaviors to QA/PI meeting for review and continued compliance. **Date of Compliance:** 05/09/2022	

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	and would follow the policy. On 4/21/22 at 1:00 p.m., Resident 30's clinical record was reviewed. The diagnoses included, but not limited to: COPD (Chronic Obstructive Pulmonary Disease) and obstructive sleep apnea. Resident 30's April, 2022, current physician's orders indicated, on 9/29/21, the resident was ordered to have 4 liters of oxygen flowing via a nasal cannula. The Quarterly MDS assessment, dated 3/17/22, indicated the resident was cognitively intact. On 4/21/22 at 2:40 p.m., the Administrator provided the facility policy, "Smoking and/or Vaping," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...Smoking and/or Vaping are not permitted inside the facility including but not limited to (resident rooms) ..." The policy further indicated unsupervised residents were allowed to keep cigarettes in their possession and all residents were not allowed to keep a lighter/matches. During an interview on 4/21/22 at 3:00 p.m., the Administer indicated he was not aware of Resident 13 smoking inside of the facility, however, they were aware of another resident smoking in the bathrooms. He further indicated residents were allowed to keep their cigarettes, however, they were not allowed to have lighters; somehow the lighters kept making their way back into the facility. The Immediate Jeopardy, that began on 4/21/22, was removed on 4/22/22 when the facility inserviced the facility staff and residents on the			

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	smoking policy, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0888 SS=A Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.			

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	§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;			

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	(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical			

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	contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on interview and record review, the facility failed to ensure all employees were fully vaccinated or received an exemption for 1 of 38 employees reviewed for COVID-19 non vaccinated/exempted employees. (Employee 1) Finding includes: A review of the vaccinated/exempted employees on 4/18/2022 at 12:00 p.m., indicated Employee 1 was partially vaccinated and had not been granted a medical or religious exemption. During an interview on 4/20/2022 at 12:25 p.m., the Administrator indicated Employee 1 had	F 0888	**F-0888** **It is the practice of Core of Bedford Nursing and Rehabilitation to assure that all staff members are vaccinated or granted a medical or religious exemption.**vaccinated/exempted employees **What corrective action(s) will be accomplished:** Employee 1 has submitted a request for religious exemption. Employee 1 has been granted a religious exemption.	05/09/2022

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	received one dose of the COVID-19 vaccination and had planned to get the second dose but had not done so at this time. The Administrator further indicated Employee 1 no longer intended to get a second dose of the COVID-19 vaccine. During an interview on 4/22/2022 at 10:58 a.m., Employee 1 indicated she had received the first Pfizer COVID-19 vaccination dose but had no intention of receiving the other vaccination doses. She had no pending or granted requests for a medical or religious exemption. On 4/20/2022 at 12:20 p.m., the Administrator provided the policy, "COVID-19 Employee Vaccination Policy dated, 11/18/2021, and indicated it was the policy currently being followed by the facility. A review of the policy indicated, "...Vaccination process for eligible HCW's [Health Care Workers]. 1. All HCW's must be fully vaccinated no later than January 4, 2022 ...: 3.1-18(b)		**How other staff members having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All staff members have the potential to not be vaccinated or granted a medical or religious exemption. All staff members will be required to submit verification of vaccination or a request for medical or religious exemption upon being hired. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Facility has added verification of vaccination or a request for medical or religious exemption to new hire paperwork checklist. **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:** Administrator, Human Resources or designee will monitor and review new hire packets for completion. Administrator, Human Resources or designee will discuss any issues with new hire packets during QA/PI meeting for review and continued compliance. **Date of Compliance:** 05/09/2022	

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F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in multiple occupancy resident rooms. This was observed in 3 of 18 resident rooms in the facility. (Room 3, Room 6, Room 8) Findings include: Review of the facility's Rooms Size Certification, received from the Administrator on 4/18/2022 at 10:30 a.m., indicated the following: The floor areas of the following multiple resident rooms measured: Room 3: 2 beds, 153.19 sq. ft. 76.59 sq. ft. per resident, SNF/NF. Room 6: 2 beds 157.98 sq. ft. 78.99 sq. ft. per resident, SNF/NF. Room 8: 2 beds 152.97 sq. ft. 76.48 sq. ft. per resident, SNF/NF. Room 3, 6, and 8, rooms with the variances, were observed on 4/18/2022. The rooms were observed to have the following number of beds: Room 3 - 2 beds Room 6 - 2 beds	F 0912	**F-912** **It is the practice of Core of Bedford Nursing and Rehabilitation to assure that all resident** Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** Residents residing in (Room 3, Room 6, Room 8) were found to be affected. The resident residing in (Room 3, Room 6, Room 8) are given the opportunity to move to a larger room anytime one is available. **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 residing in (Room 3, Room 6, Room 8) have the potential to be affected. A letter	05/09/2022

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	Room 8 - 2 beds During an interview on 4/18/2022 at 10:32 a.m., the Administrator indicated Rooms 3, 6, and 8 had the room variance waivers. The rooms were licensed for double occupancy and currently had two beds in the room. 3.1-19(l)(2)(A)		has been sent to ISDH to request a room waiver. (Room 3, Room 6, Room 8) are equipped with privacy curtains, comfortable bed environment, and adequate space. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** A letter has been sent to ISDH to request a room waiver. (Room 3, Room 6, Room 8) are equipped with privacy curtains, comfortable bed environment, and adequate space. Residents residing in (Room 3, Room 6, Room 8) will be monitored for negative behaviors due to the size of (Room 3, Room 6, Room 8). The facility management will negate any behaviors by placement of only one or two residents in (Room 3, Room 6, Room 8). **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:** Administrator, Social Service, DON or designee will monitor resident residing in (Room 3, Room 6, Room 8) for negative behaviors due to the size of (Room 3, Room 6, Room 8). Administrator, Social Service, DON or designee will discuss new	

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CORE OF BEDFORD	514 E 16TH ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			or worsening behaviors due to residing in (Room 3, Room 6, Room 8) with Psych Consultant, Pharmacy and Medical Director for recommendations. Administrator, Social Service, DON or designee will bring new or worsening behaviors to QA/PI meeting for review and continued compliance. **Date of Compliance:** 05/09/2022	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment in 4 of 4 resident shower/bathrooms used by 32 of 32 residents. Toilets were not anchored to the floors, dark substance was around toilet bases, a sink was not anchored to the wall, a floor drain was full of a dark liquid, and an odor of sewage was emitted in shower/bathrooms. (Northeast, Northwest, Southeast, Southwest) Findings include: 1. The Northeast resident shower/bathroom floor drain emitted an odor of sewage on the following dates and times: - 4/19/22 at 10:00 A.M., 12:20 P.M., and 3:10 P.M. - 4/20/22 at 11:15 A.M. and 2:50 P.M. - 4/21/22 at 10:15 A.M. and 3:00 P.M. - 4/22/22 at 11:30 A.M. and 2:00 P.M.	F 0921	**F-921** **It is the practice of Core of Bedford Nursing and Rehabilitation to assure that it provides a Safe/Functional/Sanitary/Comfo rtable Environment. CFR**(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** The facility called Roto Rooter to service the following alleged concerns. 1. The Northeast	05/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155388	A. BUILDING 00 B. WING	04/22/2022

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	2. The Northwest resident shower/bathroom floor drain was full of a dark fluid which emitted an odor of sewage, the toilet was not anchored to the floor, and there was a dark substance around the toilet base on the following dates and times: - 4/19/22 at 10:05 A.M., 12:25 P.M., and 3:15 P.M. - 4/20/22 at 11:20 A.M. and 2:55 P.M. - 4/21/22 at 10:20 A.M. and 3:05 P.M. - 4/22/22 at 11:35 A.M. and 2:05 P.M. 3. The Southeast resident shower/bathroom toilet base was observed to have a dark substance around it on the the following dates and times: - 4/19/22 at 10:10 A.M., 12:30 P.M., and 3:20 P.M. - 4/20/22 at 11:25 A.M. and 3:00 P.M. - 4/21/22 at 10:25 A.M. and 3:10 P.M. - 4/22/22 at 11:40 A.M. and 2:10 P.M. 4. The Southwest resident shower/bathroom toilet was not anchored to the floor, a dark substance was observed around the toilet base, and the sink was not anchored to the wall on the following dates and times: - 4/19/22 at 10:15 A.M., 12:30 P.M., and 3:25 P.M. - 4/20/22 at 11:30 A.M. and 3:05 P.M. - 4/21/22 at 10:30 A.M. and 3:15 P.M. - 4/22/22 at 11:45 A.M. and 2:15 P.M. During an interview on 4/22/22 at 2:20 P.M., the Administrator indicated the resident shower/bathrooms were in need of attention to address the odor of sewage, dark fluid in the drain, unanchored toilets, dark substances around toilet bases, and unanchored sink. On 4/22/22 at 10:50 A.M., the Minimum Data		resident shower/bathroom floor drain was cleaned for the alleged emitted odor of sewage. 2. The Northwest resident shower/bathroom floor drain could not be cleaned out using a drain auger. Roto Rooter will be back at the facility to jack hammer concrete and remove and replace drain with alleged dark fluid which emitted an odor of sewage. The toilet was removed and anchored to the floor. The alleged dark substance around the toilet base was cleaned and the toilet base caulked. 3. The alleged dark substance around the toilet base in the Southeast resident shower/bathroom was cleaned and the toilet caulked. 4. The Southwest resident shower/bathroom toilet was anchored to the floor, the dark substance observed around the toilet base was cleaned and caulked. 4. The facility removed the sink in the Southwest resident shower/bathroom and reattached it to the wall with Tapcon concrete screws. New caulking was placed around the sink. **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. Staff have been in-serviced to advise maintenance	

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	Set assessment Coordinator provided the Resident Rights policy, undated, and indicated these were the Resident Rights currently used by the facility. A review of the Resident Rights indicated, "...the facility must provide...a safe, clean, comfortable environment..." 3.1-19(f)		of any issue with odors coming from the floor drains or toilets that are not securely anchored to the floor in any shower/bathroom. Staff have been in-serviced to advise maintenance of any lose fixtures (sink) in any of the shower/bathrooms. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Facility has added checking for odors, lose toilets and other fixtures to the maintenance daily rounds sheet. **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:** Administrator, Maintenance or designee will monitor resident shower/bathrooms for odors, lose toilets and other fixtures. Administrator, Maintenance, or designee will bring new concerns of odors, lose toilets and other fixtures to QA/PI meeting for review and continued compliance. **Date of Compliance:** 05/17/2022	