STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 19, 20, 21, 22 and 23, 2024. Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 36 Other: 24 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 5, 2024.	F 0000	We are respectfully requesting a desk review of our Plan of Correction in leu of a onsite revisit.	
F 0550 SS=D Bldg. 00	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. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §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. §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. §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. §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 was asked or instructed prior to repositioning for 1 of 1 resident reviewed for respect and dignity. (Resident 28) Finding includes: During an observation, on 2/20/24 at 10:30 a.m., Resident 28 was laying, in a recliner, with her head	F 0550	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements	04/02/2024

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	on the right armrest. The resident's chin was touching her chest. The resident was moving around in the recliner. During an observation, on 2/21/24 at 11:06 a.m., the resident was sleeping in a recliner in the lounge. There was no staff interaction with the resident. During an observation, on 2/22/24 at 9:48 a.m., the resident was laying, in her recliner, with her head on the right armrest. CNA 6 approached the resident and stood behind her. CNA 6 took both hands and placed them under the resident's arms. Without saying anything to the resident, CNA 6 lifted the resident up in the recliner. CNA 6 let go of the resident, she slid back down, and her head landed on the right armrest of the chair. CNA 6 walked away from the resident and left the resident with her head on the armrest. Another staff member positioned the resident in an upright position. The clinical record for Resident 28 was reviewed on 2/22/24 at 1:25 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, psychotic disorder with delusions, hypertension, depression, anxiety disorder, and reduced mobility. A care plan, dated as revised on 3/11/23, indicated the resident preferred to sleep in her personal bed from home. The interventions included, but were not limited to, assisting the resident as needed with bed mobility. A care plan, dated as revised on 3/11/23, indicated the resident preferred to sit or lay on the floor at times. The interventions included, but were not limited to, maintaining safety and frequent		established by the state and federal law. **Alleged deficiency:** Failed to ensure a resident was asked or instructed prior to repositioning. **Corrective Action for resident(s) found to have deficiency:** Employee observed (CNA 6) was educated on ensuring a resident was asked or instructed prior to repositioning, prior to survey exit. Resident 28 is no longer at facility. **Identify other residents having the same potential deficiency:** Residents that are dependent for repositioning are at risk of having the same potential deficiency. **Measures put into place or systemic changes:** Director of Nursing or designee educated all nursing staff about procedure for asking/instructing residents about what you are doing prior to initiating care. Plan to monitor performance to maintain compliance: Director of Nursing or designee will audit dependent residents being repositioned by staff- 5 residents per week x4 weeks, 3 residents per week x2 months, and 1 resident per week x3 months. If any compliance trends are	

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	rounding by staff. During an interview, on 2/22/24 at 9:35 a.m., QMA 4 indicated the resident's daughter requested for the resident to sit in her own personal recliner. QMA 4 indicated providing care without letting the resident know what you were doing was unacceptable. During an interview, on 2/22/24 at 10:16 a.m., the Administrator indicated it was not acceptable for CNA 6 to reposition the resident without telling the resident what he was doing. A current policy, titled "Resident Rights," not dated and received from the Director of Nursing on 2/22/24 at 11:11 a.m., indicated "...Employees shall treat all residents with kindness, respect and dignity...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence...be treated with respect, kindness, and dignity...." 3.1-3(t)		identified, they will be reviewed in QAPI meetings.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care			

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	planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) were completed when new mental health diagnoses were added for 2 of 4 residents reviewed for PASARR. (Resident 5 and 36) Findings include: 1. The clinical record for Resident 5 was reviewed on 2/19/24 at 2:16 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia without behavioral disturbance, atrial fibrillation, delusional disorder, and hallucinations. A PASARR level I, dated 5/25/17, indicated the resident had no mental health diagnosis and had no mental health medications. There were no known mental health behaviors which affected interpersonal interactions and no known mental health symptoms which affected the resident's ability to think through or complete tasks which the resident would be physically capable of completing. If changes occurred or new information refuted the findings, then a new screen must be submitted. The diagnoses of delusional disorder and hallucinations were added on 7/3/18. A care plan, dated 7/3/18, indicated the resident	F 0644	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure the Preadmission Screening and Resident Review (PASARR) were completed when new mental health diagnoses were added for 2 of 4 residents reviewed for PASARR. **Corrective Action for resident(s) found to have deficiency:** Residents 5 and 36 had an updated level 1 PASSRR screen submitted with all current mental health diagnoses, a level 2 was completed where applicable by the Social Worker (SW). **Identify other residents having the same potential deficiency:**	04/02/2024

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	had psychosis and could exhibit delusions and hallucinations at times. The resident reported seeing people in her room and staff reported no people were present. The resident had diagnoses of delusional disorder, dementia, and hallucinations. The approaches included, but were not limited to, administering medications as ordered. During an interview, on 2/23/24 at 9:37 a.m., the Administrator indicated the PASARR was not completed and should have been done again when the new diagnoses of delusional disorder and hallucinations were added. 2. The clinical record for Resident 36 was reviewed on 2/21/24 at 11:18 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance, major depressive disorder, Alzheimer's disease, and anxiety disorder. A PASARR level I, dated 7/16/20, indicated no level 2 PASARR was required. No serious mental illness, intellectual disabilities, or related conditions. No mental health diagnoses were known, no dementia diagnoses were known, and no mental health medications were known. A medical diagnoses sheet indicated the resident was diagnosed with major depressive disorder on 12/4/20. A medical diagnoses sheet indicated the resident was diagnosed with psychotic disorder with delusions on 1/18/21. A medical diagnoses sheet indicated the resident was diagnosed with dementia with anxiety on 10/30/23. A medical diagnoses sheet indicated the resident		An audit of all residents with a mental health diagnosis will be performed to ensure there is an appropriate PASSAR or a new one submitted, by 4/2/24. **Measures put into place or systemic changes:** SW was provided the Indiana PASRR manual with forms. A Social Services Consultant from Lacy Beyl completed education with the Social Worker related to PASARR screenings and requirements. Education included the need to resubmit a Level 1 PASSR when new mental health diagnoses are added and completing a Level 2 PASSAR if required. **Plan to monitor performance to maintain compliance**: The Social Worker or designee will audit all PASARRs upon admission for accuracy within 7 business days x 6 months. If an inaccuracy is noted, a new level 1 PASARR will be submitted, and a Level 2 completed, if indicated. When a new mental health diagnosis is added to a resident, a new Level 1 PASARR will be submitted and a Level 2 will be completed, if indicated. The Social Worker or designee will do a monthly audit of all residents with mental health diagnosis, to ensure their PASARR is up to date. If any compliance trends are	

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	was diagnosed with anxiety disorder on 4/24/23. A physician's order, with a start date of 1/8/24, indicated the resident was started on Olanzapine (an antipsychotic medication) 5 milligrams. A physician's order, with a start date of 10/16/23, indicated the resident was started on Mirtazapine (an antidepressant medication) 7.5 milligrams. During an interview, on 2/23/24 at 9:37 a.m., the Administrator indicated another PASARR should have been done. The resident did have some diagnoses which would lead to another PASARR needing to be completed. A current policy, titled "Admission Criteria," dated 5/20/20 and received from the Director of Nursing on 2/23/24 at 11:15 a.m., indicated "...The Restoracy admits only residents whose medical and nursing care needs can be met...All new admissions and readmissions are screened for mental disorders [MD], intellectual disabilities [ID] or related disorders [RD] per the Medicaid Pre-Admission Screening and Resident Review [PASARR] process...The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD< ID or RD...If the level I screen indicates that the individual may meet the criteria for MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II [evaluation and determination] screening process...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		identified, they will be reviewed in QAPI meeting.	
F 0645 SS=D	483.20(k)(1)-(3) PASARR Screening for MD & ID			

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Bldg. 00	§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an			

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	individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on interview and record review, the facility failed to complete a Level 1 Preadmission Screening and Resident Review (PASARR) prior to admission for 1 of 4 residents reviewed for PASARR. (Resident 3) Finding includes: The clinical record for Resident 3 was reviewed on 2/21/24 at 9:36 a.m. The diagnoses included, but	F 0645	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements	04/02/2024

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	were not limited to, vascular dementia, major depressive disorder, bipolar disorder, and anxiety. The resident was admitted on 1/3/22. A medical diagnoses sheet indicated the resident had the following diagnoses: a. major depressive disorder on 1/3/22. b. anxiety disorder on 1/5/22. c. bipolar disorder on 1/5/22. There was no evidence a PASARR level 1 was completed on or prior to admission. During an interview, on 2/23/24 at 9:37 a.m., the Administrator indicated the PASARR was not completed, and it should have been. A current policy, titled "Admission Criteria," dated 5/20/20 and received from the Director of Nursing on 2/23/24 at 11:15 a.m., indicated "...The Restoracy admits only residents whose medical and nursing care needs can be met...All new admissions and readmissions are screened for mental disorders [MD], intellectual disabilities [ID] or related disorders [RD] per the Medicaid Pre-Admission Screening and Resident Review [PASARR] process...The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD< ID or RD...If the level I screen indicates that the individual may meet the criteria for MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II [evaluation and determination] screening process...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		established by the state and federal law. **Alleged deficiency:** Failed to complete a Level 1 Preadmission Screening and Resident Review (PASARR) prior to admission for 1 of 4 residents reviewed for PASSAR. **Corrective Action for resident(s) found to have deficiency:** Residents 3 had a new Level 1 completed and a Level II will be completed, if applicable. **Identify other residents having the same potential deficiency:** An audit of all residents with a mental health diagnosis will be performed to ensure there is an appropriate PASRR or a new one submitted, by 4/2/24. **Measures put into place or systemic changes:** A Social Services Consultant with Lacy Beyl completed an in-service for the Social Worker, Admission Coordinator, and Business Office Manager. Education included the requirement for a Level 1 PASRR screening with Level 2 PASARR, if indicated, prior to admission to facility. **Plan to monitor performance to maintain compliance**: Admission Coordinator will audit all in-coming residents prior to	

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			admission to ensure there is a Level 1 PASARR and a Level 2 PASARR, if indicated. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record	F 0657	**Disclaimer:**	04/02/2024

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	review, the facility failed to provide quarterly care plan conferences and failed to include the use of a positioning cushion in the comprehensive care plan of 2 of 5 residents reviewed for care planning. (Resident 53 and 6) Findings include: 1. During an interview, on 2/20/24 at 10:25 a.m., Resident 53 indicated she did not remember attending any meetings about her care in a long time. During an interview, on 2/22/24 at 9:50 a.m., Resident 53 indicated she had not been invited or attended a care plan meeting in the past year. The clinical record for Resident 53 was reviewed on 2/22/24 at 10:48 A.M. The diagnoses included, but were not limited to, stage 4 pressure ulcer of left buttock, stage 4 pressure ulcer of right buttock, multiple sclerosis, type 2 diabetes mellitus, other chronic osteomyelitis, incomplete paraplegia, and benign neoplasm (mass) of spinal meninges. A Brief Interview of Mental Status (BIMS), dated 1/23/24, indicated Resident 53's cognition was intact. A social service note, dated 10/4/22 at 12:32 p.m., indicated a care conference for Resident 53 was completed. The resident, resident's daughter, and the social worker attended. This was the last recorded care conference for Resident 53 located in the medical record. A social service progress note, dated 11/27/23 at 7:58 p.m., indicated the Social Service Designee		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Facility failed to provide quarterly care plan conferences and failed to include the use of a positioning cushion in the comprehensive care plan. **Corrective Action for resident(s) found to have deficiency:** Care plan was scheduled for Resident 53. Use of positioning cushion was added to the comprehensive care plan for Resident 5. **Identify other residents having the same potential deficiency:** Long term residents that require quarterly care plans and any resident using a specialty cushion are at risk of having the same potential deficiency. Audit of all quarterly care plans was performed and any residents that require a quarterly care plan was scheduled within the next 30 days. Audit of all wheelchair cushions was performed, and care plans were updated when applicable.	

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	invited the resident's representative to schedule a quarterly care plan. During an interview, on 2/22/24 at 3:15 p.m., the Director of Nursing (DON) indicated she did not find any further documentation for care conferences except for the social services note, on 11/27/23, which she provided.2. During an observation, on 2/21/24 at 11:58 a.m., Resident 6 was sitting up in her wheelchair in front of the television, music was playing, and she had a cushion on her wheelchair with a black part protruding up between her legs. She was moving her right leg and not moving her left. The left foot was not on the footrest. During an observation, on 2/22/24 at 10:47 a.m., the resident was sitting up in her wheelchair in the common area with the pommel cushion (a cushion to provide positioning) in her chair and with th pommel protruding between her legs. The clinical record for Resident 6 was reviewed on 2/21/24 at 11:38 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, dementia, and sequalae unspecified cerebrovascular disease. There were no orders for a pommel cushion. A care plan, dated 10/12/22, indicated the resident had an ADL (activities of daily living) selfcare deficit. Interventions included, but were not limited to, anti-rollbacks, anti-tippers, left foot/leg rest, the resident had a splint for staff to place and remove per order, her daughter often took the splint home to wash and did not return it promptly, stand-up lift as ordered, required assistance from staff to turn and reposition,		**Measures put into place or systemic changes:** Director of Nursing educated Social Services about care plan requirements for long term care residents. Director of Nursing educated MDS on requirements for care planning specialty wheelchair cushions. Plan to monitor performance to maintain compliance: Social Services Director will maintain a log to ensure all residents are offered a care plan quarterly. Social Service Director or designee will perform an audit monthly x 6 months to ensure appropriate documentation regarding offering of care plan was entered, including family or resident refusal. If any compliance trends are identified, they will be reviewed in QAPI meetings. Director of Nursing or designee will perform a monthly audit specialty wheelchair cushion, to ensure they have been added to comprehensive care plan x 6 months. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

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required assistance to eat, required assistance to toilet, and required assistance to move between surfaces.

There was no intervention for a pommel cushion.

During an interview, on 2/22/24 at 11:04 a.m., the lead Physical Therapist (PT) indicated the resident had a pommel cushion. The pommel cushion was used to help with positioning, maintaining alignment, and reducing the risk for falls. It prevented falls by preventing the resident from sliding down in the chair and helped maintain the upright position.

During an interview, on 2/22/24 at 11:11 a.m., the lead PT indicated they just took over therapy from another company. He pulled the evaluation, dated 12/2/22, and it indicated the resident was referred to occupational therapy due to the daughter had requested a seating and positioning evaluation, because the resident was sliding out of her chair. The resident already had the cushion when his company took over, on November 1, 2022. He did not know the policy and was not sure the resident needed an order or a care plan or both.

A current policy, titled "Care Plans, Comprehensive Person-Centered," dated as approved on 5/20/20 and received from the DON on 2/23/24 at 3:32 p.m., indicated "The Interdisciplinary Team includes...The resident and the resident's legal representative...The comprehensive, person-centered care plan will: Incorporate identified problem areas...Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and reflect currently recognized standards of practice for problem areas and conditions...Assessments of residents are ongoing and care plans are revised as information

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	about the residents and the resident's conditions change...The Interdisciplinary Team must review and update the care plan...At least quarterly, in conjunction with the required MDS assessment. 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL) care received the oral care recommendations from the Registered Dental Hygienist for 1 of 2 residents reviewed for ADL care. (Resident 5) Finding includes: During an observation, on 2/19/24 at 2:16 p.m., the resident had her mouth open, and no teeth were observed. The clinical record for Resident 5 was reviewed on 2/21/24 at 4:42 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbance, atrial fibrillation, rheumatoid arthritis, osteoporosis, and delusional disorder. A care plan, dated 7/25/17, indicated the resident had a potential risk for an activities of daily living (ADL) self-care performance deficit related to dementia and Parkinson's disease. The resident	F 0677	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. We are respectfully requesting an IDR for this deficiency as this was a Dentist's recommendation and not an order. Also, it was noted that this resident did not have any teeth and that is incorrect as well. **Alleged deficiency:** Failed to ensure a resident who was unable to carry out activities of daily living care received the oral care	04/02/2024

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	required assistance due to impaired coordination and balance. The goal was to maintain the current level of function with dressing and hygiene. The interventions included, but were not limited to, assist to the bathroom upon rising and before and after meals and assist with the right knee brace in the morning. The care plan did not include oral care. A care plan, dated 8/8/17, indicated the resident had a potential risk for oral/dental health problems related to needing assistance with oral care. The resident had her own teeth. The goal was to be free of infection, pain, or bleeding in the oral cavity by the review date. The approaches included, but were not limited to, administering medications as ordered, coordinate arrangements for dental care, and diet as ordered. A dental hygienist note, dated 9/12/23, indicated the resident had poor periodontal health. The resident had moderate plaque (a sticky film which hardens if not removed and could damage teeth and lead to tooth decay or loss) and calculus (calcified dental plaque). The resident was partially edentulous, her oral hygiene was poor, there was moderate calculus and there were root tips where 10 teeth had been. A dental hygienist note, dated 10/10/23, indicated the resident needed to have her teeth brushed twice daily specifically at the gum line, daily mouthwash rinse was recommended for gingiva (gums of mouth) health. The resident needed daily assistance with oral hygiene. During an interview, on 2/23/24 at 2:09 p.m., the Director of Nursing (DON) 1 indicated the recommendations from the dental hygienist to		recommendations from the dentist. **Corrective Action for resident(s) found to have deficiency:** Order was placed for dental recommendation and recommendation was added to care plan for Resident 5. **Identify other residents having the same potential deficiency:** Residents seen by dental services are at risk for having same potential deficiency; dental recommendations were audited for all residents for past 90 days. **Measures put into place or systemic changes:** The Director of Nursing will educate Assistant Director of Nursing and Social Services about putting dental recommendations in as orders and in care plans. **Plan to monitor performance to maintain compliance:** Director of Nursing will audit all residents seen by dental services: monthly x 6 months. If any compliance trends are identified, we will review them in QAPI meetings.	

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assist the resident with the twice daily brushing of her teeth and the recommendation for daily mouthwash did not get entered as an order and did not get added to the resident's plan of care.

During an interview, on 2/23/24 at 2:39 p.m., DON 2 indicated the facility would complete regular brushing of the resident's teeth. The care plan did not include the recommendations from the dental hygienist about her oral health being poor, the buildup of tartar and calculus, the need to brush twice daily specifically at the gumline or the recommendation for the daily mouthwash.

A current policy, titled "Activities of Daily Living (ADL), Supporting," dated 5/20/20, indicated "...residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)...residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...appropriate care and services with be provided for residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming and oral care)...if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care...approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate...interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preference, stated goals and recognized standards

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	of practice...the resident's response to interventions will be monitored, evaluated and revised as appropriate...." 3.1-38(a)(3)(C)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to ensure cognitively stimulating activities were offered daily for 3 of 5 residents reviewed for activities. (Resident 23, 51 and 61) Findings include: 1. During an observation, on 2/20/24 at 10:46 a.m., the Activity Director entered Cottage 4's lounge carrying two children's books. The Activity Director informed the residents she was going to read a book about the month. The Activity Director read the book and left the cottage. During an observation, on 2/20/24 at 10:50 a.m., Resident 23 was sitting in a high back wheelchair in Cottage 4's lounge. The television was playing a musical and the volume was loud. The resident's head was tilted down.	F 0679	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure cognitively stimulating activities were offered daily for 3 of 5 residents reviewed for activities. **Corrective Action for resident(s) found to have deficiency:**	04/02/2024

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	During an observation, on 2/21/24 at 10:59 a.m., the resident was sitting in Cottage 4's lounge with the television on. The head of the wheelchair was leaning back, and the resident was looking around. There were no activity staff in the cottage. During an observation, on 2/23/24 at 10:15 a.m., the resident was sitting in a high back wheelchair. The television was on, and the resident's wheelchair was pointing in the opposite direction and the resident was unable to watch the television. The clinical record for Resident 23 was reviewed on 2/22/24 at 11:53 a.m. The diagnoses included, but were not limited to, contracture of left hand, quadriplegia, Alzheimer's disorder, dementia, diabetes mellitus, congestive heart failure, and anxiety disorder. The resident did not have a care plan for activities. A facility activity log, for 1/1/24 to 1/31/24, indicated the resident missed 3 activities marked for the day shift and 6 activities marked for the evening shift. A facility activity log, for 2/1/24 to 2/23/24, indicated the resident missed 4 activities marked for the day shift and 7 activities marked for the evening shift. During an interview, on 2/22/24 at 11:59 a.m., the Director of Nursing (DON) 2 indicated the activity log for January and February were missing several holes and if there was no documentation then the activity was not done.		Residents 23, 51, and 61 were reassessed for their specific needs and their activity care plans were updated. Their activity care plans will be followed, and their activity logs will be maintained. **Identify other residents having the same potential deficiency:** All residents require cognitive stimulating activities. Activity Director and Memory Care Activity Coordinator will reassess residents and update their care plan. They will ensure the activity calendar includes cognitively stimulating activities daily. **Measures put into place or systemic changes:** Director of Nursing, Assistant Director of Nursing, or designee will educate Activity Director on appropriate cognitively stimulating activities. Director of Nursing, Assistant Director of Nursing, or designee will educate Memory Care Activity Coordinator and Activity Director on cognitively stimulating activities. Director of Nursing, Assistant Director of Nursing, or designee will educate staff on the activity calendar, including the need for staff engagement and assistance for dependent residents and maintaining their activities logs. **Plan to monitor performance to maintain compliance**:	

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	2. During an observation, on 2/20/24 at 10:50 a.m., Resident 51 was sitting in a wheelchair in Cottage 4's lounge. The television was playing a musical and the volume was loud. The resident's head was tilted down. During an observation, on 2/22/24 at 10:40 a.m., the resident was sitting in a wheelchair with his eyes closed. The television was playing very loud music. During an observation, on 2/22/24 at 4:00 p.m., the resident was sitting in a wheelchair with his eyes closed. The television was playing a basketball game, and the volume was turned up. During an observation, on 2/23/24 at 10:49 a.m., the resident was sitting in his wheelchair in the lounge. The staff brought other residents into the lounge and lined all the residents up in front of the television. The clinical record for Resident 51 was reviewed on 2/22/24 at 9:18 a.m. The diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, hypertension, Alzheimer's disease, and dementia. A care plan, dated as revised on 4/4/23, indicated the resident's preference was to keep to self and participate in self-directed activities of interest and choice. The interventions included, but were not limited to, having reading materials available, listening to favorite types of music, and participating in activities with groups of people of similar and common interest. A facility activity log, for 1/1/24 to 1/31/24, indicated the resident missed 4 activities marked		Memory Care Activity Coordinator, Activity Director, or designee will audit activities to ensure they are occurring as scheduled on the calendar, staff is engaged and assisting as following: one activity daily 5 x per week for 1 month, two activity weekly x 2 months, one activity weekly x 3 months. Memory Care Activity Coordinator, Activity Director, or designee will audit activities to ensure appropriate documentation is completed daily, weekly x 1 month, every 2 weeks x 1 month, then monthly x 4 months. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

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	for the day shift and 6 activities marked for the evening shift. A facility activity log, for 2/1/24 to 2/23/24, indicated the resident missed 3 activities marked for the day shift and 7 activities marked for the evening shift. During an interview, on 2/23/24 at 10:13 a.m., QMA 4 indicated the facility had a new Activity Director. The Activity Director went between several cottages and did the activities. QMA 4 would only see the Activity Director a few times a day. 3. During an observation, on 2/20/24 at 10:33 a.m., Resident 61 was sitting in the lounge with the television on. There were no activity staff present. During an observation, on 2/20/24 at 10:56 a.m., the resident was sitting in a wheelchair in the lounge with the television on. The resident's eyes were open, and she was staring at the floor. During an observation, on 2/21/24 at 10:57 a.m., the resident was sitting in her wheelchair in the lounge with no activity staff present. The resident was opening and closing her eyes. During an observation, on 2/22/24 at 9:20 a.m., the resident was sitting in her wheelchair with the television on and no activity staff was present. During an observation, on 2/23/24 at 10:46 a.m., the resident was asleep in her wheelchair. The resident's head leaning forward. The clinical record for Resident 61 was reviewed on 2/22/24 at 11:27 a.m. The diagnoses included,			

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but were not limited to, senile degeneration of brain, depression, hypertension, and anxiety.

The resident did not have a care plan for activities.

A facility activity log, for 1/1/24 to 1/31/24, indicated the resident missed 3 activities marked for the day shift and 5 activities marked for the evening shift.

A facility activity log, for 2/1/24 to 2/23/24, indicated the resident missed 3 activities marked for the day shift and 7 activities marked for the evening shift.

During an interview, on 2/20/24 at 11:42 a.m., a family member indicated there were not a lot of activities to interact with the residents. The resident's family member did not know what the staff did for activities for Resident 61. They did not see any staff doing activities with the residents. They would like to see the residents doing more things besides sitting in front of the television all the time.

During an interview, on 2/22/24 at 3:00 p.m., DON 2 indicated if the residents did not have something charted it was probably because they had agency staff or they just did not chart the activities. When there was no documentation, it probably was not done.

During an interview, on 2/22/24 at 4:50 p.m., DON 2 indicated the resident did not have an activity care plan and should have had one.

A current policy, titled "Activities Program Policy," dated 5/27/20 and received from the Director of Nursing on 2/23/24 at 11:15 a.m.,

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	indicated "...To support our vision of enjoying each day, connecting with other and balancing with others and individual fulfillment through meaningful activities and stimulation...The Activities program at The Restoracy focuses on balancing engagement with others and individual fulfillment through meaningful activities and stimulation...The resident's activity goal will match his/her functional ability with attainable challenges and personal preferences...All residents, including those who wish to remain in their rooms, will be offered a variety or alternative activities based on their interests, hobbies, and preferences...The activity calendar is posted monthly and includes activities 7 days per week. Unplanned changes to the activity calendar will be posted as soon as possible...Activities are designed to meet the interests, physical and psychosocial wellbeing of each resident, in keeping with the individual comprehensive care plan...The activity program is directed by a qualified Activity Coordinator...." 3.1-33(a) 3.1-33(b)(8) 3.1-33(d)(2)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record	F 0684	**Disclaimer:**	04/02/2024

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	review, the facility failed to ensure a resident had documentation for the use of a positioning device, to ensure residents had splints placed as ordered by the physician, to notify the physician of a blood sugar which was out of parameter and to ensure a resident's skin impairment was accurately assessed and documented for 5 of 5 residents reviewed for quality of care. (Resident 6, 44, 64, 5 and 23) Findings include: 1. During an observation, on 2/19/24 at 2:25 p.m., Resident 6 had a device on the seat of her wheelchair with a black raised area sticking up between the resident's legs. During an observation, on 2/22/24 at 10:47 a.m., the resident was sitting up in her wheelchair in the common area. The device was still on the resident's wheelchair with the black raised area sticking up between her legs. The clinical record for Resident 6 was reviewed on 2/21/24 at 11:38 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness) following cerebral infarction affecting the left non dominant side, dementia, anxiety disorder, and depressive episodes. A care plan, dated 10/12/22, indicated the resident had an activity of daily living (ADL) self-care performance deficit related to limited mobility, pain issues, weakness, and left sided paralysis. The interventions included, but were not limited to, anti-roll backs (device to lock a wheelchair when a resident stands up), anti-tippers (a device to keep the wheelchair from tipping back), and left foot/leg rest on the wheelchair.		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a resident had documentation for the use of a positioning device, to ensure residents had splints placed as ordered by the physician, to notify the physician of a blood sugar which was out of parameter and to ensure a resident's skin impairment was accurately assessed and documented. **Corrective Action for resident(s) found to have deficiency:** Positioning device was added to orders and care plan for Resident 6. Order and care plan for splint for Resident 44 was discontinued per family request. Orders and care plans for splints for Resident 23 were discontinued as splints had been discontinued by therapy prior to survey. Resident 64 is no longer at facility. Documentation regarding skin impairment was updated in electronic medical record for Resident 5.	

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	The care plan did not include the Pommel cushion to be in the wheelchair. A physician's order, dated 2/20/24, indicated to have anti-roll backs, anti-tippers, and a left leg rest and foot support for the resident's wheelchair. The physician's orders did not include the use of the Pommel cushion in the wheelchair. During an interview, on 2/22/24 at 10:48 a.m., QMA 10 did not know what type of cushion/device was in the resident's wheelchair. During an interview, on 2/22/24 at 10:49 a.m., QMA 4 did not know what type of cushion/device was in the resident's wheelchair. At that time, QMA 11, who was also present, searched the electronic health record and could not find information about the device in the resident's electronic health record. During an interview, on 2/22/24 at 11:04 a.m., the Lead Physical Therapist (PT) indicated the resident had a Pommel cushion in her wheelchair which was used to help with positioning, to maintain alignment, and to reduce the risk for falls. It reduced the risk of falls by preventing the resident from sliding down in her wheelchair and helped the resident maintain an upright position. Occupational therapy would do a lot of wheelchair positioning devices. During an interview, on 2/22/24 at 11:11 a.m., the Lead PT indicated the current therapy department took over for another therapy company. On 12/2/22, the resident's daughter had requested occupational therapy for seating and positioning since the resident had been sliding out of her		**Identify other residents having the same potential deficiency:** Residents in facility that have positioning devices and/or splints, diabetic residents, and residents with skin impairments have the potential for same deficiency. Therapy will perform a screen and audit on all residents that have positioning devices or splints, and ensure the appropriate order is present, before the date of compliance. Director of Nursing assessed all diabetic blood sugar logs for the month, reporting any results out of parameter to the Medical Provider, before the date of compliance. The Assistant Director of Nursing will complete an audit on all residents with current skin impairment to ensure resident had appropriate documentation for impairment. **Measures put into place or systemic changes:** Therapy was educated to ensure all positioning devices and splints have the appropriate documentation and order. All licensed nurses and certified nursing assistants were educated about applying and removing positioning devices and/or splints as ordered. Director of Nursing or designee educated Licensed Nurses about notifying providers about blood sugar readings that are out of	

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	wheelchair. The Pommel cushion was secured to the wheelchair. The Lead PT was not sure if they needed a physician's order for the use of the Pommel cushion or if the Pommel cushion should be included in the plan of care. During an interview, on 2/22/24 at 3:55 p.m., the Minimum Data Set (MDS) Coordinator indicated the resident had a cushion in her wheelchair and the facility would not enter anything in the electronic record for just a cushion. The cushion in the wheelchair was not a Pommel cushion used for positioning. During an interview, on 2/22/24 at 3:56 p.m., the Director of Nursing (DON) indicated the cushion should be listed on the care plan if it was used as a fall prevention. During an interview, on 2/23/24 at 10:53 a.m., the Vice President who was also a PT indicated the resident had been at the facility since 2022 and had the Pommel cushion for 5 years. A therapist was going to do an evaluation for a replacement of the current Pommel cushion since it was 5 years old. The resident would lean to one side if the Pommel cushion was not used for positioning. The cushion helped with positioning for meals and participation in activities. The Vice President indicated the cushion was not utilized to keep the resident from sliding out of the wheelchair. The Pommel cushion was not included in the care plan and there was no physician's order for the Pommel cushion. The brand of the Pommel cushion was not known although it did look like the Secure convex Pommel cushion. 2. During an observation, on 2/19/24 at 2: 5 p.m., Resident 44 was leaned back in his Broda chair (a chair used for positioning) in the common area		range and how to document the notification appropriately in the electronic medical record. Director of Nursing educated Assistant Director of Nursing on procedure to document skin impairments in electronic medical record. Director of Nursing or designee will audit the therapy documentation, order, careplan, and placement of positioning devices and splints; use 3 residents per week x1 month, 2 residents per week x2 months, and 1 resident per week x3 months. Any inconsistencies in the audits will be reported to the QAPI committee for review and compliance. Director of Nursing or designee will audit blood sugar logs and ensure readings out of range have physician notification documentation for 3 residents per week x1 month, 2 residents per week x2 months, and 1 resident per week x3 months. Any inconsistencies in the audits will be reported to the QAPI committee for review and compliance. Director of Nursing or designee will audit altered skin areas for accurate assessment and documentation; 3 areas per week x 1 month, 2 area per week x 2	

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	and there was no splint on his right hand. During an observation, on 2/21/24 at 11:10 a/m., the resident was sitting up in his Broda chair in the common area. There was no splint on the resident's right hand. During an observation, on 2/22/24 at 9:46 a.m., the resident was in the common area in his Broda chair and staff were feeding the resident bites of food. The resident did not have a splint on his right hand. The clinical record for Resident 44 was reviewed on 2/21/24 at 10:20 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, heart failure, dementia without behavioral disturbance, and chronic kidney disease stage 3. A physician's order, dated 11/18/23, indicated to place a right-hand splint on the resident in the a.m., and to remove it before dinner. A Treatment Administration Record (TAR), dated 2/1/24 through 2/21/24, indicated the resident had the splint to the right hand in place on 2/19, 2/21 and 2/22. The splint was marked as applied and the resident did not have the splint in place. During an interview, on 2/22/24 at 11:36 a.m., CNA 6 indicated therapy staff just brought in a splint for the resident's right hand. The staff could not put the splint on the right hand because there was not a splint in the facility. CNA 6 thought the splint had been discontinued. During an interview, on 2/22/24 at 1:25 p.m., the Lead PT indicated he did just provide a splint for		months, and 1 area per week x 3 month. Any inconsistencies in the audits will be reported to the QAPI committee for review and compliance.	

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	Resident 44's right hand, on 2/22/24. He did not know how long the resident had been without a splint to the right hand. 3. The clinical record for Resident 64 was reviewed on 2/21/24 at 3:12 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, rheumatoid arthritis, congestive heart failure, atrial fibrillation, long term use of insulin, repeated falls, and a cognitive communication deficit. A physician's order, dated 11/18/23, indicated to complete accu-checks (blood glucose testing) as needed and to notify the physician for a blood sugar reading less than 70 or greater than 300. On 11/23/24 at 9:45 a.m., the resident's blood sugar was 465. There was no progress note to show the physician was notified of the blood sugar reading and no documentation of a repeat blood sugar. 4. The clinical record for Resident 5 was reviewed on 2/21/24 at 4:42 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia without behavioral disturbance, atrial fibrillation, rheumatoid arthritis, and osteoporosis. A weekly skin assessment, dated 1/31/24, indicated a new skin area was noted. There was open skin on the resident's sacrum which measured 1 centimeter (cm) by 1 cm. The area was identified as a non-pressure area, and a treatment was ordered. The treatment order was not located in the electronic health record (EHR). A care plan, dated 2/9/24, indicated the resident			

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	had a potential for impaired skin integrity related to impaired mobility and impaired cognition. The goal was for the skin to remain intact through the review date. The interventions included, but were not limited to, apply house barrier cream as needed, encourage good nutrition and hydration, and a weekly skin assessment by a licensed nurse. During an interview, the Assistant Director of Nursing (ADON) indicated the nurse had incorrectly identified the skin condition on 1/31/24. The resident had old scar tissue which was pink in color. The resident did not have open skin, so no treatment was prescribed. The ADON had forgotten to document the updated information in the electronic health record.5. During an observation, on 2/21/24 at 10:59 a.m., Resident 23 was sitting in the lounge. The resident was not wearing a right ankle brace, foam boots, or a left palm protector. During an observation, on 2/22/24 at 11:51 a.m., the resident was sitting in the lounge and was not wearing a right ankle brace, foam boots, or a left palm protector. During an observation, on 2/23/24 at 10:15 a.m., the resident did not have her heels off loaded, was not wearing a left-hand palm protector, and did not have a brace to the right ankle. During an observation, on 2/23/24 at 10:20 a.m., CNA 3 went to the resident's room and could not locate the residents left hand palm protector, a right ankle brace, or foam boots. The clinical record for Resident 23 was reviewed on 2/22/24 at 11:53 a.m. The diagnoses included, but were not limited to, contracture of the left hand, quadriplegia, Alzheimer's disorder,			

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	dementia, diabetes mellitus, congestive heart failure, and anxiety disorder. A care plan, revised on 10/21/22, indicated the resident was required to wear a left-hand splint and right ankle brace. The interventions included, but were not limited to, applying the splint per order, and observing the skin underneath the splint for redness and irritation. A quarterly Minimum Data Set assessment, dated 11/22/22, indicated Resident 23 was dependent on staff for oral hygiene, toileting, showers, bathing, dressing, and personal hygiene. The resident made no effort to complete the activity. A physician's order, dated 1/9/23, indicated to always wear a left-hand palm protector. The palm protector could be off for hand hygiene. A physician's order, dated 5/26/23, indicated to apply a brace to the right ankle during the day. A physician's order, dated 12/11/23, indicated to offload the resident's heels while in bed and in the chair. The resident was to use a foam boot or equivalent every shift. During an interview, on 2/23/24 at 10:30 a.m., CNA 3 indicated physical therapy had stopped the resident's order for the palm protector. CNA 3 indicated she had never seen the brace or splint. During an interview, on 2/22/24 at 11:59 a.m., QMA 4 indicated the CNAs normally put on braces and splints. During an interview, on 2/23/24 at 2:22 p.m., Physical Therapist 5 indicated the multiple splints were discontinued by Occupational Therapy. The			

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	order was not removed from the orders and should have been. During an interview, 2/23/24 at 2:25 p.m., DON 2 indicated they should have questioned the order for the devices when the resident was not wearing them.A current policy, titled "Pressure Injury Risk Assessment," not dated, indicated "...the purpose of this procedure is to provide guidelines for the assessment and identification of resident at risk of developing pressure injuries...skin will be assessed for the presence of developing pressure injuries on a weekly basis or more frequently if indicated...nurses will conduct skin assessments at least weekly to identify changes...the following information should be recorded in the resident's medical record utilizing facility forms: type of assessment conducted (for example, admission assessment, weekly skin integrity tool) ...the date and time and type of skin care provided, if appropriate...the name title (or initials) of the individual who conducted the assessment...any change in the resident's condition, if identified...the condition of the resident's skin (i.e. the size and location of any red or tender areas, (if identified) ...initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted...documentation in medical record addressing MD (medical doctor) notification if new skin alteration noted with change of plan of care if indicated...documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care if indicated...." A current policy, titled "Change in a Resident's Condition or Status," dated 5/20/20 and received from DON 1, on 2/23/24 at 4:03 p.m., indicated "...our facility shall promptly notify the resident,			

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	his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) ...." A current policy, titled "Assistive Devices and Equipment," dated 5/20/20 and received from the Director of Nursing on 2/23/24 at 11:25 a.m., indicated "...provides, maintains, trains, and supervises the use of assistive devices and equipment for residents...Devices and equipment that assist with resident mobility, positioning, safety and independence are provided for residents. These include but are not limited to: Positioning Aides (e.g., braces, wedges, splints, joint stabilizer) ...Recommendations for the use of devices and equipment are based on the comprehensive assessment by therapy services...Staff will be trained and will demonstrate competency in the use of devices and equipment prior to assisting or supervising residents...." 3.1-37(a)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure a resident who had a colostomy had specific direction for colostomy care for 1 of 1 resident reviewed for bowel and bladder. (Resident 25)	F 0691	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this	04/02/2024

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	Finding includes: The clinical record for Resident 25 was reviewed on 2/20/24 at 3:03 p.m. The diagnoses included, but were not limited to, colostomy. A care plan, dated 10/26/23, indicated the resident had an alteration in gastrointestinal status, and an ostomy related to colon cancer. Interventions included to assist the resident with ostomy care as needed, to give medications as ordered, to monitor and document side effects and the effectiveness of the medications, to obtain and monitor lab or diagnostic work as ordered, and to report the lab and diagnostic results to the physician and follow up as indicated. A physician's order, dated 12/23/23, indicated to change the colostomy bag every 3 days and as needed due to dislodgement. A physician's order, dated 12/25/23, indicated to check the colostomy bag for patency. There were no resident specific directions for the colostomy. During an interview, on 2/22/24 at 2:28 p.m., LPN 2 indicated she did not know what brand or size of bag the resident wore. The colostomy bags came in a red and white box. The supplies were ordered from a pharmacy and were delivered. When changing the bag, she cleaned the area around the stoma with soap and water, cut the hole in the bag, applied skin prep, and gave it time to dry. She was not sure if there were other products to be used. She indicated the resident had excoriation around the stoma because the bag was not fitted correctly.		Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. We are respectfully requesting an IDR of this deficiency as their were orders for colostomy care however they did not specifically give the directions as this is a standard of care for colostomy care and their is a policy as to how to perform the colostomy care. Furthermore, there were no concerns during the surveyors observation of our nurses performing colostomy care further showing our competency of colostomy care. **Alleged deficiency:** Failed to ensure a resident who had a colostomy had specific direction for colostomy care. **Corrective Action for resident(s) found to have deficiency:** Specific direction for colostomy care was added to order for Resident 25. **Identify other residents having the same potential deficiency:** Residents with ostomy have the potential for having the same deficiency. **Measures put into place or systemic changes:** Audit was	

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	A current policy, titled "Colostomy /Ileostomy Care - Clinical Protocol," not dated and received from the Director of Nursing, on 2/22/24 at 1:30 p.m., indicated "...the purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter...review the resident's care plan to assess for any special needs of the resident, assemble the equipment and supplies as needed...the following equipment and supplies will be necessary when performing this procedure...skin cleansing prep, clean drainage bag, soap and water, barrier creams and lotions and personal protective equipment...." 3.1-47(3)		completed of all ostomy orders currently in house and specific directions for colostomy care were added to orders. Plan to monitor performance to maintain compliance: Assistant Director of Nursing will audit all new orders for resident's admitted with an ostomy to ensure orders have specific directions weekly x4 weeks, bi-weekly x2 months, and monthly x3 months. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to recognize, provide interventions, and to notify the physician of a weight loss for 2 of 5 residents reviewed for nutrition. (Resident 51 and 5) Findings include: 1. The clinical record for Resident 51 was reviewed on 2/22/24 at 9:18 a.m. The diagnoses included, but were not limited to, diabetes mellitus, cardiomyopathy, congestive heart failure, hypertension, Alzheimer's disorder, and dementia. A care plan, dated as revised on 3/11/23, indicated the resident had a self-care performance deficit. The interventions included, but were not limited to, the resident required assistance from staff to eat. A care plan, dated as revised on 3/11/23, indicated the resident had diabetes mellitus. The interventions included, but were not limited to, a dietary consult for nutritional regimen and ongoing monitoring, to monitor, document and report compliance with diet and to document any problems, and to offer a substitute for foods not eaten. A physician's order, dated 3/12/23, indicated the resident was on a regular diet and received Mighty shakes (a dietary supplement) with all meals. The resident had the following weights: a. On 11/13/23, the weight was 164.0 pounds.	F 0692	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to recognize, provide interventions, and to notify the physician of a weight loss. **Corrective Action for resident(s) found to have deficiency:** Physician was notified of weight loss on Residents 51 and 5. Residents 51 and 5 are currently being followed by Registered Dietitian for significant weight loss and interventions have been put into place. Care plans and orders have been updated for Resident 51 and Resident 5. **Identify other residents having the same potential deficiency:** All Residents have the potential for significant weight loss have the potential for the same deficiency. An audit has been conducted to ensure all residents with	04/02/2024

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	b. On 11/20/23, the weight was 146.0 pounds. The resident had a 10.98% weight loss in one week. There was no documentation of the physician being notified of the weight loss. During an interview, on 2/23/24 at 12:19 p.m., DON 2 indicated the CNAs obtained the residents' weights and the nurses were supposed to look at the weights. Resident 51 should have been reweighed within a day or two.2. The clinical record for Resident 5 was reviewed on 2/21/24 at 4:42 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia without behavioral disturbance, rheumatoid arthritis, vitamin D deficiency, and dysphagia (difficulty swallowing). A care plan, dated 7/31/2017, indicated the resident had a potential to be at a nutritional risk and for unintended weight changes related to the diagnosis of Parkinson's disease and dementia. The goal included the resident would maintain adequate nutritional status as seen by no further significant weight changes. The interventions included, but were not limited to, monitor for signs and symptoms of dysphagia, refusing to eat, and to monitor, record and report to the physician and Registered Dietician (RD) significant weight loss of 5% in one month, 7.5% in 3 months and 10% in 6 months and the RD was to evaluate and make recommendations as needed. A physician's order, dated 1/4/24, indicated a regular diet with a mechanical soft texture. The resident had the following weights: a. On 12/12/24, the weight was 110 pounds.		significant weight loss have been recognized, provided interventions, and have physician notification. **Measures put into place or systemic changes:** Registered Dietitian will run a weekly report on Tuesdays to determine if any residents have a significant weight loss and require interventions. Weekly meetings were initiated with Director of Nursing, Assistant Director of Nursing, and Registered Dietitian to discuss weight changes. Director of Nursing and Registered Dietitian are regulating weekly weights using weight sheets on Monday to be reviewed by Director of Nursing, Registered Dietitian or designee to eliminate errors in documentation and timely requests for reweights. MD and Families will be notified by Registered Dietitian of significant weight losses. Plan to monitor performance to maintain compliance: Registered Dietitian will audit significant weight losses for appropriate interventions, orders, and MD and family notification for 3 residents weekly x4 weeks, 2 residents weekly x2 months, and 1 resident weekly x4 months. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

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	b. On 12/18/24 the weight was 106.4 pounds. c. On 1/1/24, the weight was 106.2 pounds. d. On 1/8/24, the weight was 106 pounds. e. On 1/22/24, the weight was 107.4 pounds. f. On 1/29/24, the weight was 103.2 pounds which was a weight loss of 6.18% in 47 days. g. On 2/1/24, the weight was 99 pounds which was a significant weight loss in 10 days of 7.82% and a 10% weight loss in 50 days from the weight on 12/12/24. During an interview, on 2/23/24 at 11:38 a.m., the RD indicated she would calculate the weight changes from the month before and the resident did not hit the 5% mark for a significant weight loss. There was no nutrition note completed and no assessment for a significant weight change completed. During an interview, on 2/23/24 at 11:40 am., DON 1 indicated there was no physician or resident representative notification for the weight changes. A current policy, titled "Weight Assessment and Interventions," revised on 5/20/20 and received from the DON on 2/23/24 at 11:27 p.m., indicated "...The nursing staff will measure residents' weights on admission and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in each unit's Weight Record in the electronic chart...The Dietician will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria "significant' weight change has been met...The threshold for significant unplanned and undesired weight loss will be based on the following criteria...1 month - 5% weight loss is			

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	significant; greater than 5% is severe. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. 6 months - 10% weight loss is significant; greater than 10% is severe...If the weight change is desirable, this will be documented and no change in the care plan will be necessary...." 3.1-46(a)(1)			
F 0756 SS=E Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the			

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	identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, interview and record review, the facility failed to ensure the provider documented the rationale for not agreeing with a pharmacist recommendation for gradual dose reductions and pharmacy reviews and failed to give a rational for not discontinuing the use of a prophylactic antibiotic for 4 of 5 residents reviewed for unnecessary medications. (Residents 3, 36, 38 and 42) Findings include: 1. The clinical record for Resident 3 was reviewed on 2/21/24 at 9:36 a.m. The diagnoses included, but were not limited to, major depressive disorder, bipolar disorder, vascular dementia, and anxiety. A gradual dose reduction (GDR), dated 1/2/24, indicated the resident was due for a trial reduction of olanzapine (an antipsychotic medication). Discontinue the morning dose of 2.5 mg (milligram) and continue the evening dose of 10 mg. The provider disagreed with the recommendation and the note indicated "verbal from MD" and was dated 1/5/24.	F 0756	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. We are respectfully requesting an IDR for this deficiency as the rationale was documented in the providers note as to why they did not agree with the pharmacist's recommendation for gradual dose reductions they just were not written on the pharmacy recommendation form itself. **Alleged deficiency:** Failed to ensure the provider documented the rationale for not agreeing with a pharmacist recommendation for	04/02/2024

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	There was no clinical rationale as to why the provider disagreed with the pharmacist recommendations. A note to the attending physician/provider, dated 2/7/24, indicated the current dose of olanzapine 30 mg at night was considered high dose therapy. The labeled max dose was 20 mg at night. The recommended action was to evaluate the continued need of the current dose. The note indicated the doctor was aware and refused the GDR. The document was signed on 2/8/24. There was no clinical rationale as to why the provider disagreed with the pharmacist recommendations. A GDR, dated 3/9/24, indicated the resident was due for a trial reduction of lorazepam (an antianxiety medication) 0.5 mg in the evening for anxiety. If therapy was to continue at the current dose, please provide a statement of rationale. The provider marked disagree and did not provide any notes or rationales. 2. The clinical record for Resident 36 was reviewed on 2/21/24 at 11:18 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance, major depressive disorder, Alzheimer's disease, and anxiety disorder. A note to the attending physician/provider, dated 1/2/24, indicated the resident was on mirtazapine (an antidepressant medication) 7.5 mg in the evening for appetite stimulation. The resident's weight had remained stable. The recommendation was to avoid the use of the medication and work with dietary to utilize non-pharmacologic methods		gradual dose reductions and pharmacy reviews and failed to give rationale for not discontinuing the use of prophylactic antibiotics. **Corrective Action for resident(s) found to have deficiency:** Medical provider was asked to provide a rationale for not agreeing with pharmacist recommendation for residents 3, 36, 38, 42. **Identify other residents having the same potential deficiency:** Residents with pharmacy recommendations are at risk of having the same potential deficiency. **Measures put into place or systemic changes:** The Director of Nursing will educate providers about documenting their rationales on pharmacy recommendation form. Plan to monitor performance to maintain compliance: Director of Nursing will audit all pharmacy recommendations monthly x6 months for rationales on pharmacy recommendations. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

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	to achieve sustainable weight goals. The provider disagreed with the recommendation and indicated "failed prior GDR". The prior GDR was in November of 2023, almost 2 months prior. During an interview, on 2/22/24 at 3:13 p.m., the Director of Nursing (DON) 2 indicated they would need to do education on documentation on the pharmacy reviews.3. During an observation, on 2/19/24 at 3:17 p.m., Resident 38 appeared calm and smiled frequently. During an observation, on 2/20/24 at 10:30 a.m., Resident 38 was calm and appeared comfortable while lying in bed after breakfast with his wife at his bedside. During an observation, on 2/22/24 at 9:42 a.m., Resident 38 was trying to eat breakfast with his eyes closed. Despite frequent cuing from staff, the resident kept closing his eyes again and was having difficulty eating his breakfast. The clinical record for Resident 38 was reviewed on 2/22/24 at 11:07 a.m. The diagnoses included, but were not limited to, Parkinson's disease with dyskinesia, dementia in other diseases with psychotic disturbance, hallucinations, and insomnia. A care plan, initiated 11/18/22, indicated the physician was to consider dosage reductions when clinically appropriate for the psychotropic medications of Resident 38. In a pharmacist's note to the attending physician/prescriber, dated 5/19/23, the prescriber disagreed to a gradual dose reduction for			

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	quetiapine for depression to 25 mg at bedtime with no rationale given. In a pharmacist's note to the attending physician/prescriber, dated 11/10/23, the prescriber disagreed to a gradual dose reduction for quetiapine to 25 mg in the evening and 50 mg at bedtime for dementia with no rationale given. The prescriber noted neurology was aware of the recommendation. In a pharmacist's note to the attending physician/prescriber, dated 12/4/23, the prescriber disagreed to a gradual dose reduction for sertraline to 50 mg each day for depression and indicated the resident was stable on the current dose. During an interview, on 2/22/24 at 3:15 p.m., DON 2 indicated the physician may have documented the reasons for refusing the pharmacist's recommendation for the gradual dose reductions somewhere else in the clinical record. She did not know the prescriber needed to document a clinical reason for disagreeing with the pharmacy recommendation. 4. During an interview, on 2/21/24 at 10:58 a.m., Resident 42 indicated her urologist had put her on cephalexin (an antibiotic) prophylactically after she had a severe urinary tract infection with sepsis and was in the intensive care unit at the hospital. The clinical record for Resident 42 was reviewed on 2/21/24 at 11:06 a.m. The diagnoses included, but were not limited to, multiple sclerosis, recurrent major depressive disorder, anxiety disorder, and insomnia.			

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	A physician's order, dated 11/17/22, indicated to give Fluoxetine 20 mg every morning for depression. A physician's order, dated 11/17/22, indicated to give Cephalexin 500 mg every morning and had no stop date recorded. In a pharmacist's note to the attending physician/prescriber, dated 5/19/23, the prescriber disagreed to a gradual dose reduction for fluoxetine for depression to 10 mg with no rationale given. In a pharmacist's note to the attending physician/prescriber, dated 11/14/23, the prescriber disagreed to a gradual dose reduction for fluoxetine for depression to 10 mg with no rationale given. In a pharmacist's note to the attending physician/prescriber, dated 4/24/23, the prescriber disagreed to discontinuing the cephalexin with no rationale given. In a pharmacist's note to the attending physician/prescriber, dated 10/23/23, the prescriber checked agree to discontinuing cephalexin and then marked disagree indicating the resident refused. In a pharmacist's note to the attending physician/prescriber, dated 12/11/23, the prescriber disagreed to discontinuing cephalexin and indicated the resident refused. During an interview, on 2/22/24 at 3:15 p.m., DON 2 indicated the physician might have documented the reasons for refusing the pharmacist's recommendation for gradual dose reductions and			

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	discontinuing the antibiotic for Resident 42 somewhere else in the clinical record. She did not know the prescriber needed to document a clinical reason for disagreeing with the pharmacy recommendation. A current policy, titled "Tapering Medications and Gradual Dose Reduction," dated as approved on 5/20/20 and received from DON 1 on 2/2324 at 11:35 a.m., indicated "...the GDR may be considered contraindicated if...the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder...Attempted tapering of psychopharmacologic medications...The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder...." 3.1-25(i)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to ensure the refrigerators and freezers were clean, food was sealed, labeled, and dated, and expired foods were discarded for 4 of 6 kitchens reviewed. (Kitchen 3, 4, 5 and 6) Findings include: 1. During an observation, on 2/19/24 at 1:10 p.m., the kitchen in Cottage 3 had the following: a. cooked cream of wheat brought in by a family which was dated 2/3/24. b. The freezer drawers were very dirty and had brown dried liquid spilled inside. c. The refrigerator in the kitchen had lime built up near the ice machine. During an interview, on 2/19/24 at 1:13 p.m., the Dietary Manager (DM) indicated the cooked cream of wheat should have been discarded after 3 days and the freezer looked like a soda exploded. During an interview, on 2/19/24 at 1:15 p.m., Cook 8 indicated the cream of wheat was frozen and was taken out when needed.	F 0812	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Facility failed to ensure the refrigerators and freezers were clean, food was sealed, labeled, and dated, and expired foods were discarded for 4 of 6 kitchens reviewed. (Kitchen 3,4,5 and 6) **Corrective Action for resident(s) found to have the same deficiency:** All dietary staff will be educated on proper food handling and storage, ensuring food in the	04/02/2024

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	2. During an observation, on 2/21/24 at 10:37 a.m., the kitchen in Cottage 4 had the following: a. The refrigerator in the kitchen was dirty on the outside. The left side of the refrigerator where the ice came out had lime buildup. b. Three spices in the cabinet above the right side of the counter had one bottle of black pepper, seasoned salt, and cinnamon without an opened date and the bottles were sticky. c. The refrigerator in the storage room had a brown sticky substance on the door and inside on the bottom shelf. During an interview, on 2/21/24 at 10:39 a.m., the DM indicated the spices should have a date when opened on the label. The refrigerators were to be wiped off every shift. 3. During an observation, on 2/19/24 at 1:05 p.m., the kitchen in Cottage 5 had the following: a. The refrigerator in the dry storage area had meat defrosting with no thermometer in the refrigerator. 4. During an observation, on 2/19/24 at 1:10 p.m., the kitchen in Cottage 6 had the following: a. The cans in the dry storage did not have received dates. b. The bags of cereal were open and undated. c. Two bags of rice were undated. During an interview, on 2/19/24 at 1:49 p.m., Cook 7 indicated she did not know when the facility received the cans, and the cans should have received dates on them. A current policy, titled "Food Receiving and Storage," dated 5/27/20 and received from DON 1 on 2/23/24 at 3:53 p.m., indicated "...Foods shall be received and stored in a manner that complies		kitchen and dry storage, food is properly sealed, dated with open and expiration dates, and expired food are discarded. All dietary staff will be educated in maintaining their equipment and cleaning their kitchen areas, including refrigerators and freezers within the kitchen areas. **Measures put into place or systemic changes:** During orientation, all oncoming dietary staff will be educated on appropriate food handling and storage, sealing of food, dating of food items, maintaining and cleaning of equipment, including cleaning of refrigerators and freezers. This education will be reviewed at least annually. **Plan to monitor performance to maintain compliance**: Dietary manager or designee will audit all refrigerators, freezers and dry storage for appropriate labeling, dating, proper storage and handling of food, and kitchen equipment cleanliness. This audit will take place a minimum of 5 times a week x 1 month, then 3 times a week x 1 month, then weekly x 4 months. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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	with safe food handling practices...Food Services, or other designated staff, will maintain clean food storage area at all times...Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by' date). Such foods will be rotated using a "first in-first out" system...All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date) ...Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods...." A current policy, titled "Food Brought by Family/Visitors," dated 5/20/20 and received from DON 1 upon entrance, indicated "...Food brought to the facility be visitors and family is permitted. Facility staff will strive to balance residents' choice and a homelike environment with the nutritional and safety needs of residents...The nursing staff will discard perishable foods on or before the "use by" date...The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger...." 3.1-21(i)(1) 3.1-21(i)(3)			
F 0882 SS=D Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related			

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RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to ensure a designated Infection Preventionist was onsite to work within the facility and completed the qualifying training or certification for 1 of 1 Infection Preventionist reviewed. (DON 2) Finding includes: During an interview, on 2/23/24 at 9:20 a.m., DON 1 indicated the DON of the Restoracy of Whitestown (DON 2) was overseeing the infection control program at the Carmel facility. DON 1 indicated DON 2 was not an employee of this facility. She provided a certificate of training to show DON 2 had completed Module 2 of the CDC Infection Preventionist training course. From the CDC website, https://www.cdc.gov/longtermcare/training.html, reviewed on 2/23/24 at 6:30 p.m., the CDC Infection Preventionist Training course was for individuals responsible for infection prevention and control programs in long term care and contained 23 modules which must be completed to obtain the certification. During an interview, on 2/23/24 at 11:35 a.m., DON 2 indicated she was currently acting as the Infection Preventionist for the Carmel facility. She	F 0882	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a designated Infection Preventionist was onsite to work within the facility and completed the qualifying training or certification. **Corrective Action for resident(s) found to have deficiency:** Assistant Director of Nursing took certification for Infection Prevention and is currently certified **Identify other residents having the same potential deficiency:** n/a	04/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	worked full-time at the Whitestown facility and did not work part-time at the Carmel facility although she performed the Infection Preventionist duties for the Carmel facility. The plan was for the Assistant Director of Nursing to take over the Infection Control program after the Assistant Director of Nursing completed the Infection Preventionist certification. The facility did not provide a certificate of completion for a complete Infection Preventionist course from any source for any of the current employees in the facility. 3.1-18(b)		**Measures put into place or systemic changes:** Assistant Director of Nursing took certification for Infection Prevention and is currently certified. A nurse manager will also obtain the certification by the date of compliance to be an alternative Infection Preventionist, if necessary. Plan to monitor performance to maintain compliance: Director of Nursing or designee will ensure Infection Preventionist is on staff at facility and will do a weekly audit that an IP works at facility every week x6 months. If a staffing change is made, newly hired Assistant Director of Nursing or a nurse manager will be required to take Infection Preventionist course within first 30 days of employment. Any inconsistencies in the audits will be reported to the QAPI committee for review and compliance.	