STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 00 B. WING	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISTOWN MANOR	868 S WASHINGTON ST MORRISTOWN, IN 46161

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00398672, IN00393248, IN00393035, and IN00385960. Complaint IN00398672 - Substantiated. Federal/State deficiencies related to the allegations are cited at F661, F690, F695, and F880. Complaint IN00393248 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393035 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F760. Complaint IN00385960 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 17, 18, 19, 20, 23, and 24, 2023 Facility number: 000422 Provider number: 155691 AIM number: 100291030 Census bed type: SNF: 16 SNF/NF: 93 Total: 109 Census payor type: Medicare: 6 Medicaid: 72 Other: 31 Total: 109	F 0000	**This plan of correction is to serve as Morristown Manor's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Morristown Manor or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Morristown Manor respectfully requests a desk review for the plan of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Buzzard		02/10/2023

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

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 27, 2023			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to perform a self-administration of medication assessment prior to allowing a resident to self-administer medications for 1 resident randomly observed for self-administration of medications (Resident 104). Findings include: The clinical record for Resident 104 was reviewed on 1/20/23 at 9:22 a.m. The Resident's diagnosis included, but were not limited to, chronic congestive heart failure. On 1/20/23 at 9:22 a.m., LPN (Licensed Practical Nurse) 1 was observed standing at the medication cart in the hallway outside of the unit dining room. Dietary Aide 17 approached the medication cart and informed LPN 1 that Resident 104's medications were sitting on his breakfast tray in the dining room. LPN 1 locked her medication cart and went to the dining room table where Resident 104 had been setting. She picked up a plastic medication cup which contained several pills and brought it back to the medications cart. During an interview on 1/20/23 at 9:23 a.m., LPN 1	F 0554	**F554 Resident Self-Admin Meds** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident 104 no longer resides at the facility **II. The facility will identify other residents that may potentially be affected by this practice.**Residents who self-administer medications have the potential to be affected and have been audited to ensure a self- administration assessment has been completed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**Licensed nurses and Qualified Medication Aides (QMA) were educated regarding completing self-administration assessments for residents who self-administer their medications. Licensed nurses and QMAs will be educated upon hire and annually. Attachment A **IV. The**	02/14/2023

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	indicated that she had given Resident 104 his medications while he was sitting at the table. He had brought them to his mouth, and she had thought that he had swallowed them. He must not have taken them, or he possible spit them back into the cup. During an interview on 1/20/23 at 3:14 p.m., the Nurse Consultant indicated Resident 104 did not have a self-medication assessment. On 1/20/23 at 3:14 p.m., the Nurse Consultant provided the current Licensed Nurse Med Pass Clinical Skills Validation which read "...24. Remained with the resident to ensure that the medication was swallowed..." 3.1-11(a)		**facility will monitor the corrective action by implementing the following measures.** Director Of Nursing (DON) or designee will audit 5 random residents who self-administer their medications to ensure a self-administration assessment has been completed weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance.	
F 0580 SS=G Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or			

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	(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to immediately notify a resident's physician of an x-ray result timely which indicated, the resident had sustained an elbow fracture from a fall that occurred days prior resulting in delayed treatment and a significant change in the resident's condition for 1 of 2 residents reviewed for accidents. (Resident 56)	F 0580	**F 580 Notify of Changes** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident 56's physician was notified of x-ray results and they continue to be followed by orthopedics. **II. The facility will**	02/14/2023

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	Findings include: The clinical record for Resident 56 was reviewed on 1/20/23 at 11:57 a.m. Resident 56's diagnoses included, but not limited to, irritable bowel syndrome, congestive heart failure, weakness, and chronic obstructive pulmonary disease. A nursing note dated 10/8/2022 at 5:18 p.m. indicated, she had received a phone call from Resident 56's roommate indicating, Resident 56 had gotten up out of bed, walked herself to the bathroom, slipped and fell. Upon arriving at the resident's room, Resident 56 was sitting on her bottom and when asked if she hit her head, she stated "no". Resident 56 had a laceration noted to bilateral elbows and she complained of pain to her left elbow where the laceration was noted. Resident was reminded that she needs to use her call light for assistance when she needs to get up. Resident was taken to "assist" dining room for dinner. A nursing note dated 10/9/2022 at 3:18 a.m. indicated, Resident 56's neurological checks continued, no further injuries were noted, all range of motion to all extremities without difficulty, and resident denied pain from fall but stated, "I always hurt somewhere". A nursing note dated 10/10/2022 at 2:32 p.m. was recorded as a "Late Entry on 10/10/22 at 2:32 p.m." indicated, Resident 56 was lethargic that morning, refused to take her medications, and did not eat breakfast. Resident 56 "screams out in pain when touching the left arm". Resident's Nurse Practitioner (NP) gave a new order for a STAT (sic, without delay.) x- ray of her left shoulder and arm.		**identify other residents that may potentially be affected by this practice.**Residents residing at Morristown Manor have the potential to be affected by this alleged deficient practice. Resident events from the last 30 days have been audited to ensure timely physician notification. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.**Licensed nurses, Inter Disciplinary Team (IDT), and nurse managers were re-educated on notifying physicians of any resident changes. Attachment B **IV. The facility will monitor the corrective action by implementing the following measure.** DON/Designee will audit 5 random residents records daily for 4 weeks, then weekly for 8 weeks, then biweekly for 3 months, then monthly for 6 months to ensure physicians are notified of any resident condition changes. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

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A physician's order dated 10/10/22 indicated, to obtain a two-view x-ray of left shoulder and arm STAT.

A radiology report dated 10/10/22 at 8:51 p.m. EDT (sic, eastern standard time) was received on 1/19/23 at 2:24 p.m. from DON (Director of Nursing). The report indicated; Resident 56 had a nondisplaced left ulna olecranon (elbow) fracture with soft tissue swelling over the fracture.

A nursing note dated 10/12/22 at 9:30 a.m. indicated, Resident 56 was being sent to the local emergency room related to a fractured elbow. At the time of the transfer to the hospital's emergency room, Resident 56's fall occurred 4 days prior, and the x-ray had been resulted for approximately 36 hours.

An interview with DON conducted on 1/20/23 at 10:52 a.m. indicated, the person who retrieved Resident 56's x-ray results from 10/10/22 placed the results in NP 6's folder instead of immediately calling the on-call physician or NP 6. NP 6 found Resident 56's x-ray result on 10/12/22 when she reviewed the contents of her folder. DON indicated, the expectation was whomever took the x-ray result off the fax machine, should have read the report, called the results to the on-call physician or the NP, and not simply place the report in a folder. She further indicated, whenever there is a fall, pain assessments should be done and charted, and the fall event should have a narrative fall assessment.

An interview with Resident 56's NP 6 conducted on 1/20/23 at 11:42 a.m. indicated, the on-call service had been informed of the fall on 10/8/22. NP 6 indicated, she had come into the facility on

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	the 12th and found the x-ray result in her folder. "There was nothing documented on it whatsoever. I can tell from the report that the x-ray was sent to the facility on the 10th at 8:11 p.m." She stated, "someone should have been notified of the result". "The facility could have called me personally on Tuesday..." NP 6 indicated, the facility had a lot of agency staff working there at that time and they "can't stick it in a folder and not address it." NP 6 indicated, had she been made aware of the result sooner, Resident 56 would have received treatment quicker. Resident 56's Annual MDS (minimum data set) dated 9/1/22 indicated, prior to the fall on 10/8/22, she required limited assistance of one person for bed mobility, transfers, toileting, and personal hygiene; supervision with set up for eating; physical help in part of one person for bathing; could walk in room and on the unit with limited assistance of one person. Resident 56's quarterly MDS dated 10/26/22, after the fall on 10/8/22, indicated she required, extensive assistance of two persons for bed mobility, transfers, toileting, and personal hygiene; extensive assistance of one person for eating; and was totally dependent on one person for bathing. Resident 56's care plan dated 7/28/22 indicated, she was risk for decreased walking self-performance related to unsteadiness on feet. Interventions included, but not limited to, apply gait belt and provide rolling walker prior to walking, monitor for signs/symptoms of pain, shortness of breath, and fatigue, and refer to therapy as needed.			

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	3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from abuse related to a resident getting intentionally pushed out of her room by her roommate and threatening them with clinched fists (Resident 53 and 73) and intentionally pushing another resident into their walker (Resident 53 and 14) for 2 of 2 residents reviewed for abuse. Findings include: The clinical record for Resident 53 was reviewed on 1/23/23 at 9:52 a.m. Resident 53's diagnoses included, but not limited to, cognitive social or emotional deficit following cerebral infarction (stroke), vascular dementia with behavioral	F 0600	**F600 Free from Abuse and Neglect** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 14 was assessed for psychosocial distress, and has suffered no ill effects from the alleged deficient practiceResident 73 was assessed for psychosocail distress, and has suffered no ill effects from the alleged deficient practice **II. The facility will identify other residents that may potentially be affected by the practice.**A facility audit was	02/14/2023

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	disturbance, generalized anxiety disorder, and delusional disorder. Resident 53's quarterly MDS (minimum data set) dated 8/12/22 indicated, she had moderate cognitive impairment. Resident 53's quarterly MDS dated 11/7/22 indicated, she had no behaviors. 1. An event note dated 10/29/22 indicated, Resident 53 had aggressively pushed her roommate, Resident 73, while in her wheelchair, out of their room and into the hallway, then shook her fist in Resident 73's face, and Resident 73 screamed. A nursing note dated 10/29/22 at 6:58 p.m. indicated, Resident 53 was moved to another room. A nursing note dated 10/31/2022 at 3:30 p.m. indicated, new orders were received to send Resident 53 to a psychiatric facility related to aggressive behaviors towards Resident 73. A nursing note dated 10/29/2022 at 4:36 p.m. and recorded as a Late Entry on 10/31/2022 at 3:41 p.m. indicated, "Resident [sic, Resident 53] was physically aggressive towards roommate [sic, Resident 73] by pushing roommate out of room aggressively while roommate was in her wheelchair[sic] out into hallway then roommate screamed out and this resident shook her fist in roommates face.[sic] resident did not make contact with fist. Resident walked away from roommate..." A nursing note from Resident 73's electronic health record (EHR) dated, 10/29/2022 at 4:49 p.m.		done by the Administrator or designee to identify any other residents in the last 7 days that have behaviors affecting others that are not able to be re-directed or could require increased supervision. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**Facility staff were re-educated on reporting new and worsening behaviors. The IDT team was educated on the practice of reviewing documented behaviors daily in the IDT meeting for any new or worsening behaviors. Attachment B **IV. The facility will monitor the corrective action by implementing the following measures.**The facility department leaders will interview all interviewable residents and the responsible party for non-interviewable residents residing in the facility monthly for 3 months then quarterly for 9 months to total 12 months of monitoring. Any identified concerns will be immediately reported to the Administrator and handled per the reporting guidelines The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	indicated, "QMA [sic, qualified medication assistant] reported to writer that resident stated her roommate pushed her out of her room by her w/c[sic, wheelchair]. Resident stated her finger did get pinched when her w/c[sic] moved. Head to toe shows only a small bruise on 4th finger of her right hand...Resident stated roommate threatens her to beat her up in the middle of the night. Resident stated once that she drew her fist at her and the nurse came in just in time to stop it. ED[sic, Executive Director] and DON [sic, Director of nursing] notified of incident..." A Social services note from Resident 73's EHR dated 11/2/2022 at 4:09 p.m. indicated, Resident 73 had been fine since her roommate was no longer in the same room as her. Both Resident 73 and her family had voiced that they did not want Resident 53 to be roommates. An incident report was received on 1/23/23 from ED (Executive Director) at 12:51 p.m. The incident report indicated; the incident date was 11/1/22 at 11:30 a.m. The brief description of incident stated, "11/2/22 (sic, Resident 73's first name) stated to staff that (sic, Resident 53's first name) her roommate at the time pushed her into the hallway while she was seated in her wheelchair." Type of injury added was a small bruise noted on Resident 73's 4th finger of her right hand and "was possibly pinched by the wheelchair moving forward." The follow up dated 11/9/22 indicated, Resident 53 and 73 will no longer be roommates. An interview with Resident 73 was conducted on 1/23/23 at 11:00 a.m. She indicated, Resident 53 had Alzheimer's and would get more confused during the night. She stated, when she and Resident 53 were roommates, Resident 53 would turn off the lights and yell at her to stop wasting			

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	electricity. She indicated the evenings were most unpleasant and that she had "faced her double fists more times than I could count". She stated, since Resident 53 moved out of her room, she tries not to come in direct contact with her but, there have been a few times she wandered into her room in the middle of the night and was trying to get in bed with her new roommate. She indicated, the staff came in and had to redirect her out of the room. Resident 73 stated, "I don't want her to terrify my roommate." Resident 73's annual MDS dated 12/1/22 indicated, she was cognitively intact. 2. An incident report dated 12/27/22 was received on 1/23/23 from ED (Executive Director) at 12:51 p.m. It indicated, on 12/27/22 Resident 14 stated, Resident 53 came into her room, so she grabbed her arm to redirect her when Resident 53 pushed back and caused Resident 14 to move backwards up against her door. No injury was noted. The immediate action taken was a pain and skin assessment was completed on Resident 14. Preventive measure stated, an investigation had been initiated into the interaction between Resident 14 and Resident 53 and a sign had been placed on Resident 53's door to identify it as hers. The follow up dated 1/3/23 indicated, Resident 14 wasn't showing any signs of distress from the incident and interviews conducted with staff didn't coincide with Resident 14's version of the incident. Resident 53 was unable to recall the incident and staff will continue to redirect Resident 53 as needed. A Social services note dated 12/27/2022 at 3:57 p.m. indicated, social services had spoken with Resident 14 that afternoon and asked her if she was still feeling unsafe. Resident 14 replied yes as			

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	long as she was still next door to her. Resident 14 stated, she was going to put her chair in front of door as long as Resident 53 was next door to her. A nursing note dated 12/27/2022 at 4:54 p.m. indicated, Resident 14's skin was assessed that morning and no bruising or skin issues were noted. Resident 14 had pointed to her right buttock/hip area and stated, "right there, but I haven't bruised yet, but I will later." An interview with Resident 14 was conducted on 1/23/23 at 11:16 a.m. Resident 14 indicated, Resident 53 wanders at nighttime. On 12/26/22, Resident 53 had wandered into Resident 14's room so Resident 14 took Resident 53 by her arm and had guided her back out of her room. She stated, about an hour later, Resident 53 was back in her room near the doorway, so she approached her went to guide her out of her room when Resident 53 "shoved me back" and she had hit her hip on the walker which was behind her. Resident 14 stated, that area "didn't have a bruise but I hurt for days". Resident 14 indicated, when referencing Resident 53 during the nighttime hours that "she's like a crazy person at nighttime". She continued by stating, she was afraid of having her live next door to her. She admitted there were a few nights she had put her chair against the door because she was afraid of her. Resident 14's annual MDS dated 11/16/22 indicated, she was cognitively intact. The investigation file related to Resident 53 and 14's incident contained a handwritten sheet with the names of staff who worked the evening/night shift on 10/26/22 into 10/27/22. The handwritten note next to an agency CNA's name (certified nursing assistant 25) indicated, "[sic, Resident			

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	53's name] came in + [sic, and] started yelling @ [sic, at] her +[sic] felt fearful +[sic] was putting a chair to block her door...going into rooms, turning off lights," An interview with ED (Executive Director) was conducted on 1/23/23 at 12:11 p.m. ED indicated, he didn't believe the incident between Resident 53 and 73 was abuse related to Resident 53 pushing on resident 73's wheelchair and not her person. He further indicated, he did not report the incident between Resident 53 and 73 timely related to him being on vacation. An Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy was received on 1/17/23 at 2:03 p.m. from ED. The policy indicated, "Our abuse prevention/intervention program includes, but is not limited to, the following... j. Assessing, care planning, and monitoring of residents with needs and behaviors that may lead to conflict or neglect; k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues;... r. Reporting any allegation of abuse or neglect to the State licensing/certification agency...immediately with a brief description of the alleged occurrence. s. Thoroughly investigating each allegation regardless of source or credibility of information... Reporting to the Administrator...5...Abuse is the 'willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...b. Verbal abuse is defined as any use of oral, written or gestured language... d. Physical abuse is defined as hitting, slapping, pinching, kicking...7. When an incident of resident abuse is suspected or determined, such incident must be			

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	reported to the Administrator, or designee, regardless of the time lapse since the incident occurred." 3.1-27(a)(1) 3.1-27(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1)			

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	and (2) of the Act. Based on interview and record review, the facility failed to implement the facility's abuse policy and obtained criminal background checks prior to working in the facility for 2 of 10 staff members reviewed. (Certified Nurse Assistant trainee (CNAT) 4 and Dietary Aide (DA) 5) Findings include: 1. An employee records document indicated CNAT 4's start date in the facility was on 11/30/22. 2. An employee record indicated DA 5's start date in the facility was on 10/5/22. CNAT 4 and DA 5's personnel files were provided by Human Resources on 1/23/23 at 3:30 p.m. The files did not include criminal background checks that had been obtained for CNAT 4 nor DA 5 prior to working in the facility. CNAT 4 and DA 5's timecards that provided days worked in the facility were provided by Human Resources on 1/24/23 at 12:02 p.m. CNAT 4's time card indicated she had worked in the building on the following days: 11/30/22, 12/1/22, 12/2/22, 12/7/22, 12/8/22, 12/14/22, 12/15/22, 12/20/22, 12/21/22, 12/22/22, 12/25/22, 12/26/22, 12/27/22, 12/28/22, 12/29/22, 12/30/22, 1/2/23, 1/4/23, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/9/23, 1/11/23, 1/12/23, 1/13/23, 1/16/23, 1/18/23, and 1/20/23. DA 5's timecard indicated DA 5 had worked in the facility on the following days: 10/5/22, 10/19/22, 10/20/22, 10/21/22, 10/25/22, 10/27/22, 10/28/22, 11/4/22, 11/5/22, 11/6/22, 11/10/22, 11/11/22, 11/17/22, 11/18/22, 11/19/22, 11/20/22, 11/24/22, 11/25/22, 12/1/22, 12/2/22, 12/03/22, 12/4/22,	F 0607	**F607 Develop/Implement Abuse/Neglect Policies** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**CNAT 4 and DA 5 background checks are complete with no concerns and able to resume working . No residents were affected by the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice**The files of current employees were audited to ensure they include background checks, and no further concerns were noted. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**Human Resources was re-educated per the abuse policy on ensuring background checks are complete prior to any staff working a shift. Attachment C **IV. The facility will monitor the corrective action by implementing the following measures.** Administrator/designee will check new hire files at the end of each month to make sure they have a background check present weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months.	02/14/2023

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	12/8/22, 12/9/22, 12/15/22, 12/16/22, 12/17/22, 12/18/22, 12/22/22, 12/30/22, 12/31/22, 1/1/23, 1/5/23, 1/6/23, 1/12/23, 1/13/23, 1/14/23, 1/15/23, 1/19/23, and 1/20/23. An interview was conducted with Human Resources on 1/24/23 at 11:30 a.m. She indicated she was unable to provide background checks that had been obtained for CNAT 4 and DA 5 prior to working in the facility. The abuse policy was provided by the Executive Director on 1/17/23 at 2:03 p.m. It indicated "...I. Background Screening Investigations. Our Community will not knowingly hire any individual who has a history of abusing other persons. The Community will conduct employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with this facility. 1. The Human Resources Consultant, or other person designated by the administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this Community. Such screening will be initiated prior to employment or offer of employment. 2. When conducting background investigations, our facility may consult any or all of the following agencies: a. Local, state, and/or federal law enforcement agencies; b. Department of pubic safety; c. Banks or other financial institutions; d. Consumer reporting agencies; and e. Other agencies as may become necessary..." 3.1-28(a)		The results of these audits will be discussed at the facility Quality Assurance meetings monthly times 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of			

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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to timely report a resident's alleged abuse for 1 of 2 incidents reviewed for abuse. (Residents 53 and 73) Findings include: The clinical record for Resident 53 was reviewed on 1/23/23 at 9:52 a.m. Resident 53's diagnoses	F 0609	**F 609 Reporting Alleged Violations** **I. The corrective actions to be accomplished for those residents found to be affected by the practice.**The incident was reported to the ISDH immediately following Administrator's knowledge of the incident. Resident has not experienced any	02/14/2023

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	included, but not limited to, cognitive social or emotional deficit following cerebral infarction (stroke), vascular dementia with behavioral disturbance, generalized anxiety disorder, and delusional disorder. Resident 53's quarterly MDS (minimum data set) dated 8/12/22 indicated, she had moderate cognitive impairment. Resident 53's quarterly MDS dated 11/7/22 indicated, she had no behaviors. An event note dated 10/29/22 indicated, Resident 53 had aggressively pushed her roommate, Resident 73, while in her wheelchair, out of their room and into the hallway, then shook her fist in Resident 73's face, and Resident 73 screamed. A nursing note dated 10/29/22 at 6:58 p.m. indicated, Resident 53 was moved to another room. A nursing note dated 10/31/2022 at 3:30 p.m. indicated, new orders were received to send Resident 53 to a psychiatric facility related to aggressive behaviors towards Resident 73. A nursing note dated 10/29/2022 at 4:36 p.m. and recorded as a Late Entry on 10/31/2022 at 3:41 p.m. indicated, "Resident [sic, Resident 53] was physically aggressive towards roommate [sic, Resident 73] by pushing roommate out of room aggressively while roommate was in her wheelchair[sic] out into hallway then roommate screamed out and this resident shook her fist in roommates face.(sic) resident did not make contact with fist. Resident walked away from roommate..." A nursing note from Resident 73's electronic		negative outcomes related to alleged incident. **II. The facility will identify other residents that may potentially by affected by the practice.**Residents with a BIMS of 10 or greater are being interviewed with an abuse questionnaire to ensure all abuse allegations are identified and handled according to state, federal and CarDon Policy and Procedures. Resident family members are being interviewed for non-interviewable residents using an abuse questionnaire to ensure all abuse allegations are identified and handled according to state, federal and CarDon Policy and Procedures. **III. The facility will put into place the following systematic changes to ensure that the practice will not recur.**Administrative Staff and front line staff will be educated by the corporate consultant regarding reporting alleged incidents timely, according to the Abuse Reporting Policy and Procedure. Attachment C **IV.The facility will monitor the corrective action by implementing the following measures.** The administrator or Designee will do 5 random staff interviews, including various departments, to ensure staff is aware of the Policy and Procedure for Abuse Reporting and timely reporting weekly times 4 weeks, then biweekly for 8 weeks, then	

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	health record (EHR) dated, 10/29/2022 at 4:49 p.m. indicated, "QMA [sic, qualified medication assistant] reported to writer that resident stated her roommate pushed her out of her room by her w/c[sic, wheelchair]. Resident stated her finger did get pinched when her w/c[sic] moved. Head to toe shows only a small bruise on 4th finger of her right hand...Resident stated roommate threatens her to beat her up in the middle of the night. Resident stated once that she drew her fist at her and the nurse came in just in time to stop it. ED[sic, Executive Director] and DON[sic, Director of nursing] notified of incident..." A Social services note from Resident 73's EHR dated 11/2/2022 at 4:09 p.m. indicated, Resident 73 had been fine since her roommate was no longer in the same room as her. Both Resident 73 and her family had voiced that they did not want Resident 53 to be roommates. An incident report was received on 1/23/23 from ED (Executive Director) at 12:51 p.m. The incident report indicated; the incident date was 11/1/22 at 11:30 a.m. The brief description of incident stated, "11/2/22 (sic, Resident 73's first name) stated to staff that (sic, Resident 53's first name) her roommate at the time pushed her into the hallway while she was seated in her wheelchair." Type of injury added was a small bruise noted on Resident 73's 4th finger of her right hand and "was possibly pinched by the wheelchair moving forward." The follow up dated 11/9/22 indicated, Resident 53 and 73 will no longer be roommates. The incident occurred on 10/29/22 but the incident was not reported to the State until 11/1/22. An interview with Resident 73 was conducted on 1/23/23 at 11:00 a.m. She indicated, Resident 53 had Alzheimer's and would get more confused		monthly for 9 months to ensure compliance. The results of these audits will be discussed at the facility Quality Assurance meetings monthly times 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	during the night. She stated, when she and Resident 53 were roommates, Resident 53 would turn off the lights and yell at her to stop wasting electricity. She indicated the evenings were most unpleasant and that she had "faced her double fists more times than I could count". She stated, since Resident 53 moved out of her room, she tries not to come in direct contact with her but, there have been a few times she wandered into her room in the middle of the night and was trying to get in bed with her new roommate. She indicated, the staff came in and had to redirect her out of the room. Resident 73 stated, "I don't want her to terrify my roommate." Resident 73's annual MDS dated 12/1/22 indicated, she was cognitively intact. An interview with ED (Executive Director) was conducted on 1/23/23 at 12:11 p.m. ED indicated, he didn't believe the incident between Resident 53 and 73 was abuse related to Resident 53 pushing on resident 73's wheelchair and not her person. He further indicated, he did not report the incident between Resident 53 and 73 timely because he was on vacation. An Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy was received on 1/17/23 at 2:03 p.m. from ED. The policy indicated, "Our abuse prevention/intervention program includes, but is not limited to, the following... j. Assessing, care planning, and monitoring of residents with needs and behaviors that may lead to conflict or neglect; k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues;... r. Reporting any allegation of abuse or neglect to the State licensing/certification			

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	agency...immediately with a brief description of the alleged occurrence. s. Thoroughly investigating each allegation regardless of source or credibility of information... Reporting to the Administrator...5...Abuse is the 'willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...b. Verbal abuse is defined as any use of oral, written or gestured language... d. Physical abuse is defined as hitting, slapping, pinching, kicking...7. When an incident of resident abuse is suspected or determined, such incident must be reported to the Administrator, or designee, regardless of the time lapse since the incident occurred." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to thoroughly investigate two incidents of alleged abuse for 2 of 2 incidents reviewed for abuse. (Residents 53, 73 and 14) Findings include: The clinical record for Resident 53 was reviewed on 1/23/23 at 9:52 a.m. Resident 53's diagnoses included, but not limited to, cognitive social or emotional deficit following cerebral infarction (stroke), vascular dementia with behavioral disturbance, generalized anxiety disorder, and delusional disorder. Resident 53's quarterly MDS (minimum data set) dated 8/12/22 indicated, she had moderate cognitive impairment. Resident 53's quarterly MDS dated 11/7/22 indicated, she had no behaviors. 1. An event note dated 10/29/22 indicated, Resident 53 had aggressively pushed her roommate, Resident 73, while in her wheelchair, out of their room and into the hallway, then shook her fist in Resident 73's face, and Resident 73 screamed. A nursing note dated 10/29/22 at 6:58 p.m. indicated, Resident 53 was moved to another room. A nursing note dated 10/31/2022 at 3:30 p.m. indicated, new orders were received to send Resident 53 to a psychiatric facility related to aggressive behaviors towards Resident 73. A nursing note dated 10/29/2022 at 4:36 p.m. and recorded as a Late Entry on 10/31/2022 at 3:41 p.m.	F 0610	**F610** **Investigate/Prevent/Correct Alleged Violation** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** ="" span="">Residents 53 no longer is 73's roommate and resides in a private room. The facility conducted staff interviews related to Resident 73's allegation. The facility received written and signed statements from resident 14 and 73 related to alleged incident reported to the facility. **II. The facility will identify other residents that may potentially be affected by this practice.**All grievances, received in the last 90 days, have been reviewed to ensure the facility completed a comprehensive investigation, including staff interviews. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** The Administrator and Director of Nursing received education related to the facility's policy/procedure for conducting and documenting the findings of a complete investigation with emphasis placed on the importance and inclusion of well documented staff and resident interviews. Attachment C **IV. The facility will monitor the corrective action by**	02/14/2023

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	indicated, "Resident [sic, Resident 53] was physically aggressive towards roommate [sic, Resident 73] by pushing roommate out of room aggressively while roommate was in her wheelchair[sic] out into hallway then roommate screamed out and this resident shook her fist in roommates face.(sic) resident did not make contact with fist. Resident walked away from roommate..." A nursing note from Resident 73's electronic health record (EHR) dated, 10/29/2022 at 4:49 p.m. indicated, "QMA [sic, qualified medication assistant] reported to writer that resident stated her roommate pushed her out of her room by her w/c[sic, wheelchair]. Resident stated her finger did get pinched when her w/c[sic] moved. Head to toe shows only a small bruise on 4th finger of her right hand...Resident stated roommate threatens her to beat her up in the middle of the night. Resident stated once that she drew her fist at her and the nurse came in just in time to stop it. ED[sic, Executive Director] and DON[sic, Director of nursing] notified of incident..." A Social services note from Resident 73's EHR dated 11/2/2022 at 4:09 p.m. indicated, Resident 73 had been fine since her roommate was no longer in the same room as her. Both Resident 73 and her family had voiced that they did not want Resident 53 to be roommates. An incident report was received on 1/23/23 from ED (Executive Director) at 12:51 p.m. The incident report indicated; the incident date was 11/1/22 at 11:30 a.m. The brief description of incident stated, "11/2/22 (sic, Resident 73's first name) stated to staff that (sic, Resident 53's first name) her roommate at the time pushed her into the hallway while she was seated in her wheelchair." Type of		**implementing the following measure.** To ensure ongoing compliance, the Administrator/Designee is responsible for reviewing grievances daily to ensure a comprehensive investigation, including staff interviews, resident/representative follow-up, and documentation of all actions taken, has been completed in accordance with the facility's policy/procedure. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

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	injury added was a small bruise noted on Resident 73's 4th finger of her right hand and "was possibly pinched by the wheelchair moving forward." The follow up dated 11/9/22 indicated, Resident 53 and 73 will no longer be roommates. An interview with Resident 73 was conducted on 1/23/23 at 11:00 a.m. She indicated, Resident 53 had Alzheimer's and would get more confused during the night. She stated, when she and Resident 53 were roommates, Resident 53 would turn off the lights and yell at her to stop wasting electricity. She indicated the evenings were most unpleasant and that she had "faced her double fists more times than I could count". She stated, since Resident 53 moved out of her room, she tries not to come in direct contact with her but, there have been a few times she wandered into her room in the middle of the night and was trying to get in bed with her new roommate. She indicated, the staff came in and had to redirect her out of the room. Resident 73 stated, "I don't want her to terrify my roommate." Resident 73's annual MDS dated 12/1/22 indicated, she was cognitively intact. The investigation file for the incident between Resident 53 and 73 was received on 1/23/23 at 3:04 p.m. The investigation file contained a copy of the incident report and an undated statement from ED (Executive Director). The ED's statement indicated, "Staff called discussing incident with [sic, Resident 73's first name] and [sic, Resident 53's first name] . [sic, Resident 53] and [sic, Resident 73] are roommates, so I asked that [sic, Resident 53] be moved to another room. The investigation file did not contain: an interview with the person reporting the incident; any interviews of any witnesses or potential witnesses			

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	to the incident including staff, residents, and visitors; interviews with the residents involved; or interviews with staff (on all shifts) who have had contact with the resident before, during, and immediately after the period of the alleged incident. 2. An incident report dated 12/27/22 was received on 1/23/23 from ED at 12:51 p.m. It indicated, on 12/27/22 Resident 14 stated, Resident 53 came into her room, so she grabbed her arm to redirect her when Resident 53 pushed back and caused Resident 14 to move backwards up against her door. No injury was noted. The immediate action taken was a pain and skin assessment was completed on Resident 14. Preventive measure stated, an investigation had been initiated into the interaction between Resident 14 and Resident 53 and a sign had been placed on Resident 53's door to identify it as hers. The follow up dated 1/3/23 indicated, Resident 14 wasn't showing any signs of distress from the incident and interviews conducted with staff didn't coincide with Resident 14's version of the incident. Resident 53 was unable to recall the incident and staff will continue to redirect Resident 53 as needed. A Social services note dated 12/27/2022 at 3:57 p.m. indicated, social services had spoken with Resident 14 that afternoon and asked her if she was still feeling unsafe. Resident 14 replied yes as long as she was still next door to her. Resident 14 stated, she was going to put her chair in front of door as long as Resident 53 was next door to her. A nursing note dated 12/27/2022 at 4:54 p.m. indicated, Resident 14's skin was assessed that morning and no bruising or skin issues were noted. Resident 14 had pointed to her right buttock/hip area and stated, "right there, but I			

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	haven't bruised yet, but I will later." An interview with Resident 14 was conducted on 1/23/23 at 11:16 a.m. Resident 14 indicated, Resident 53 wanders at nighttime. On 12/26/22, Resident 53 had wandered into Resident 14's room so Resident 14 took Resident 53 by her arm and had guided her back out of her room. She stated, about an hour later, Resident 53 was back in her room near the doorway, so she approached her went to guide her out of her room when Resident 53 "shoved me back" and she had hit her hip on the walker which was behind her. Resident 14 stated, that area "didn't have a bruise but I hurt for days". Resident 14 indicated, when referencing Resident 534 during the nighttime hours that "she's like a crazy person at nighttime". She continued by stating, she was afraid of having her live next door to her. She admitted there were a few nights she had put her chair against the door because she was afraid of her. Resident 14's annual MDS dated 11/16/22 indicated, she was cognitively intact. The investigation file related to Resident 53 and 14's incident contained a copy of the incident report and two handwritten sheets with the names of staff who worked the evening/night shift on 10/26/22 into 10/27/22. The hand written sheets with staff names and possible staff statements were not signed nor dated as to when they occurred of who conducted the interviews. The investigation file did not contain a written and signed statement from Resident 14 An Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy was received on 1/17/23 at 2:03 p.m. from ED. The policy indicated, "Our abuse prevention/intervention program			

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	includes, but is not limited to, the following... s. Thoroughly investigating each allegation regardless of source or credibility of information... Abuse Investigations 1. Should an incident or suspected incident of resident abuse, neglect...be reported, the Administrator...ensure the immediately protection and safety of the involved resident(s) and will appoint a member of management to investigate the alleged incident while retaining ultimate responsibility for ensuring a timely and thorough investigation... c. Interview the person(s) reporting the incident: d. Interview any witnesses or potential witnesses to the incident including staff, residents, and visitors; e. Interview the resident... g. Interview staff (on all shifts) who have had contact with the resident before, during, and immediately after the period of the alleged incident... 6. The following guidelines will be used when conducting interviews...c. The interview will be documented and, as appropriate, followed up with a written statement from the individual interviewed. 7. Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports when possible. Reporting to the Administrator...5...Abuse is the 'willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...b. Verbal abuse is defined as any use of oral, written or gestured language... d. Physical abuse is defined as hitting, slapping, pinching, kicking...7. When an incident of resident abuse is suspected or determined, such incident must be reported to the Administrator, or designee, regardless of the time lapse since the incident occurred."			

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	3.1-28(d)			
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on interview and record review, the facility failed to perform a Significant Change of Status Minimum Data Set Assessment for a resident who experienced a fracture with a decline in ADL abilities for 1 of 1 resident reviewed for Minimum Data Set Accuracy (Resident 56) Findings include: The clinical record for Resident 56 was reviewed on 1/18/23 at 11:20 a.m. The Resident's diagnosis included, but were not limited to, diabetes. An Annual MDS (Minimum Data Set) Assessment, completed 9/1/22, indicated Resident 56 needed supervision with eating after staff set up, was able to walk in her room with limited assist of 1 staff person and was able to walk in the hallway with supervision of 1 staff member.	F 0637	**F637-Comprehensive Assessment after Significant Change** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident 56's chart was reviewed, and a significant change Minimum Data Set (MDS) was scheduled to be completed by the MDS team. **II. The facility will identify other residents that may potentially be affected by this practice.**Residents with changes in ADLS in the last 30 days have been reviewed by the IDT team per the Significant Change criteria per Chapter 2 of the Resident Assessment	02/14/2023

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	A Quarterly MDS Assessment, completed 10/26/22, indicated Resident 56 needed extensive assist of 1 staff member with eating, and did not walk in her room or the corridor during the assessment period. During an interview on 1/20/23 at 10:44 a.m., the MDS Coordinator indicated that a Significant Change of Status MDS Assessment should have been completed instead of the 10/26/22 Quarterly MDS Assessment due to Resident 56 experiencing a fracture in October and having a decline in her ADL abilities. The facility used the RAI (Resident Assessment Instrument) manual as the policy for completing MDS Assessments. The Resident Assessment Instrument Version 1.16, last revised October 2018, read "...A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting', 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..." 3.1-31(d)(1)		Instrument (RAI) Manual. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.**Residents will be reviewed daily by IDT during clinical review for Significant Change criteria per RAI Manual. Attachment D **IV. The facility will monitor the corrective action by implementing the following measures.**Facility MDS Coordinators will monitor for Significant Change criteria per the RAI 3.0 Manual with MDS completion –	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses,			

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	course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure a discharge summary recapitulation of the resident's stay and a final summary of the resident's condition was completed for a resident discharging to home for 1 of 2 residents reviewed for discharge. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/18/23 at 2:30 p.m. The diagnoses for the resident included, but were not limited to, Parkinson's Disease and dementia. The resident was admitted on 11/30/22 and discharged on 12/15/22.	F 0661	**F661 Discharge Summary** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident B no longer resides at the facility. **II. The facility will identify other residents that may potentially be affected by practice.**Other residents that have transferred/discharged in the last 7 days have been reviewed for development of a discharge summary. If indicated, a summary has been provided. **III. The**	02/14/2023

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	A nursing progress note dated 12/15/22 indicated "Resident [B] discharging facility with wife to home at this time, transport provided by facility bus, all meds sent with resident and additional scripts sent to family's pharmacy of choice by NP [Nurse Practitioner]...." A discharge summary form for Resident B written by Unit Manager (UM) 2 dated 12/15/22 at 11:15 a.m., indicated Resident B was discharging from the facility to home with home health care. It did not include a clinical discharge narrative, special treatments and procedures or the condition of the resident at discharge. A discharge functional abilities assessment dated 12/15/22 indicated Resident B's function ability and self-care needed at the time of the discharge. The assessment did not include a recapitulation of the resident's stay nor a final summary of the resident's condition at that time of discharge. During a confidential interview on 1/18/23, She indicated Resident B was discharged from the facility on 12/15/22 to home on hospice care. She had observed that morning, Resident B was not feeling well and had a new red bump on his forehead. After leaving the facility, the resident arrived at the home incontinent with a new skin area to his bottom. An interview was conducted with Nurse Practitioner (NP) 6 on 1/20/23 at 11:14 a.m. She indicated on the morning of 12/15/22, Resident B was discharging to home. She was asked to assess Resident B by his representative due to the resident was running a fever, his CPAP had not been on during the night, and the resident had a small red bump on his forehead. It looked like a		**facility will put into place the following systemic changes to ensure that the practice does not recur.**Licensed nurses and social services are being educated regarding the development of discharge summaries per home discharge process. Attachment E **IV. The facility will monitor the corrective action by implementing the following measures.** The DON or designee will review all discharges to ensure development of a discharge summary weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

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	"pimple." She had pushed on the skin, and it was blanchable. An interview was conducted with UM 2 on 1/20/23 at 2:48 p.m. She indicated Resident B had discharged on 12/15/22 at approximately 11:00 a.m., due to her nursing progress note time stamped at 11:15 a.m. She had documented the progress note shortly after the resident had left the building. The resident was not soiled prior to leaving the building. He did have one spot that was not blanchable on his bottom, and a little red bump on his forehead. She had assessed the little red bump on his forehead that morning, and the CPAP straps aligned placement to the little area on his forehead. She would not have noted the new skin area in the medical chart due to the resident was leaving shortly after. An interview was conducted with the Nurse Consultant (NC) on 1/20/23 at 10:15 a.m. She indicated she was unable to locate a discharge summary and a recap of Resident B's condition at that time of the discharge. A discharge planning policy was provided by the NC on 1/20/23 at 1:44 p.m. It indicated "...I. When the community anticipates a resident's discharge to a private residence, another nursing care facility..., a discharge summary and a post discharge plan will be developed which will assist the resident to adjust to his or her living environment. II. The discharge summary will include a recapitulation of the resident's stay at this community and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: A.			

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	Current diagnoses; B. Medical history (including any history of mental disorders and intellectual disabilities); C. Course of illness, treatment and/or therapy since entering the facility; D. Current laboratory, radiology, consultation, and diagnostic test results; E. Physical and mental functional status; F. Ability to perform activities of daily living...G. Sensory and physical impairments..., H. Nutritional status and requirements:,...I. Special treatments or procedures..., J. Mental and psychosocial status..., L. dental condition..., M. Activities potential..., N. Rehabilitation potential..., O. Cognitive status...,P. Medication therapy...XIII. A copy of the following will be provided to the resident and any receiving provider and a copy will be filed in the resident's medical records: A. An evaluation of the resident's discharge needs; B. The post-discharge plan; and C. The discharge summary..." This Federal tag relates to Complaint IN00398672. 3.1-36(a)(1) 3.1-36(a)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record	F 0684	**F684 Quality of Care** **I. The corrective actions to be**	02/14/2023

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	review, the facility failed to assist a resident with eating, as ordered; prime an insulin pen prior to administering an insulin dose; and administer medication as ordered for 1 of 6 residents reviewed for unnecessary medications, 1 of 1 resident randomly reviewed for injection administration, and 1 of 4 residents reviewed for ADLs (activities of daily living.) (Residents 56, 60, and 62) Findings include: 1. The clinical record for Resident 60 was reviewed on 1/17/23 at 3:21 p.m. His diagnoses included, but were not limited to, Parkinson's disease and dysphagia. The 6/27/22 ADL care plan, last revised 1/5/23, indicated he was unable to independently perform late loss ADLs related to his Parkinson's Disease and required assistance/encouragement for eating. Interventions were to monitor for any eating/swallowing/meal issues and provide assistance and encouragement as needed and report any issues. The 10/25/22 and 1/7/23 Quarterly MDS (Minimum Data Set) assessments indicated he required extensive assistance of one person for eating. The physician's orders read, "Please feed resident Three Times A Day," for breakfast, lunch, and dinner, starting 7/26/22. There was an order to weigh the resident weekly, starting 6/24/22 and an order for speech therapy evaluation and treatment, starting 1/10/23. The 1/10/23 Speech Therapy Evaluation indicated his current level of function was that he required supervision at mealtime 91% to 100% of the time.		**accomplished for those residents found to have been affected by the practice.** **Resident 56 is receiving medication as ordered by the physician.** **Resident 60's orders were reviewed and updated to reflect current need for meal assistance.** **Resident 62 is being administered her insulin injections after the insulin pen has been primed. No negative effects were noted. The licensed nurse was re-educated on priming an insulin pen prior to administration.** ="" span="">="" span="">="" p="">="" span="">="" span="">="" p="">**II. The facility will identify other residents that may potentially be affected by this practice.** ="" p="">All resident charts have been reviewed to determine the physician orders are being followed. If any discrepancies were noted the physician was notified. All residents who need assistance with meals have been identified and are receiving assistance from	

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	He had no recent weight loss. His vision appeared within functional limits, but he was noted to close his eyes frequently, but responded to verbal cues to open them. He was right-handed; able to make needs known, confused, yet participative, cooperative, and easily distracted. He had reduced recognition of routine/tasks and required consistent instruction. He needed assistance feeding himself. The Clinical Bedside Assessment of Swallowing section of the evaluation indicated for thin liquids that "Clinical s/s [signs/symptoms] dysphagia: full staff assist." Staff provided sips of liquids after 2-3 bites and verbally cued patient's attention to task for oral preparation. For Soft & Bite-Sized foods, "Clinical s/s dysphagia: Full assist per staff. Patient requires cut solids with ground meat/moist to facilitate PO [by mouth] safety, bolus management. Staff provided setup and total assist with feeding, alternated solids/liquids, provided small bites and extra time." For Minced & Moist Foods, "Staff to provide setup and verbal cues to alternate liquids/solids and to take small bites." For supervision, he required supervision/assistance at mealtime due to swallow safety 91% to 100% of the time. He had impaired cognitive skills for problem solving and demonstrated adequate cognitive skills to complete routine/simple living tasks only 0% to 25% of the time. The evaluation indicated a diagnosis of oropharyngeal phase dysphagia. An interview was conducted with CNA (Certified Nursing Assistant) 34 on 1/23/23 at 11:01 a.m. She indicated his ability to eat fluctuated. Sometimes he could do it on his own and sometimes he couldn't. Staff would sometimes provide him with weighted silverware during meals, and that helped him to eat on his own. She didn't think weighted silverware was part of		staff as needed. Residents receiving insulin were reviewed and no negative outcomes were observed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** **Education has been provided to licensed nursing staff regarding following MD orders for administering medication as ordered, providing assistance with eating, and priming insulin pens prior to each administration per the facility policy. Attachment F** IV. The facility will monitor the corrective action by implementing the following measures. ="" span="">
="" span="">The DON/designee will audit through direct observation and/or documentation review 5 random residents to determine their medications are administered correctly, their receiving assistance with eating per their plan of care and being administered insulin injections after the insulin pen has been primed. This auditing will occur weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance.
="" span="">	

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	his plan of care, staff just took it upon themselves to provide it. When he used regular silverware, he was "more shaky" She noticed him needing more assistance with eating in the last few months. He used to eat in the assisted dining room, but was currently eating in the main dining room, where the residents don't need as much assistance. She stated, "He does need extra assistance sometimes, and I think he should be in assisted. We as CNAs pop in the main dining room, but we don't sit down and feed them." He'd only been in the main dining room for a week or two. An observation of Resident 60 was made on 1/23/23 at 12:23 p.m. during the lunch meal in the main dining room. He was sitting in his wheelchair at a table, directly across from another resident with his head down. A staff member placed his meal, regular silverware, and 2 drinks in front of him at 12:23 p.m., positioned him closer to the table, and left the table. His meal included ground ham, cheesy potatoes, a bowl of sauerkraut, a slice of red velvet cake, a piece of corn bread, a glass of soda, and a glass of water. By 12:29 p.m., he was not eating or drinking, nor had he attempted to eat or drink. The DM (Dietary Manager) came over to the table and verbally encouraged him to eat, but Resident 60 remained with his head down and did not attempt to eat. At 12:32 p.m., his tablemate continued eating her food, but Resident 60 remained still, with his head down, and was not attempting to eat. The DM came back to the table, then left and walked over to a sink in the dining room. At 12:36 p.m., Resident 60 remained at the table with his head down and had not attempted to eat. All of the food he was served remained untouched. At 12:37 p.m., the DM came back to the table, bent down beside him, left the table, and came back to the table. At 12:38 p.m., the DM asked Resident 60 if		=" span="">The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%. =" span="">	

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	he was going to eat. Resident 60 then picked up his cup of soda and took a sip. The DM patted him on the back. Another staff member approached the table, picked up his fork and demonstrated picking up a bite of food. Resident 60 then picked up his spoon with his left hand, retrieved some potatoes, and placed them into his mouth. A staff member then placed a clothing protector on him at 12:42 p.m., as Resident 60 now had potatoes on his left thumb. At 12:43 p.m., Resident 60 put his spoon down on the table after having taken 3 bites of potatoes. A second observation of Resident 60 was made on 1/23/23 at 12:53 p.m. Resident 60 remained sitting at the table but was not eating. At 12:54 p.m., CNA 34 approached the table and encouraged him to open his eyes. CNA 34, while kneeling on the floor, retrieved a spoonful of potatoes and placed the spoon in his mouth. CNA 34 then fed him another bite and continued to encourage him to open his eyes. CNA 34 then suggested he try the cake, retrieved a bite of cake and fed him the bite while standing. CNA 34 then went to another table, got a chair and began feeding him at 12:56 p.m. At 12:58 p.m., CNA 34 continued to encourage him to eat, but was no longer feeding him. A third observation was made in the main dining room on 1/23/23 at 1:12 p.m. Resident 60 was no longer there. The majority of his food remained at his table place. The NC (Nurse Consultant) provided Resident 60's 1/23/23 lunch meal ticket. It indicated he ate 10% of his meal and 120 ml of fluid. An interview was conducted with the NC and			

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	DON (Director of Nursing) on 1/23/23 at 1:00 p.m. The DON indicated Resident 60 moved to the main dining room from the assisted dining room last week, per his daughter's request. His daughter thought he would eat better having interactions with other tablemates. His daughter was typically there with him and felt like he belonged in a higher functioning setting. The NC indicated staff was aware he may need more assistance, but to provide him one on one care during meals was not always possible. There were plenty of staff in the main dining room, but not enough to feed residents. An interview was conducted with NP (Nurse Practitioner) 6 on 1/23/23 at 2:43 p.m. She indicated she was "tired of seeing him sitting in the dining room with his food sitting in front of him," so she wrote the order to feed him 3 times a day. Sometimes he did okay feeding himself, but she wanted him fed three times a day. She was unaware he was moved into the main dining room from the assisted dining room. He liked social interaction, so was not opposed to him being in the main dining room. Now that she knew he was moved, she could put him on weights 3 times weekly for 2 weeks and to report any loss. The facility should have informed her they switched dining rooms. If she had known, she would have informed nursing they needed to make sure he was eating. She stated, "They should have let me know, so I could change the order for weights." 2. The clinical record for Resident 62 was reviewed on 1/19/23 at 11:30 a.m. The Resident's diagnosis included, but was not limited to, diabetes. A physician's order, dated 10/5/22, indicated to administer Novolog (type of insulin) Flexpen per sliding scale depending on blood glucose results.			

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	If blood sugar was 181 to 240 give 4 units of Novolog. On 1/19/23 at 11:30 a.m., LPN (Licensed Practical Nurse) 16 was observed administering insulin to Resident 62. LPN 16 indicated Resident 62's blood sugar had been 221. LPN 16 removed the Novolog insulin pen from the medication cart, took the cap off of the pen and attached the needle to the pen. LPN 16 then moved the dial on the insulin pen to 4 units. She did not prime the insulin pen prior to moving the dial to 4 units. She then performed hand hygiene and went to Resident 62's room. She donned a pair of disposable gloves and administered the 4 units of insulin to Resident 62. During an interview on 1/19/23 at 11:45 a.m., LPN 16 indicated that she did not normally prime the insulin pen prior to each dose. She only primed the pen when it was first opened. On 1/19/23 at 3:48 p.m., the Nurse Consultant provided the current Licensed Nurse Insulin Pen Skill Validation which read "...12. Pulled off needle cap 16. Turn dose selector to 2 units 17. Held the needle pointing up...19. Keep needle pointing upwards, press push-button all the way in [dose selector returns to 0] drop of insulin should appear at the needle tip 20. Turned dose selector to number of units needed to inject, pointer should line up with the dose...22. Pressed the push button all the way in when injected..." During an interview on 1/20/23 11:06 a.m., Registered Pharmacist 33 indicated that not priming the insulin pen would cause a small difference in the amount of insulin administered to the patient. 3. The clinical record for Resident 56 was reviewed on 1/20/23 at 11:57 a.m. Resident			

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	56's diagnoses included, but not limited to, irritable bowel syndrome, congestive heart failure, weakness, and chronic obstructive pulmonary disease. A physician's order dated 8/11/22 indicated to give Resident 56 one 90 milligram capsule of IBgard (peppermint oil) orally three times a day before meals. Resident 56's October and December 2022 MARs (medication administration record) as well as January 2023 MAR were received on 1/24/23 at 9:27 a.m. from NC (nurse consultant). The October 2022 MAR indicated, on the following days and doses, the IBgard medication was unavailable: 10/1/22 - morning dose 10/2/22 - all three doses 10/3/22 - all three doses 10/4/22- all three doses 10/5/22 - all three doses 10/6/22 - all three doses 10/7/22 - dinner dose 10/8/22 - dinner dose 10/9/22 - all three doses 10/10/22 - morning dose 10/11/22 - all three doses 10/12/22- morning dose 10/13/22 - lunch and dinner doses 10/14/22 - morning and dinner doses 10/15/22- morning and dinner doses 10/16/22 - all three doses 10/17/22 - all three doses 10/18/22 - all three doses 10/19/22- all three doses 10/25/22 - lunch dose Resident 56's December 2022 MAR indicated on			

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	the following dates and doses the IBgard was unavailable: 12/1/22 - all three doses 12/2/22 - morning and lunch doses 12/17/22 - all three doses 12/18/22 - lunch and dinner doses 12/19 through 12/21/22 - all three doses 12/22/22 - lunch and dinner doses 12/23/22 - morning dose 12/24/22 - morning and dinner doses 12/25/22 - all three doses 12/26/22- all three doses 12/27/22 - morning dose 12/28/22- morning dose 12/29/22 - morning and lunch doses 12/30/22 - all three doses 12/31/22 - lunch and dinner doses Resident 56's January 2023 MAR indicated on the following dates and doses the IBgard was unavailable: 1/1/23 - all three doses 1/2/23 - morning dose 1/3/23 - all three doses 1/4/23 - lunch and dinner doses 1/5/23 - lunch and dinner doses 1/6/23 - morning and lunch doses 1/7/23 - lunch and dinner doses 1/8/23 - morning and lunch doses 1/9/23 and 1/10/23 - all three doses 1/14/23 - all three doses 1/18/23 - all three doses Resident 56's progress notes did not contain any notes regarding IBgard unavailability or communication with pharmacy regarding refills/re-orders.			

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	An interview with Pharmacy Technician (Pharm T 32) was conducted on 1/20/23 at 11:22 a.m. Pharm T 32 indicated, Resident 56's IBgard is not on a refill cycle and so it must be requested by nursing when the medication needs to be refilled. She indicated, the last time the IBgard was requested was on 11/30/22 and was filled on 12/1/22. She indicated, when requested and refilled, they send an 8-day supply of the IBgard. She also stated, when that medication was stocked there but, when requested it usually arrived the next day. Prior to the 11/30/22 request, the other more recent filled dates were 11/11/22 and 11/18/22. 3.1-37(a)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure staff were present while a resident with a history of losing his balance and falling was toileting, resulting in the resident falling and obtaining a clavicle (collar bone) fracture; review a resident's fall during a collective Interdisciplinary Team meeting; and evaluate a resident's reported fall, per policy, for 1 of 3 residents reviewed for falls, 1 of 1 resident reviewed for notification of change, and 1 of 2 residents reviewed for pain. (Residents L, 42, and	F 0689	**F 689 483.25 Free of Accident Hazards/Supervision/Devices** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident L no longer resides at the facility.Resident 42's care needs have been updated based off of their plan of care.Resident 76 will have falls reviewed during a collective	02/14/2023

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	76) Findings include: 1. The clinical record for Resident 42 was reviewed on 1/18/23 at 12:30 p.m. The diagnosis for the resident included, but was not limited to, left and right above the knee amputation. The 12/4/22 Annual Minimum Data Set (MDS) Assessment for Resident 42 indicated he was cognitively intact. The functional status the resident was needing for toileting and transfers were extensive assistance of 2 staff persons. The fall care plan for Resident 42 dated 2/24/21 indicated "Resident [42] at risk for falling and fall related injuries related to history of falls with fracture, unsteadiness on feet, opioid use, antidepressant use. Short term goal. Will minimize risk for injuries....Approach start date 8/31/22: Staff to not leave while resident sitting on toilet..." An Event dated 12/9/22 for Resident 42 indicated resident had an unwitnessed fall in his room. He indicated he was sitting in his wheelchair and attempted to scoot himself back into the wheelchair. He lost his balance and fell onto the floor. The resident did not obtain any injuries. An IDT (Interdisciplinary Team) note dated 12/9/22 indicated "IDT met and reviewed recent fall from early this morning. resident had been refusing to go to bed, so resident was sitting up in wheelchair watching his laptop, he went to scoot himself back into his wheelchair and lost his balance and fell forward. no injuries noted. Spoke with therapy and OT [occupational therapy] to eval for w/c [wheelchair] positioning d/t [due to] recent amputation. Care plan reviewed and		interdisciplinary team meeting per policy. II. The facility will identify other residents that may potentially be affected by the practice.All residents with falls in the last 90 days have been reviewed to ensure falls have been evaluated per policy. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur**The Interdisciplinary team will be re-educated on the fall prevention policy.Nursing staff will be re-educated on implementing fall interventions per the plan of care. Attachment G **IV. The facility will monitor the corrective action by implementing the following measures.**DON or Designee will review daily fall report to ensure all falls are being evaluated per policy. The DON/designee will observe randomly 5 residents to ensure fall interventions are in place daily for 4 weeks, then weekly for 8 weeks, then biweekly for 3 months, then monthly for 6 months to ensure physicians are notified of any resident condition changes. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews	

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	updated." A nursing progress note written by License Practical Nurse (LPN) 1 dated 12/22/22 indicated "Heard yelling from [Resident 42]'s room..., ran in to find res [resident] on floor on R [right] side with active red blood from rectum with blood clots noted and gross amt blood in toilet from stool...order rec'd [received] to send to ER [emergency room] for eval [evaluation] and tx [treatment]..." A hospital discharge summary dated 12/23/22 indicated Resident 42 was admitted on 12/22/22. He had a recent left above knee amputation 3-4 weeks ago. Resident 42 indicated he was reaching for some toilet paper when he lost his balance and fell off the toilet. The report indicated he had a clavicle fracture from the fall. Resident 42's clinical record did not include a fall event nor an IDT review for the resident's fall that had occurred on 12/22/22. An observation was made of Resident 42 on 1/23/23 at 10:22 a.m. The resident was observed in his bed with a sling on his left arm. He indicated in December; he had fallen off the toilet and had broken his collar bone. Two staff members had assisted him onto the toilet then left the bathroom. After he finished, he reached to grab some toilet paper and fell off the toilet. The two staff members were not present in the resident's bathroom or room at the time of the fall. An interview was conducted with LPN 1 on 1/23/23 at 10:28 a.m. She indicated she had heard Resident 42 yelling from his room. He was found in the bathroom with no staff presence lying on his stomach leaning on his right side. She had		will be increased as needed if compliance is below 100%.	

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	assessed him at that time. She had also noticed the resident had blood clots on the floor. She believed after he fell, he rolled himself on his right side. She notified the medical provider and received an order to send the resident to the hospital. The resident had a fracture to his left clavicle and possibly a bleeding hemorrhoid due to being on an anticoagulant from his amputation. Resident 42 was always transferred with 2 staff members. The staff members that day had stepped out of the room to gather supplies and left him unattended. "He usually is just fine being left alone." An interview was conducted with the Nurse Consultant on 1/23/23 at 3:23 p.m. She indicated there should have been an IDT review, but there was no fall event assessment opened after Resident 42's fall on 12/22/22. After a fall occurs, the staff will open a fall event then it will trigger an IDT review. 2. The clinical record for Resident 76 was reviewed on 1/17/23 at 3:00 p.m. The Resident's diagnoses included, but were not limited to, urinary tract infection and dementia. A Quarterly MDS (Minimum Data Set) Assessment, completed 10/25/22, indicated she had severely impaired cognition and required extensive assistance of 1 staff member for transfers. A Post Fall Assessment Event Report, dated 12/24/22, indicated that Resident 76 had fallen will sitting in a chair in the dining room. She had not sustained an injury. An IDT progress note, dated 12/25/22 at 1:09 a.m., indicated the IDT (Interdisciplinary Team) had med and reviewed the recent witnessed fall from			

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	12/24/22. During an interview on 1/17/23 at 3:09 p.m., Family Member 18 indicated that Resident 76 had a fall on Christmas eve. During an interview on 1/24/23 at 11:10 a.m., the IP (Infection Preventionist) indicated that she had written the IDT progress note on 12/25/22 at 1:09 a.m. Resident 76's fall had been reviewed by the IP and the Director of Nursing Services prior to the IDT note being written. The IDT team had not been present at the time of the review. 3. The clinical record for Resident L was reviewed on 1/19/23 at 10:56 a.m. His diagnoses included, but were not limited to, anxiety. He was admitted to the facility on 9/25/22 for aftercare following a joint replacement surgery revision and discharged from the facility on 11/2/22. The 9/23/22 hospital discharge summary, signed 9/26/22 at 9:01 a.m., indicated he was admitted to the hospital on 9/20/23 with a diagnosis of infected right total hip arthroplasty. He underwent a resection hip arthroplasty with insertion of antibiotic-impregnated cement spacer...The patient will follow up for a two-week follow-up visit for wound inspection and general recovery." The facility's physician's orders indicated for him to be seen 5 times per week for up to 4 weeks to address therapeutic exercise, therapeutic activities, neuromuscular re-education, and gait training in order to improve safe functional mobility, starting 9/27/22 through 10/27/22. The orders indicated his activity level was partial weight bearing with assist times one per his orthopedic nurse practitioner, effective 10/3/22 to 11/2/22.			

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	An interview was conducted with Resident L on 1/20/23 at 9:41 a.m. He indicated towards the end of his stay, he fell while at the facility and reinjured his right hip. He saw his orthopedic surgeon following the fall for an x-ray and was told it looked like his hip joint moved a quarter inch, but nothing was broken. The 10/24/22 Physical Therapy note, co-signed by PT (Physical Therapist) 16, read, "Pt [Patient] states that he experience [sic] a fall on 10/22 while performing HEP [home exercise program] given to him by physician. Pt has printed copy and has provided copy to Therapy and Nrsg. [Nursing.] Pt states he was performing L [left] hip Add in standing with FWW [Four Wheeled Walker] for support @ BS [bedside] when he felt pain and a 'pop' in R [right] hip and he fell to floor. Pt reports he was able to get himself back in bed and then informed nrsg. Nrsg reports pt complained of pain after performing exs [exercises] and x-ray was ordered. Pt also had his brother and father transport him to [name of hospital] for R hip x-rays on 10/23. X-rays results unknown at this time. Pt states that he was by physician not to participate in therapy x [times] 1 week. Nrsg attempting to clarify. Pt education to perform standing hip abduction LLE [lower left extremity] as this is contraindicated based on current WB [weight bearing] orders." An interview was conducted with PT 16 on 1/20/23 at 12:45 p.m. He indicated to his knowledge; Resident L's orthopedic physician sent him back with a home exercise program. Resident L was attempting to do the exercises on his own in his room. The program was a preprinted one, one not specialized to Resident L specifically. PT 16 reviewed the HEP after finding out about the 10/22/22 fall, as Resident L did not			

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	share it with them prior. One of the exercises included was full weight bearing on each leg, but Resident L was only 50% weight bearing at the time. PT 16 spoke to nursing about it. PT 16 had never heard of this type of situation before. Residents may have outside appointments, "but they never give home exercise programs." Normally, residents would give a copy to nursing and if there was something important for therapy to know, he would get it. If PT 16 had known about this HEP program given to Resident L, he would have suggested holding off on the exercises to get clarification, because the HEP contradicted the weight bearing orders and it was not safe for him to do these exercises by himself. The HEP was sent to Resident L's email. If Resident L had asked therapy, they could have provided some guidance. He was uncertain if the facility knew about the appointment that day. The 10/22/22, 12:21 p.m. nurse's note, recorded as a late entry on 10/23/22 at 12:22 p.m. by LPN (Licensed Practical Nurse) 1, indicated he complained of increased pain and inability to bear weight on his right leg. An order for a right hip x-ray was placed. The note did not reference a fall. The 10/22/22, 2:55 p.m. nurse's note, written by LPN 1, indicated he complained of intense pain and weakness after doing recommended exercises from his orthopedic surgeon at last visit. An order was placed for an x-ray of the right hip. The note did not reference a fall. The 10/23/22, 12:23 p.m. nurse's note, written by LPN 1, read, "[Name of company performing x-ray] here to do xray, was told xray could not be shared with his surgeon and so now he is demanding to go to [name of hospital] for xray that his surgeon can interpret. Explained that we can fax his xray to			

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his physician, but he would not relent. Father here to take him to ER [emergency room] for evaluation per res [resident] request. Res signed self out LOA [leave of absence] for this."

An interview was conducted with LPN 1 on 1/20/23 at 10:53 a.m. She indicated Resident L mentioned therapy having him "do something" and he was sore, so she suggested getting an x-ray. He informed her therapy wanted him to do exercises on his own as well and he got up to go to bathroom on his own and when he went to stand up, he had intense pain, and felt a pop, but "he didn't tell me anything about falling." He may have fallen at some point while at the facility, "but I don't remember it being tied to that." When a resident had an unwitnessed fall, their process was to do neurological checks, do one on one monitoring, if necessary, do vitals every 15 minutes for the first hour, then every hour for 4 hours, then every shift. As far as documentation, they would complete an event in the electronic health record for each fall.

There were no events/post fall assessments in Resident L's clinical record relating to his reported 10/22/22 fall. The facility's Safety Events--Post Fall Assessment from their electronic health record system included the following information: position of the resident immediately following the fall; what resident was doing prior to the fall; resident's location after the fall; environmental factors that may have contributed to the fall; whether the resident was using an assistive device at the time of the fall; what the resident said happened: whether the fall was witnessed; the physical assessment of the resident; and interventions initiated.

An interview was conducted with UM (Unit

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	Manager) 2 on 1/20/23 at 11:08 p.m. She indicated she did not recall Resident L falling while at the facility. She remembered him coming back from an orthopedic visit saying he was non-weight bearing, but not providing any paperwork. Resident L would tell nursing the notes were on his phone and couldn't give it to them. The 10/31/22 orthopedic note read, "He states that he has been bearing some weight on that side and it is not more painful than before, but we discussed that out of an abundance of caution I would like to make him non weightbearing to prevent any displacement if there is a fracture." On 1/20/23 at 2:32 p.m., the NC (Nurse Consultant) provided page 3 of a home exercise program. An interview was conducted with the NC at this time. The page had a picture of a person standing, holding onto the back of a chair, with their left leg on the ground, and their right leg lifted outward to the side. It read, "Stand facing your kitchen counter or straight back chair with hands counter for balance and bring your operated leg out to the side....you may need to work up to holding for a count of 10..." The NC indicated UM 2 gave her the above referenced page from her email, as it was not scanned into his clinical record. An interview was conducted with the Nurse Consultant on 1/23/23 at 3:23 p.m. She after a fall occurs, the staff were to open a fall event which would also trigger an IDT review. A fall policy was provided by the Nurse Consultant on 1/23/23 at 2:30 p.m. It indicated "...Purpose. The purpose of this policy is to provide CarDon communities with best practices and evidence based approaches to prevent falls and protect residents who are at risk for falling.			

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	Policy...The components of this fall program include: 1. Fall risk assessment; 2. Fall event assessment; 3. Strategies of prevention; 4. Strategies of intervention; 5. Interdisciplinary guidance; 6. Care planning; and 7. staff education. As such, the Community must take reasonable steps to ensure it implements, best practices and evidence-based approaches to prevent falls and protect residents who are at risk for falling. Due to the risks associated with falls for older adults living in long-term care facilities, compliance with this policy is essential. Procedure. This section describes the process for the prevention of falls and accurate documentation when there is a fall. Accurate documentation of fall risks and falls provides a clinical picture of a resident and is utilized in developing their plan of care. It is the responsibility of the interdisciplinary team to document falls prevention, when a fall occurs, and interventions to avoid future falls. General Overview of fall program. Step one: Fall risk assessment...Step two: Fall Event Assessment. The fall event assessment will be completed by the charge nurse if a patient experiences a fall. This data will be utilized by the community to thoroughly investigate the root cause for each fall and ensure effective interventions are put into place to prevent additional falls. Step three: Strategies of Prevention... Step four: Strategies of Intervention...Step five: Interdisciplinary Guidelines. If a fall occurs, the interdisciplinary team (IDT) will meet collectively and examine the fall using the following criteria: i. Review the post fall assessment completed by the charge nurse; ii. GEMBA "the actual place, the real place" where the current process is in action (University of Indianapolis and the Indiana Department of Health, 2014). An IDT member/designee will physically visit the place of the fall to verify the post fall assessment and investigate for any			

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	additional information that could be useful in preventing a reoccurrence; iii. A root cause analysis will be performed utilizing the "5 whys" CarDon process; iv. A member/designee of the IDT will assist the team and update the care plan and the nurse aide assessment sheets to ensure accuracy of fall preventions; v. The therapy-nursing IDT communication form will be opened; vi, The community will be encouraged to record fall history that can be used in the QAPI [Quality Assurance & Performance Improvement] and QA [Quality Assurance] meetings; and vii. A narrative IDT note will include: a. Root cause explanation with new intervention strategy to prevent reoccurrence b. Associate communication update c. Therapy/nursing communication completion d. Care plan updated e. Physician and family notification Step six: Care planning...Step seven: Staff Education..." This Federal Tag relates to Complaint IN00393035. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized			

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	unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure monitoring of urine outputs for a resident with a catheter for 1 of 1 resident reviewed for catheters. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/18/23 at 2:30 p.m. The diagnoses for the resident included, but were not limited to, Parkinson's Disease and dementia. The resident was admitted on 11/30/22 and discharged on 12/15/22. A urinary incontinence care plan for Resident B dated 12/5/22 indicated "Resident has urinary incontinence and requires staff assist with toileting and toileting	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident B no longer resides at the facility **II. The facility will identify other residents that may potentially be affected by this practice.**Residents with a foley catheter have the potential to be affected by this alleged deficient practice. Residents with a foley catheter were reviewed to ensure monitoring of outputs were documented in the medical record. **III. The facility will put**	02/14/2023

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	hygiene...Approach...Monitor I (intakes) and O (outputs) per facility protocol...." A I and O care plan for Resident B dated 12/1/22 indicated the staff was to accurately document intakes and outputs on the following shifts and times: day shift = 6:30 a.m. - 2:30 p.m., evening shift = 2:30 p.m. -10:30 p.m., night shift =10:30 p.m. - 6:30 a.m. A physician order dated 11/30/22 indicated Resident B was to have a 16 French catheter due to urinary retention. The vitals report for urine outputs for Resident B's catheter indicated the following days and shifts there were no urine output recorded on every shift: 12/1/22 8:25 a.m., - staff recorded large, 12/2/22 day and evening shift, 12/3/22 - day and evening shift, 12/4/22 - evening shift, 12/6/22 - day shift, 12/7/22 - evening shift, 12/9/22 - evening shift, and 12/14/22 - night shift An interview was conducted with Unit Manager 2 on 1/20/22 at 2:48 p.m. She indicated she thought the staff should at least record outputs twice a day. This Federal tag relates to Complaint IN00398672. 3.1-41(a)(2)		**into place the following systemic changes to ensure that the practice does not recur.**Nursing staff have been re-educated on proper procedure for documenting urinary output for residents with a foley catheter. Attachment H **IV. The facility will monitor the corrective action by implementing the following measure.**DON/Designee will review urinary output documentation for completion daily for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure proper documentation of urinary output.The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to ensure CPAP (a machine that assists with breathing utilizing air pressure) was placed on a resident as ordered for 1 of 1 resident's reviewed for respiratory care. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/18/23 at 2:30 p.m. The diagnoses for the resident included, but were not limited to, Parkinson's Disease and dementia. The resident was admitted on 11/30/22 and discharged on 12/15/22. A care plan for Resident B dated 12/5/22 indicated "Resident has a diagnosis of sleep apnea and is at risk for respiratory difficulties or distress...Approach...Apply CPAP or Bipap (advice that assists with breathing utilizing air pressure) as ordered..." A physician order for Resident B dated 11/30/22 indicated "Home CPAP via home orders to be worn at HS (night) and for naps, staff to assist resident in applying face mask and turning machine on dx [diagnosis] obstructive sleep apnea...." discontinued on 12/6/22	F 0695	**F-695: Respiratory/Tracheostomy Care and Suctioning** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident B no longer resides at the facility. **II. The facility will identify other residents that may potentially be affected by the practice.**All residents residing in the facility with orders for non-invasive ventilation have the potential to be affected by the alleged deficient practice. An audit of all current residents with orders for non-invasive ventilation have been reviewed to ensure appropriate order with nurse sign-off. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**The DON or designee will re-educate all licensed staff regarding the proper documentation required for non-invasive ventilation, and education was given on providing residents with proper assistance	02/14/2023

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	A physician order for Resident B dated 12/6/22 indicated Staff was to apply CPAP machine on resident utilizing home settings and equipment. The settings were 15 cmh20 ramp 15 minutes (centimeters of water pressure and gradual increase measurement). Start 9.0cm h20 with humidity room air. Discontinued after discharge 12/15/22. The November 2022 and December 2022 Medication and Treatment Records (MAR/TAR) for Resident B indicated the staff had documented CPAP placement until the order had discontinued on 12/6/22. Resident B's clinical record did not include documentation of the CPAP placement after 12/6/22. During a confidential interview on 1/18/23, She indicated staff was not ensuring Resident B wore the CPAP during sleeping hours. It was observed on 12/2/2, the resident's CPAP was not placed on the resident. On the morning of 12/15/22, Resident B was also observed not wearing the CPAP. It had been recorded; it had been off approximately since 2:00 a.m. An interview was conducted with Nurse Practitioner (NP) 6 on 1/20/23 at 11:14 a.m. She indicated on the morning of 12/15/22, she was asked to assess Resident B by his representative due to the resident was running a fever and his CPAP had not been on. He was in the process of discharging that morning. NP 6 had offered to do an x-ray, but the representative had declined. She just wanted to proceed with the discharge. An interview was conducted with the Nurse Consultant on 1/20/23 at 10:15 a.m. She indicated		to don a non-invasive ventilation mask. Attachment H **IV. The facility will monitor the corrective action by implementing the following measures.** The DON or designee will review 5 random resident's with orders for non-invasive ventilation to ensure staff are following MD orders for the non-invasive ventilation and correct documentation of the device weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

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	the 12/6/22 CPAP order was placed for Resident B, but in error it was not showing up on MAR/TAR. This Federal tag relates to Complaint IN00398672. 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to assure a resident had adequate indication for use of an antibiotic and did not receive duplicate antibiotic therapy for 1 of 2 residents reviewed for urinary tract infections (Resident 77).	F 0757	**F-757 Drug Regimen is Free From Unnecessary Drugs** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**	02/14/2023

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	Findings include: The clinical record for Resident 77 was reviewed on 1/17/23 at 2:30 p.m. The Resident's diagnosis included, but was not limited to, dementia and personal history of urinary tract infections. A physician's order, dated 6/2/22, indicated she was to receive nitrofurantoin macrocrystal (antibiotic) 50 md (milligram) daily for prophylactic due to diagnosis of personal history of urinary tract infection. This order was discontinued on 1/18/23. A care plan, dated 6/03/22, indicated Resident 77 had a history of urinary tract infections and was prescribed a prophylactic antibiotic. The goal was for her to be free from symptoms of UTI (urinary tract infections). The approaches, initiated 6/03/22, were to assist with incontinent care, to report continued or worsening symptoms of UTI, report adverse side effects of antibiotic, encourage fluids, and administer antibiotics as ordered. A Quarterly MDS (Minimum Data Set) Assessment, completed 10/26/22, indicated she had severely impaired cognition, needed extensive assistance of one staff member for toilet use, had not had a urinary tract infection in the last 30 days, and had received antibiotics for all 7 days of the assessment period. An Infection Control Event Report, dated 10/31/22, indicated Resident 77 had a possible UTI. The symptoms had started on 10/28/22. She had received Keflex (antibiotic) and Rocephin (Antibiotic). A culture had been performed. She had foul smelling urine, and the intervention was antibiotic treatment.		Resident 77 suffered no ill effects. Resident 77 was assessed with no negative findings. Resident 77 reviewed to ensure antibiotic use is necessary and needed and Provider is informed and in agreement of current treatment regimen. **II. The facility will identify other residents that may potentially be affected by the practice** All current Residents that have prescribed antibiotics will be reviewed to ensure that medication; a) is not excessive in dose or duration b) is not without adequate monitoring or indication c) is not in the presence of adverse consequences. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing managers and Providers will be re-educated by 2/14/2023 on Antibiotic Stewardship/Unnecessary Medication. Attachment J **IV. The facility will monitor the corrective action by implementing the following measures.** The DON or Designee will review 5 Residents receiving Antibiotic therapy to ensure prescribed therapy: a) is not excessive in	

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	A CBC (Complete Blood Count), completed 10/30/22, indicated she had elevated white blood cells of 14.2 with the normal reference range being 4.5-11.0. A urinalysis, completed 10/31/22, indicated that her urine was yellow and cloudy. it was negative for ketone, blood, protein, nitrite, and leukocytes. There were trace ketones, which was the only abnormal result. There was no culture and sensitivity complete to identify an organism or bacteria. A physician's order, dated 11/1/22, indicated she was to receive cephalexin (Keflex antibiotic) 500 mg twice daily for personal history of urinary tract infections. The November 2022 MAR (Medication Administration Record) indicated Resident 77 had received Cephalexin 500 mg on 11/2/22 in the morning and before bedtime, 11/3 in the morning and at bedtime, 11/4 in the morning, and 11/5 in the morning and at bedtime. The November 2022 MAR indicated she had received nitrofurantoin daily on 11/1/22 through 11/30/22, with the exception on 11/11, 11/13, 11/14, and 11/23/22. A Quarterly MDS Assessment, completed 11/8/22, indicated Resident 77 was severely cognitively impaired, had not had a urinary tract infection in the last 30 days, and had received an antibiotic for all 7 days of the assessment period. A physician's order, dated 1/14/23, indicated to obtain a urinalysis with culture and sensitivity.		dose or duration b) is not without adequate monitoring or indication c) is not in the presence of adverse consequences weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

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	A physician's order, dated 1/14/23, indicated Resident 77 was to receive Bactrim DS (antibiotic) 800-160 mg, twice daily for five days for chronic kidney disease, with a discontinuation date of 1/16/23. A physician's order, dated 1/14/23, indicated Resident 77 was to receive ceftriaxone (antibiotic) 1 gram injection one time only on 1/14/22. A nursing progress note, dated 1/14/23 at 7:38 a.m., indicated Resident 77 had a urinalysis collected and sent to the lab. She had received the 1-time dose on ceftriaxone injection in the left buttock. A urine culture, dated 1/16/23, indicated Resident 77 had Escherichia Coli present in her urine that possessed ESBL (Extended Spectrum Beta-Lactamases), which could potentially become resistant to all beta-lactam drugs. The sensitivity indicated the organism was resistant to the following antibiotics: ampicillin, cefazolin, cefepime, ceftazidime, ceftriaxone, ciprofloxacin, levofloxacin, nitrofurantoin, and trimethoprim/ sulfamethoxazole. A physician's order, dated 1/16/23, indicated she was to receive ertapenem (antibiotic) 1 gram reconstituted with lidocaine (numbing medication) one time on 1/16/23. A physician's order, dated 1/17/23, indicated she was to receive ertapenem 1 gram, reconstituted with lidocaine, one time on 1/17/23. A physician's order, dated 1/18/23, indicated she was to receive ertapenem 1 gram, reconstituted with lidocaine, one time on 1/18/23.			

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	A physician's order, dated 1/17/23, indicated to institute contact isolation precautions related to her being positive for ESBL in her urine. A care plan, dated 1/17/23, indicated Resident 77 has ESBL. The goal was for her to be free of symptoms of UTI upon completion of antibiotics. On 1/17/23 at 2:00 p.m., Resident 17 was observed sitting in a chair in the common area. She was bent over with her head on the arm of the chair. A visitor was talking to her, and she did not respond. The visitor continued to talk with her and try to arise her. The visitor asked the staff to assist with waking her up. She did wake up and walk down the hall to visit. The January 2023 MAR indicated she had received nitrofurantoin 50 mg daily from 1/1/23 through 1/18/23 with the exception of 1/3/23 and 1/10/23, Bactrim (sulfamethoxazole/trimethoprim) 800/160 mg twice on 1/15/23 and once on 1/16/23, and ertapenem 1 gram on 1/16, 1/18, and 1/19/23. A nurse practitioner progress note, dated 1/18/23 at 4:49 p.m., indicated Resident 77 was seen for a follow up for UTI with ESBL and treatment with ertapenem 1 gram intramuscularly for 3 days. A new order was given to discontinue macrodantin (nitrofurantoin), as she has developed resistance to drug with ESBL E. Coli (Escherichia Coli). An Infection Event Progress Note, dated 1/19/23 at 2:40 p.m., indicated Resident 77 was very lethargic on that shift and unable to ambulate (walk). She had a poor appetite. An Infection Event Progress Note dated 1/19/23 at 6:32 p.m., indicated that NP (Nurse Practitioner) 9 had given an order to discontinue the ertapenem			

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	because Resident 77 had received all the doses required. A nurse practitioner progress note, dated 1/20/23 at 11:10 a.m., indicated Resident 77 was treated with ertapenem for 3 days only. She exhibited decreased function in dexterity after the third dose with neurological side effects of antibiotic. During an interview on 1/23/22 at 3:52 p.m., NP (Nurse Practitioner) 9 indicated she was unsure if she had been made aware of the negative urinalysis on 10/31/22. She had prescribed the Keflex due to leukocytosis (high white blood cells). It was not her normal pattern to prescribe Keflex for 5 days. Resident 77 had also received the nitrofurantoin. The nitrofurantoin had been prescribed as a prophylactic to head off infections due to her increased behaviors. She had discontinued it when she reviewed the culture which indicated Resident 77 had ESBL which was resistant to it. She was unsure if the prophylactic use had contributed to the development of the resistance. She had prescribed ertapenem to treat the ESBL E. Coli because it had the best sensitivity, but that the drug could be very neurotoxic (poisonous to the nervous system). Resident 77 had received 3 doses of it instead of 5 doses because her mental status had declined. The facility had discussed antibiotic stewardship with her and the Mc Geer's criteria. During an interview on 1/24/23 at 10:45 a.m., QMA (Qualified Medication Aide) 15 indicated that Resident 77 had been up for breakfast but kept falling asleep and had to be laid back down. She was unsure what was going on with Resident 77, but she had been declining. During an interview on 1/24/23 at 12:45 p.m., the IP			

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	(Infection Preventionist) indicated the Keflex Resident 77 had received in November had not met the Mc Greer's criteria for a urinary tract infection. She expected that antibiotic orders to the medication, dose, how many days it should be administered and the diagnosis. If culture and sensitivity was done, then the nurse practitioner would use that to prescribe the appropriate antibiotic. 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(4)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to administer a resident's antibiotic, as ordered, to 1 of 6 residents reviewed for unnecessary medications. (Resident L) Findings include: The clinical record for Resident L was reviewed on 1/19/23 at 10:56 a.m. His diagnoses included, but were not limited to, anxiety. He was admitted to the facility on 9/25/22 for aftercare following a joint replacement surgery revision. An interview was conducted with Resident L on 1/20/23 at 9:41 a.m. He indicated he did not receive his IV (intravenous) antibiotic as ordered for at least 3 days while at the facility. The 9/23/22 hospital discharge summary, signed 9/26/22 at 9:01 a.m., indicated he was admitted to	F 0760	**F760 Residents are Free of Significant Medications Errors** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**Resident L no longer resides at the facility. **II. The facility will identify other residents that may potentially be affected by the practice**An audit of current residents was completed by Nursing to ensure that all residents with orders for antibiotics have received as ordered, and physician notified of any lapse in treatment. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**DON or Designee will	02/14/2023

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	the hospital on 9/20/23 with a diagnosis of infected right total hip arthroplasty. He underwent a resection hip arthroplasty with insertion of antibiotic-impregnated cement spacer. He "was placed on IV antibiotics throughout the entire hospitalization. Infectious disease [ID] was consulted. The selection of the most appropriate antibiotic regimen was carried out by the Infectious Disease Service, as well as dosing, monitoring and safety of the antibiotics and PICC [peripherally inserted central catheter] line....The patient was believed to be discharged to rehab [rehabilitation] after he was approved by [name of facility] in [name of a city.] Instead, the patient went home after discharge from the hospital, transported by his daughter....Information regarding the care of the PICC line, antibiotic administration and appropriate follow up was provided by the infectious disease service....Home Medications...vancomycin 1 GM [gram] = 10 mL [milliliters,] IVPB [intravenous piggyback,] Q12H [every 12 hours,] last dose 11/2/22....IV Antibiotics will continue to [sic] dosed, managed and monitored by the infectious disease department under the direction of [name of ID physician] for a total of 6 weeks postoperatively. The medication and dosing has been reviewed with the patient. FOLLOWUP: The patient will follow up for a two-week follow-up visit for wound inspection and general recovery." The facility's physician orders indicated to administer vancomycin intravenously twice a day upon rising and before bedtime, starting 9/25/22 through 10/19/22. The October, 2022 MAR (medication administration) indicated the vancomycin was not administered on the following dates and times due to the medication being unavailable: before bedtime on 10/5/22, at bedtime on 10/8/22, upon rising on 10/19/22, before bedtime on 10/10/22,		re-educate all licensed nursing staff on the medications administration policy. Education will include the process for following up with medications that were not delivered from the pharmacy timely and prompt notification of physician when a medication is not readily available as ordered. Attachment K **IV. The facility will monitor the corrective action by implementing the following measures.** DON or Designee will conduct an audit of the medication cart to confirm that medications correspond to the MAR, to ensure medication availability and ensure physician notified of any delay in medication availability weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

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	and before bedtime on 10/12/22. The MAR indicated the vancomycin was not administered before bedtime on 10/11/22 due to "IV completed." The 10/3/22 orthopedic note indicated, "Good hygiene and timely IV antibiotics are pertinent to helping him clear his peri-prosthetic infection." An interview was conducted with the DON (Director of Nursing) on 1/19/23 at 3:20 p.m. She indicated she was unsure why the vancomycin was not administered as ordered. The 9/27/22 IV antibiotic care plan, discontinued on 11/3/22, indicated he required IV antibiotics related to infection and inflammatory reaction due to internal right hip prosthesis. An intervention was to administer the IV medication as ordered. The Licensed Nurse Medication Pass Clinical Skills Validation was provided by the NC (Nurse Consultant) on 1/23/23 at 9:57 a.m. Step 29 was to ensure medication was given within the 60 minutes before or after the time designated unless otherwise directed by the physician. This Federal Tag relates to Complaint IN00393035. 3.1-48(c)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to assure the hub of an insulin pen was cleansed prior to attaching the needle, perform hand hygiene and don disposable gloves before touching medications for 2 residents randomly observed during medication administration (Resident 62 and 222). Findings include: 1. The clinical record for Resident 62 was reviewed on 1/19/23 at 11:30 a.m. The Resident's diagnosis included, but was not limited to, diabetes. On 1/19/23 at 11:30 a.m., LPN (Licensed Practical Nurse) 16 was observed administering insulin to	F 0880	F880 Directed POC The directed plan of correction (DPOC) is to serve as Morristown Manor's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Morristown Manor or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey	02/14/2023

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	Resident 62. LPN 16 removed the insulin pen from the medication cart, took the cap off of the pen and attached the needle to the pen. She did not cleanse the hub of the insulin pen with an alcohol swab prior to attaching the needle. She then performed hand hygiene and went to Resident 62's room. She donned a pair of disposable gloves and administered the insulin to Resident 62. During an interview on 1/19/23 at 11:45 a.m., LPN 16 indicated that she did not cleanse the hub of the insulin pen prior to attaching the needle. On 1/19/23 at 3:48 p.m., the Nurse Consultant provided the current Licensed Nurse Insulin Pen Skill Validation which read "...12. Pulled off pen cap 13. Wiped rubber stopper with alcohol swab 14. Removed protective cover from disposable needle and screw on pen..." 2. The clinical record for Resident 222 was reviewed on 1/20/23 at 9:11 a.m. The Resident's diagnosis included, but were not limited to, dysphagia (inability to swallow) and heart failure. On 1/20/23 at 9:11 a.m., LPN 1 was observed administering medications to Resident 222. LPN 1 went to a sink and performed hand hygiene, washing her hands with soap and water. When she finished washing her hands, she removed paper towel from the dispenser and turned off the water using the paper towel. She then used those paper towels to dry her hands and threw them away. LPN 1 then went to the medication cart and opened the cart with the keys from her pocket. She removed Resident 222's medications from the drawer. She opened the medications and put them into a plastic medications cup. While opening the medications packages, LPN 1 readjusted the		allegations. **The facility respectfully requests desk review for the following citation.** **F880 Infection Prevention and Control** **S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no residents harmed by the alleged practice. The staff members found to have deficient practices were immediately educated on proper insulin preparation and administration, hand hygiene, and handling of medication during administration. **II. The facility will identify other residents that may potentially be affected by practice.** Any residents receiving insulin injections or receiving medications crushed or with capsules that need opened have the potential to be affected by the deficient practice. Rounds were immediately made to ensure staff were cleaning the hub of insulin pen prior to use, performing proper hand hygiene, and donning gloves	

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	surgical mask on her face several times and did not perform hand hygiene after touching her surgical mask. LPN 1 then indicated Resident 222 required her medication to be crushed. LPN 1 crushed the tablets and indicated she needed to open the capsules to place them in the applesauce. LPN 1 picked up a fish oil capsule, with her bare hands, no hand hygiene was performed, and attempted to use a lancet to puncture the capsule but was unable to squeeze the oil out of the capsule. LPN 1 indicated that normally she would use scissors to cut the capsule open in order to open the capsules. She withdrew pink handled scissors from the draw of the medication cart and wiped them with an alcohol swab. LPN 1 then wiped the scissors with a tissue from the tissue box on the medication cart to dry the alcohol off of the scissors. She took the fish oil capsule, in her bare hands without performing hand hygiene, and cut the end of the fish oil capsule. LPN 1 squeezed the capsule contents into the applesauce. LPN 1 then picked up the PreserVision Vitamin with her bare hand and cut it open, squeezing the contents into the apple sauce. LPN 1 then picked up the Florastor (supplement) and pulled the capsule open, using her bare hands, to empty the contents into the applesauce. LPN 1 then performed hand hygiene with alcohol get and stirred the applesauce containing the medications. LPN 1 administered the medications to Resident 22. On 1/20/23 at 3:14 p.m., the Nurse Consultant provided the current Handwashing/ Handrub Procedure which read "...1. Turn on faucet...11. Rinse hands with water down from wrists to fingertips. 12. Dry thoroughly with single use towels. 13. Use towel to turn off faucet and discard towel..."		before touching medications. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · Root Cause Analysis (RCA) with facility consultant Infection Preventionist, including input from the facility Medical Director/DON/IP was completed. · Consultant Infection Preventionist educated IDT/Nursing Leadership team on proper insulin preparation and administration, hand hygiene, and infection control practices during medication administration to prevent possible contamination of medication. · All staff who administer medications were educated on proper insulin preparation and administration, hand hygiene, and infection control practices during medication administration to prevent possible contamination of medication. **IV.** The facility LTC Infection Control Self-assessment was reviewed with the consulting Infection Preventionist resulting in an updated LTC Infection Control assessment being completed with input from the Consultant IP/Medical Director and DON	

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	On 1/20/23 at 3:14 p.m., the Nurse Consultant provided the current Licensed Nurse Med Pass Clinical Skills Validation which read "...6. Check medication administration record. 7. Gel hands....16. Tablets and capsules were handled so that fingers do not touch medication..." This Federal Tag relates to Complaint IN00398672 3.1-18(b)(1) 3.1-18(l)		**V. The facility will monitor the corrective action by implementing the following measures.** · The IP/DON or designee will observe the staff to ensure proper infection control practices are maintained during medication administration daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit tool. · The IP/DON or designee, will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with proper PPE utilization daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 (2) audit tool The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if	

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			compliance is below 100%. **VI. Plan of correction completion date.** Date of compliance: February 14, 2023 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Morristown Manor's credible allegation of compliance.	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program to include monitoring trends in antibiotic resistance and implementing a Quality Assurance and Performance Improvement program to address antibiotic usage for 1 of 2 residents reviewed for urinary tract infections and 1 of 5 residents reviewed for unnecessary medications (Resident 76 and 77). For more information about Resident 77 cross reference F 757.	F 0881	**F-881 Antibiotic Stewardship Program** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 76 and 77 suffered no ill effects. Resident 76 and 77 were assessed with no negative findings. Resident 76 and 77 were reviewed to ensure antibiotic use	02/14/2023

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	Findings include: 1. The clinical record for Resident 76 was reviewed on 1/17/23 at 3:00 p.m. The Resident's diagnoses included, but were not limited to, urinary tract infection and dementia. A Quarterly MDS (Minimum Data Set) Assessment, completed 10/25/22, indicated she had severely impaired cognition and required extensive assistance of 2 staff members for toileting. A physician's order, dated 11/10/22, indicated a urine culture was to be obtained for Resident 76. A urinalysis with a culture and sensitivity, dated 11/13/22, indicated Resident 76 had an organism identified as Escherichia Coli present in her urine that possessed ESBL (Extended Spectrum Beta-Lactamases), which could potentially become resistant to all beta-lactam drugs. The sensitivity indicated the organism was resistant to the following antibiotics: ampicillin, cefazolin, ceftazidime, ceftriaxone, ciprofloxacin, levofloxacin, and trimethoprim/ sulfamethoxazole. A physician's order, dated 11/14/22, indicated Resident 76 was to receive nitrofurantoin macrocrystal (antibiotic) 100 mg (milligrams) twice a day. The November 2022 Medication Administration Record indicated she had received nitrofurantoin 100 mg twice daily from 11/14/22 through 11/18/22. 2. The clinical record for Resident 77 was reviewed on 1/17/23 at 2:30 p.m. The Resident's		is necessary and needed and Provider is informed and in agreement of current treatment regimen. **II. The facility will identify other residents that may potentially be affected by the practice** All current Residents that have prescribed antibiotics will be reviewed to ensure that medication; a) is not excessive in dose or duration b) is not without adequate monitoring or indication c) is not in the presence of adverse consequences. Review the Infection Prevention and Control Program to ensure that the facility has an established infection prevention and control program (IPCP) that include, at a minimum, the following elements: An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing managers and Providers will be re-educated on Antibiotic Stewardship/Unnecessary Medication and QAPI Policy and Procedure Attachment L **IV. The facility will monitor the corrective action by implementing the following**	

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	diagnoses included, but was not limited to, dementia and personal history of urinary tract infections. A physician's order, dated 6/2/22, indicated she was to receive nitrofurantoin macrocrystal (antibiotic) 50 md (milligram) daily for prophylactic due to diagnosis of personal history of urinary tract infection. This order was discontinued on 1/18/23. An Infection Control Event Report, dated 10/31/22, indicated Resident 77 had a possible UTI. The symptoms had started on 10/28/22. She had received Keflex (antibiotic) and Rocephin (Antibiotic). A culture had been performed. She had foul smelling urine, and the intervention was antibiotic treatment. A CBC (Complete Blood Count), completed 10/30/22, indicated she had elevated white blood cells of 14.2 with the normal reference range being 4.5-11.0. A urinalysis, completed 10/31/22, indicated that her urine was yellow and cloudy. it was negative for ketone, blood, protein, nitrite, and leukocytes. There were trace ketones, which was the only abnormal result. There was no culture and sensitivity complete to identify an organism or bacteria. A physician's order, dated 11/1/22, indicated she was to receive cephalexin (Keflex antibiotic) 500 mg twice daily for personal history of urinary tract infections. The November 2022 MAR (Medication Administration Record) indicated Resident 77 had received Cephalexin 500 mg on 11/2 in the morning		**measures.** The DON or Designee will review 5 Residents receiving Antibiotic therapy to ensure prescribed therapy: a) is not excessive in dose or duration b) is not without adequate monitoring or indication c) is not in the presence of adverse consequences weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months to ensure compliance. The DON or Designee will review Infection Control tracking and trending monthly for 12 months to ensure all elements of the Infection Prevention and Control Program are implemented and followed per protocol. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	

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	and before bedtime, 11/3 in the morning and at bedtime, 11/4 in the morning, and 11/5 in the morning and at bedtime. The November 2022 MAR indicated she had received nitrofurantoin daily on 11/1/22 through 11/30/22, with the exception on 11/11, 11/13, 11/14, and 11/23/22. A physician's order, dated 1/14/23, indicated to obtain a urinalysis with culture and sensitivity. A physician's order, dated 1/14/23, indicated Resident 77 was to receive Bactrim DS (antibiotic) 800-160 mg, twice daily for five days for chronic kidney disease, with a discontinuation date of 1/16/23. A physician's order, dated 1/14/23, indicated Resident 77 was to receive ceftriaxone (antibiotic) 1 gram injection one time only on 1/14/22. A nursing progress note, dated 1/14/23 at 7:38 a.m., indicated Resident 77 had a urinalysis collected and sent to the lab. She had received the 1-time dose on ceftriaxone injection in the left buttock. A urine culture, dated 1/16/23, indicated Resident 77 had Escherichia Coli present in her urine that possessed ESBL (Extended Spectrum Beta-Lactamases), which could potentially become resistant to all beta-lactam drugs. The sensitivity indicated the organism was resistant to the following antibiotics: ampicillin, cefazolin, cefepime, ceftazidime, ceftriaxone, ciprofloxacin, levofloxacin, nitrofurantoin, and trimethoprim/ sulfamethoxazole. A physician's order, dated 1/16/23, indicated she			

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	was to receive ertapenem (antibiotic) 1 gram reconstituted with lidocaine (numbing medication) one time on 1/16/23. A physician's order, dated 1/17/23, indicated she was to receive ertapenem 1 gram, reconstituted with lidocaine, one time on 1/17/23. A physician's order, dated 1/18/23, indicated she was to receive ertapenem 1 gram, reconstituted with lidocaine, one time on 1/18/23. The January 2023 MAR indicated she had received nitrofurantoin 50 mg daily from 1/1/23 through 1/18/23 with the exception of 1/3/23 and 1/10/23, Bactrim (sulfamethoxazole/trimethoprim) 800/160 mg twice on 1/15/23 and once on 1/16/23, and ertapenem 1 gram on 1/16, 1/18, and 1/19/23. A nurse practitioner progress note, dated 1/18/23 at 4:49 p.m., indicated Resident 77 was seen for a follow up for UTI with ESBL and treatment with ertapenem 1 gram intramuscularly for 3 days. A new order was given to discontinue macrodantin (nitrofurantoin), as she has developed resistance to drug with ESBL E. Coli (Escherichia Coli). During an interview on 1/23/23 at 3:52 p.m., NP (Nurse Practitioner) 9 indicated she was unsure if she had been made aware of Resident 77's negative urinalysis on 10/31/22. She had prescribed the Keflex due to leukocytosis (high white blood cells). It was not her normal pattern to prescribe Keflex for 5 days. Resident 77 had also received the nitrofurantoin. The nitrofurantoin had been prescribed as a prophylactic to head off infections due to her increased behaviors. She had discontinued it when she reviewed the culture which indicated Resident 77 had ESBL which was resistant to it.			

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	She was unsure if the prophylactic use had contributed to the development of the resistance. She had prescribed ertapenem to treat the ESBL E. Coli because it had the best sensitivity, but that the drug could be very neurotoxic (poisonous to the nervous system). Resident 77 had received 3 doses of it instead of 5 doses because her mental status had declined. The facility had discussed antibiotic stewardship with her and the Mc Geer's criteria On 1/24/23, the IP (Infection Preventionist) provided the October, November, and December 2022 Infection Control Data logs for the facility. She indicated that she did not specifically track ESBL infections on the infection control data logs. She monitored the Infection Events and the laboratory results to identify organisms that had caused infections. She did not receive reports from the pharmacy about antibiotic trends. She did not receive reports from the laboratory about infection trends in the facility. She discussed the facility antibiotic use monthly with the Director of Nursing Services, the Minimum Data Set Coordinator, and the Executive Director. The Medical Director, Pharmacist, and Nurse Practitioners did not normally attend the meeting where the antibiotic trends were discussed. The October 2022 Infection Control Data Log indicated there had been a total of 24 infection for the month. 7 of the infections did not meet the McGeer's criteria. There had been 12 urinary tract infections, which represented 50% of the facilities infections for the month of October. The November 2022 Infection Control Data Log indicated that there had been a total of 21 infections for the month. 6 of the infections did not meet the McGeer's criteria. There had been 11			

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	urinary tract infections which represented 52% of the facilities infections for the month of November. The December 2022 Infection Control Data Log indicated that there had been a total of 32 infections for the month. 13 of the infections did not meet the McGeer's criteria. There had been 15 urinary tract infections, which represented 47% of the facilities infections for the month of November. During an interview on 1/24/23 at 11:07 a.m., the IP indicated she used the McGeer's criteria to determine if there was a true infection. She reviewed infections and made a progress note to if the infection met the criteria or not. The nurse practitioners came in while the residents were receiving antibiotics to evaluate them. She communicated to the nurse practitioners if the infections met the criteria for a true infection and if the resident was getting better or not. During an interview on 1/24/23 at 12:45 p.m., the Nurse Consultant and the Executive Director indicated that the Medical Director did not come to the QAPI (Quality Assurance and Performance Improvement) meetings and there was not an active action plan concerning urinary tract infections, antibiotic use, or antibiotic resistant bacteria. On 1/17/23 at 2:03 p.m., the Executive Director provided the Infection Prevention and Control Program Policy, dated 6/6/2019, which read "...The elements of the infection prevention and control program consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and			

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	employee health and safety...C. The infection Prevention and Control Committee is responsible for reviewing and providing feedback on the overall program. 1. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: a. Whether physician management of infections is optimal, b. Whether antibiotic use patterns need to be changed because of the development of resistant strains; c. Whether information about culture results or antibiotic resistance is transmitted accurately and in timely fashion, and d. Whether there is appropriate follow-up of acute infections. 2. The committee meets regularly, at least quarterly, and consists of team members from across disciplines, including the Medical Director....Antibiotic Stewardship...A. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. B. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. C. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews..." On 1/24/23 at 10:00 a.m., the IP provided the Infection Control Antibiotic Stewardship (page 38) policy which was undated, it read "... Antibiotic Stewardship refers to a set of commitments and activities designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use.'... The IP [sic] and QA [sic] team is committed to provide our residents with safe and appropriate antibiotic usage in our communities. The QA [sic] committee will review the usage in the facility monthly and provide interventions to help reduce the usage of antibiotics in the facility...Quarterly, the prescribing physicians will receive a report of			

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	their ATB [sic] usage in the facility to better help with the proper prescribing of antibiotics..."			
F 9999 Bldg. 00	Based on interview and record review, the facility failed to ensure staff received 6 hours of dementia in-servicing training within 30 days prior to working in a dementia unit for 2 of 10 staff personnel files reviewed. (Certified Nursing Assistant (CNA) 3 and Certified Nursing Assistant trainee (CNAT) 4) Findings include: 1. An employee records document indicated CNAT 4's start date in the facility was on 11/30/22. CNAT 4's personnel included dementia training in-servicing training that she received on the following days and hours: 12/29/22 - 1 hour & 1/23/23 - 2 hours total of 3 hours A document that listed the dates CNAT 4 had worked on the facility's Memory Care Unit was provided by Human Resources on 1/24/23 at 11:00 a.m. It indicated the following dates: 12/29/22 and 1/12/22. 2. An employee record indicated CNA 3's start date in the facility was on 11/1/22. CNA 3's personnel file included dementia in-servicing training she had received on the following days and hours:	F 9999	**F9999 Final Observations** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** CNA 3 and CNAT 4 have completed their 6 hours of dementia in-servicing training. **II. The facility will identify other residents that may potentially be affected by the practice**A house wide audit of all dementia training has been conducted and all staff are currently in compliance with annual dementia training **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**The administrative team has been re-educated on the requirements that staff must receive six hours of dementia in-servicing training within 30 days of hire and prior to working on a dementia unit. Attachment M**IV. The facility will monitor the corrective action by implementing the following measures.** The staff development coordinator (SDC) or designee will conduct audits of dementia training weekly times 4 weeks, then biweekly for 8 weeks, then monthly for 9 months	02/14/2023

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	11/2/22 - 2 hours, 12/29/22 - 1 hour, & 1/6/23 - 1 hour. Total of 4 hours A document that listed the dates CNA 3 had worked on the facility's Memory Care Unit was provided by Human Resources on 1/24/23 at 11:00 a.m. It indicated the following dates: 11/3/22, 11/4/22, 11/5/22, 11/10/22, 11/11/22, 11/12/22, 11/13/22, 11/16/22, 11/17/22, 11/21/22, 11/22/22, 11/23/22, 11/24/22, 11/25/22, 11/26/22, 11/27/22, 11/28/22, 11/30/22, 12/1/22, 12/9/22, 12/10/22, 12/11/22, 12/12/22, 12/14/22, 12/15/22, 12/16/22, 12/21/22, 12/23/22, 12/24/22, 12/26/22, 12/28/22, 12/29/22, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/9/23, 1/11/23, 1/13/23, 1/16/23, 1/18/23 and 1/19/23 An interview was conducted with Human Resources on 1/24/23 at 11:30 a.m. She indicated CNAT 4, and CNA 3 do work on the Memory Care Unit. They had not received 6 hours of dementia training prior to working on the special care unit.		to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	