STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. BUILDING 00 B. WING	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FREELANDVILLE COMMUNITY HOME	310 W CARLISLE STREET FREELANDVILLE, IN 47535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 13, 14,15,16, 2023 Facility number: 000355 Provider number: 155688 AIM number: 100273640 Census Bed Type: SNF/NF: 33 Total:33 Census Payor Type: Medicare: 2 Medicaid: 20 Other: 11 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 28, 2023.	F 0000	12/10/2023 Brenda Buroker, Deputy Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Freelandville Community Home Survey Event ID 4HNO11 Dear Ms. Buroker; On November 16, 2023 a Recertification and State Licensure Survey was conducted at our facility. By submitting the enclosed material we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective December 16, 2023 to the State findings of the Recertification and State Licensure Survey conducted on November 16, 2023. We respectfully request a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Parker	Administrator	12/10/2023

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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			review to validate the facility's compliance to the findings of the Recertification and State Licensure survey of November 16, 2023. Please feel free to contact the facility is any additional information is needed. Respectfully submitted, Cathy Jo Parker Cathy Parker, HFA Freelandville Community Home	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.			

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	(iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the			

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	facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on interview and record review, the facility failed to ensure Quarterly MDS (Minimum Data Set) Assessments were completed timely for 3 of 23 residents reviewed. (Resident 10, Resident 33, Resident 19) Findings include: 1. On 11/14/23 at 1:36 P.M., Resident 10's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) Assessment was dated 7/23/23. The record indicated the MDS Assessment due on 10/23/23, with a completion date of 11/6/23, was "in progress". 2. On 11/14/23 at 12:28 P.M., Resident 33's clinical record was reviewed. Resident 33's most recent admission Minimum Data Set (MDS) Assessment was dated 7/28/23. The facility failed to complete the quarterly MDS that should have been completed on 10/27/23. 3. On 11/16/23 at 10:29 A.M., Resident 19's clinical record was reviewed. Resident 19's most recent quarterly MDS was dated 7/23/23. The facility failed to complete the annual MDS that should have been completed on 10/23/23. During an interview on 11/16/23 at 12:00 P.M., the MDS Coordinator indicated that she was an LPN (Licensed Practical Nurse) and there was an RN consultant that signs off on the facilities MDS Assessments when they were completed. She indicated the consultant worked remotely and had the capability to sign off on the MDS assessments within 7 days after completion. During an interview on 11/16/23 at 12:28 P.M., the	F 0636	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective December 16, 2023 to the state findings of the Recertification and State Licensure Survey conducted on November 16, 2023. F - 636 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the quarterly MDS for the resident identified as resident 10 has now been completed, signed by the RN and accepted. *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* the quarterly MDS dated 10-27-23 for the resident identified as resident 33 has now been completed, signed by the RN and accepted. *3. The corrective action taken for those residents found to have been affected by the deficient practice is that* the annual MDS	12/16/2023

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	MDS Coordinator indicated they did not have a policy, but follow the Resident Assessment Instrument (RAI) manual for the MDS process. 3.1-31(d)(3)		dated 10-23-23 for the resident identified as resident 19 has now been completed, signed by the RN and accepted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide MDS audit has been conducted to ensure that all MDSs that are due have been completed, signed off by the RN and submitted in a timely manner in accordance with the RAI manual. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on their responsibilities to ensure that each required MDS is completed accurately, timely and submitted timely in accordance with the RAI manual. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the timely completion of all MDSs in accordance with the RAI manual. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

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			reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to implement a care plan for 1 of 1 residents reviewed for urinary catheters and 1 of 5 residents reviewed for unnecessary medications. A resident	F 0657	F - 657 *1. The corrective action taken for those residents found to have been affected by the deficient*	12/16/2023

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	with a urinary catheter lacked a care plan related to the catheter, and a resident on an antidepressant lacked a care plan related to the antidepressant. (Resident 17, Resident 6) 1. On 11/14/23 at 1:04 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and anemia. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 11/14/23, indicated Resident 17 had an indwelling catheter. Current Physician Orders included, but were not limited to, change indwelling catheter every 28 days, dated 10/23/23. Resident 17's clinical record lacked a care plan related to the urinary catheter. During an interview on 11/15/23 at 1:30 P.M., the Director of Nursing (DON) indicated there should have been a care plan related to the urinary catheter. 2. On 11/14/23 at 2:05 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, insomnia. The most recent Quarterly MDS Assessment, dated 8/18/23, indicated no cognitive impairment, and use of antidepressants. Current physician's orders included, but were not limited to: Trazodone HCl (an antidepressant) 25mg (milligrams) by mouth at bedtime related to insomnia, dated 5/30/23. Resident 6's clinical record lacked a care plan related to use of antidepressants.		*practice is that* the care plan for the resident identified as resident 17 has been updated and now contains a care plan for the use and care of their urinary catheter. *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* care plan for the resident identified as resident 6 has been reviewed and updated. The resident's care plan now includes a care plan related to the use of an antidepressant. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all comprehensive care plans has been conducted to ensure that each of the resident's individualized needs/concerns have been identified and addressed in their respective care plans. All residents' needs have now been care planned. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility's care planning policy to ensure their knowledge level of their responsibility for ensuring that each of the residents' needs have been appropriately care planned in a timely manner. *The corrective action taken to*	

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	On 11/16/23 at 10:54 A.M., the Director of Nursing (DON) indicated Resident 6 should have had a care plan in place for antidepressant use implemented by Social Services. On 11/16/23 at 1:25 P.M., the DON provided a current Comprehensive Care Plans policy, revised 8/2023 that indicated "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident" 3.1-35(a)		*monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor resident's care plans to ensure all needs have been identified and addressed in the care plan. This tool will be completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence			

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	unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure residents with limited mobility received appropriate services to maintain or improve mobility for 3 of 6 residents reviewed for restorative therapy. Residents did not receive intervention of restorative nursing services as indicated . (Resident 10, Resident 12, Resident 23) Findings include: 1. On 11/13/23 at 11:55 A.M., Resident 10 was observed seated in the main dining room. On 11/14/23 at 1:36 P.M., Resident 10's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's, cerebral infarction, and diabetes mellitus type II. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/23, indicated Resident 10's cognition status was unable to be assessed, he had not received any restorative therapy, and he was an extensive assist of 1 staff for transfers and toileting. Current Physician's Orders were reviewed and lacked an order for restorative therapy. Current interventions/tasks for Resident 10 included, but were not limited to, the following intervention: Active ROM (Range of Motion) Resident 10 will complete 10 reps (repetitions) to upper bilateral extremities and lower bilateral extremities (arm rolls/leg lifts/knee bends/arm circles)safety maintained in group setting 5 out of 6 days a week Sunday-Friday	F 0688	F - 688 *1 1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the restorative program for the resident identified as resident 10 has been reviewed and revised. Based on assessment of the resident's needs an appropriate restorative nursing programs has been established for the resident. The resident is now receiving restorative services in accordance with their plan of care. The CNA assignment sheets have been updated to include assigned restorative programs. Resident 10's care plan has been updated to reflect the current restorative programs that are being provided. *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* the restorative program for the resident identified as resident 12 has been reviewed and revised. Based on assessment of the resident's needs an appropriate restorative nursing program has been established for the resident. The resident is now receiving restorative services in accordance with their plan of care. The CNA assignment sheets have been updated to include assigned restorative programs. Resident	12/16/2023

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	A current Self Care Deficit Care Plan, dated 4/8/22 included, but was not limited to, the following intervention: Evaluate resident's ability to perform ADLs (Activities of Daily Living), initiated 4/8/22 On 11/15/23 at 3:52 P.M., a current list of resident's who were supposed to be receiving restorative therapy was provided by CNA (Certified Nurse Aide) 8 and included Resident 10. On 11/15/23 at 7:15 A.M., current CNA Assignments were provided by the DON (Director of Nursing) and Resident 10's care did not include restorative therapy. The last physical therapy evaluation of Resident 10 was requested but not provided during the survey period. A CNA tasks document that included the intervention of active range of Motion from October 1-31, 2023 was provided on 11/16/23 at 12:30 P.M., by the MDS Coordinator and indicated the intervention for Resident 10 was "not applicable" on the following days: Sunday, 10/1/23 Monday, 10/2/23 Tuesday, 10/3/23 Friday, 10/6/23 Wednesday, 10/11/23 Thursday, 10/12/23 Monday, 10/15/23 Sunday, 10/22/23 Tuesday, 10/24/23 Wednesday, 10/25/23 Thursday, 10/26/23 Monday, 10/30/23		12's care plan has been updated to reflect the current restorative programs that are being provided. *3. The corrective action taken for those residents found to have been affected by the deficient practice is that* the restorative program for the resident identified as resident 23 has been reviewed and revised. Based on assessment of the resident's needs an appropriate restorative nursing program has been established for the resident. The resident is now receiving restorative services in accordance with their plan of care. The CNA assignment sheets have been updated to include assigned restorative programs. Resident 23's care plan has been updated to reflect the current restorative programs that are being provided. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has been conducted to identify any residents with any limited mobility needs. All new admissions will continue to be assessed for any limited mobility issues. No additional residents were identified at this time. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff	

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	During an interview on 11/15/23 at 3:43 P.M., CNA 8 indicated she noticed Resident 10 seemed weaker and had a harder time transferring. 2. On 11/13/23 at 12:07 P.M., Resident 12 was sitting in the front room eating with staff present. On 11/14/23 at 1:00 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and muscle weakness. The most current MDS Assessment, dated 9/29/23, indicated Resident 12 had severe cognitive impairment, no restorative therapy, and an extensive assist of two staff for bed mobility and transfers. Current Physician's Orders were reviewed and lacked an order for restorative therapy. Current interventions/tasks for Resident 12 included, but were not limited to, the following interventions: Active ROM: Resident 12 will complete 10 reps (repetitions) to upper bilateral extremities and lower bilateral extremities (arm rolls/leg lifts/knee bends/arm circles)safety maintained in group setting 5 out of 6 days a week Sunday-Friday, dated 11/15/22 Walking: Resident 12 will meet and or exceed walking goal of approximately 50 feet with RW (rollating walker) 5 out of 6 days a week, dated 11/9/22 A current LTC (Long Term Care) Care Plan, dated 4/10/23, included, but was not limited to, the following intervention: Staff will assist with ADL care PRN (as needed),		and the MDS coordinator on the facility's restorative nursing program. The nursing staff members were instructed on their responsibility to provide restorative services for each resident as identified in their plan of care. The nursing staff was also instructed on their responsibility for documenting the provision of these restorative services in each respective resident's clinical record. F – 688 continued *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the effectiveness of the facility's restorative program. The tool will monitor to ensure that any resident with limited mobility needs has a restorative program put in place to meet those needs and that there is documentation to support that the resident is receiving those services in accordance with their plan of care. This tool will be completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the	

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	initiated 4/10/23 On 11/15/23 at 3:52 P.M., a current list of resident's who were supposed to be receiving restorative therapy was provided by CNA 8 and included Resident 12. The last physical therapy evaluation of Resident 12 was requested but not provided during the survey period. A CNA tasks document that included the intervention of active range of Motion from October 1-31, 2023 was provided on 11/16/23 at 12:30 P.M., by the MDS (Minimum Data Set) Coordinator and indicated the intervention for Resident 12 was "not applicable" on the following days: Sunday, 10/1/23 Monday, 10/2/23 Tuesday, 10/3/23 Friday, 10/6/23 Wednesday, 10/11/23 Thursday, 10/12/23 Monday, 10/15/23 Sunday, 10/22/23 Tuesday, 10/24/23 Wednesday, 10/25/23 Thursday, 10/26/23 Monday, 10/30/23 A CNA tasks document that included the intervention of walking from October 1-31, 2023 was provided on 11/16/23 at 12:30 P.M., by the MDS (Minimum Data Set) Coordinator and indicated the intervention for Resident 12 was "not applicable" on the following days: Sunday, 10/1/23 Monday, 10/2/23 Tuesday, 10/3/23		facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	155688	A. BUILDING 00 B. WING	11/16/2023

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	Friday, 10/6/23 Sunday, 10/8/23 Monday, 10/9/23 Wednesday, 10/11/23 Thursday, 10/12/23 Monday, 10/15/23 Thursday, 10/19/23 Sunday, 10/22/23 Tuesday, 10/24/23 Wednesday, 10/25/23 Thursday, 10/26/23 Monday, 10/30/23 During an interview on 11/14/23 at 9:56 A.M., Resident 10's family member indicated she thought he "was slowing down a bit" when asked about ADLs declining. 3. During an observation on 11/13/23 at 12:00 P.M., Resident 23 was observed sitting in the dining room. On 11/16/23 at 10:07 A.M., Resident 23's clinical record was reviewed. Current diagnoses included, but were not limited to, dementia, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 10/5/23, indicated the restorative nursing program was not completed for active range of motion, passive range of motion, or splint and brace assistance. Resident 23 lacked a current order for range of motion. Resident 23 lacked a care plan related to range of motion. On 11/15/23 at 3:52 P.M., a current list of resident's who were supposed to be receiving restorative			

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	therapy was provided by CNA 8 and included Resident 23. The last physical therapy evaluation of Resident 23 was requested but not provided during the survey period. Current tasks included, but were not limited to, "NURSING REHAB: Walking [name of Resident] will meet and or exceed walking goal of approx [approximately]. 25 ft [feet] to/from meals with stand by assist of 1 for cueing/supervision to help maintain safety. Staff to cue resident to pick feet up when walking as he tends to have a shuffle gait at time...Sunday thru [sic] Friday." The facility failed to complete the task on the following days for the month of October 2023: 10/1/23 10/2/23 10/3/23 10/7/23 10/8/23 10/11/23 10/12/23 10/14/23 10/15/23 10/21/23 10/22/23 10/24/23 10/25/23 10/26/23 10/28/23 10/30/23 During an interview on 11/15/23 at 3:33 P.M., the DON indicated there used to be a full time restorative aide but they needed her on the floor. She was not exactly sure when that transpired, but since the DON started the end of July 2023, there			

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	has not been a restorative aide. The CNAs are responsible for doing that since then and they would document it under their tasks in (name of computer program). She indicated that the tasks were considered orders and she expected those interventions to be completed as ordered. At that time, she indicated that the MDS Coordinator was supposed to monitor those residents to make sure restorative therapy was completed with the resident. During an interview on 11/16/23 at 11:45 A.M., CNA 6 indicated she does not perform the restorative care because it was not her responsibility. During an interview on 11/16/23 at 11:50 A.M., CNA 10 indicated she does not do the restorative care because therapy does it. During an interview on 11/16/23 at 12:00 P.M., the MDS Coordinator indicated when residents were admitted the nurses would put in interventions for them and the facility technically did not have anyone working as a restorative aide at that time. She further indicated CNAs should do the active range of motion with morning and night care. She indicated staff talked about their charting a lot and not applicable is probably a button that is set up in there and needs to be fixed. At that time, she indicated CNAs know they are responsible for that task and they should mark it complete when it is done and residents are evaluated by therapy when Quarterly MDS Assessments were due to look for declines in the resident's mobility. On 11/16/23 at 1:25 P.M., a current Restorative Nursing Program Policy, dated 10/23/22, was provided by the DON and indicated " ... It is the policy of the facility to assist each resident to			

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	attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal Regulations ... Residents will be screened and evaluated by therapy services and or nurse designated to oversee the restorative nursing process for inclusion into the appropriate facility restorative nursing programs when it has been identified by the interdisciplinary team that the resident is in need or may benefit from such program(s) ... The above programs will be documented on the facility designated restorative care forms/tools in the resident's electronic medical record ... the designated nurse will be responsible for the following: a. Documentation on a monthly basis (at a minimum), and b. Initiation (sic) and updating restorative care plans ... Once in an appropriate restorative nursing program, the designated nurse will continue to monitor the resident's progress ... " 3.1-42(a)(2)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or			

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	fewer residents. Based on interview and record review, the facility failed to ensure services of an RN (Registered Nurse) were available at least 8 consecutive hours a day, 7 days a week for 4 of the days reviewed from the PBJ (Payroll Based Journal) Staffing Data Report during Quarter 3 of 2023 (April 1, 2023 through June 30, 2023). Findings include: On 11/12/23 at 5:30 P.M., the Casper report was reviewed and indicated there was not an RN for 8 consecutive hours on the following dates: 5/29/23 6/3/23 6/4/23 6/30/23 On 11/14/23 at 11:30 A.M., the as worked nursing schedules for Monday, 5/29/23, Saturday 6/3/23, Sunday 6/4/23, and Friday 6/30/23 were provided by the DON (Director of Nursing) and indicated there was no RN coverage. During an interview on 11/15/23 at 3:55 P.M., the DON indicated the BOM (Business Office Manager) submitted the staffing data to PBJ. During an interview on 11/15/23 at 4:00 P.M., the BOM indicated she did submit the facility staffing data for Quarter 3 of 2023 to PBJ. She indicated 5/29/23, 6/3/23, 6/4/23, and 6/30/23 did not have RN coverage because they did not have the staff to do it at that time. On 11/16/23 at 11:45 A.M., a current Nursing Services and Sufficient Staff policy, dated August 2023 was provided by the DON and indicated " ... A registered nurse shall be scheduled 8	F 0727	F - 727 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey, however all residents have the potential to be affected by this deficient practice. The Director of Nursing has been re-educated on the requirements of eight consecutive hours of RN coverage seven days a week. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents were reviewed and no residents were affected by this deficient practice. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Director of Nursing on the requirement of eight consecutive hours of RN coverage seven days a week to ensure this standard is met when developing the nursing work schedules. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the nursing work schedules to ensure there is eight consecutive hours of RN coverage	12/16/2023

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	consecutive hours seven days a week in accordance with the regulations... " 3.1-17(b)(3)		seven days a week. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents using psychotropic medications received gradual dose reductions (GDR) for continued use of the medications for 2 of 5 residents reviewed for unnecessary medications. Antidepressants and antianxiety medications were not reduced and a clinical contraindication for the reduction was not documented. (Resident 6, Resident 9) Findings include: 1. On 11/14/23 at 2:05 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, insomnia. The most recent Quarterly MDS (minimum data set) Assessment, dated 8/18/23, indicated no cognitive impairment,	F 0758	F - 758 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 6 now has documentation in their clinical record from their physician to support that gradual dose reduction is clinically contraindicated at this time. The resident will continue to be monitored in accordance with the regulation for gradual dose reductions as warranted. *The corrective action taken for those residents found to have*	12/16/2023

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	and use of antidepressants. The MDS indicated no GDR had been attempted, and a clinical contraindication to the GDR had not been documented. Current physician orders included, but were not limited to: Trazadone HCl (an antidepressant) 25mg (milligrams) by mouth at bedtime related to insomnia, dated 5/30/23. The original date on the order was 6/24/22, with no change made when the new order was put in on 5/30/23. Resident 6's clinical record lacked information related to a GDR for Trazodone for the last 12 months, and lacked a clinical contraindication to the GDR. On 11/15/23 at 9:00 A.M., a Complete Psychotropic Listing form was provided that indicated discontinuing Trazodone was refused by family on 6/21/23, family provided history of REM sleep behavior disorder symptoms when Trazodone was discontinued in the past on 7/19/23. At that time, the DON indicated the form was not part off the resident's clinical record, and no one was able to locate that information in Resident 6's clinical record. 2. On 11/15/23 at 8:51 A.M., Resident 9's clinical record was reviewed. Diagnosis included, but were not limited to, depression and anxiety. The most recent annual MDS Assessment, dated 9/19/23, indicated no cognitive impairment, and use of antidepressant and antianxiety medications. The MDS indicated no GDR had been attempted, and a clinical contraindication to the GDR had not been documented. Current physician orders included, but were not		*been affected by the deficient practice is that* the resident identified as resident 9 now has documentation in their clinical record from their physician to support that gradual dose reduction is clinically contraindicated at this time. The resident will continue to be monitored in accordance with the regulation for gradual dose reductions as warranted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide review of all psychotropic drug orders has been conducted to ensure that all psychotropic medications that are eligible for a gradual dose reduction have been addressed. No other issues have been identified. All psychotropic medications will be reviewed for possible gradual dose reduction per regulations and facility policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses, QMAs and social services on the facility's gradual dose reduction policy. The staff was directed on their responsibilities to ensure these reviews are conducted timely, recommendations reported to the physician timely and that a timely	

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	limited to: Wellbutrin XL (an antidepressant) 300mg, give 1 tablet by mouth daily for depression, dated 11/9/23, originally ordered on 5/2/14. Wellbutrin XL 150mg, give 1 tablet by mouth daily in addition to the 300mg tablet for a total of 450mg daily for depression, dated 11/9/23, originally ordered on 5/2/14. Buspirone HCl (an antianxiety) 15mg, give 1 tablet by mouth twice a day related to depressive episodes, dated 5/26/23, originally ordered on 9/29/22. A current psychotropic/psychoactive medication care plan, dated 1/24/14, included, but was not limited to, and intervention to follow GDR schedule. Resident 9's clinical record lacked information related to a GDR for Wellbutrin XL or Buspirone for the last 12 months, and lacked a clinical contraindication to the GDR. A Consultant Pharmacist Communication to Physician form, dated 3/15/23, indicated a GDR request from the pharmacist for Wellbutrin XL with no physician response checked. A Consultant Pharmacist Communication to Physician form, dated 3/15/23, indicated a GDR request from the pharmacist for Buspirone with no physician response checked. A handwritten note on the form indicated the order was changed on 5/26. The clinical record lacked a dosage change at that time. On 11/15/23 at 12:00 P.M., the DON indicated prior to her arrival, several pharmacy recommendation		response has been received from the physician. If the physician chooses not to reduce the identified medication that there is documentation by the physician as to why the dose reduction is clinically contraindicated. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the use of psychotropic medications. The tool will monitor to ensure the following; that the medication is reviewed in a timely manner in accordance with the regulations, that the physician has been notified of the recommendations and provided a timely response and that if in the physician's opinion the reduction is clinically contraindicated that the physician has documented the medically justified reason to not reduce the dosage in the clinical record. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	forms had not been scanned, and staff may have been shredding them. She indicated she was aware that GDRs needed to be done for psychotropic medications, and was currently working on a system for those to be completed on time. On 11/16/23 at 11:47 A.M., the DON provided a current non-dated Medication Monitoring and Management policy that indicated "Other Psychopharmacological Medications ... After the first year, a tapering should be attempted annually, unless contraindicated" 3.1-48(b)(2)			
F 0880 SS=E 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. §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			

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	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 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.			

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	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 ensure infection control practices were followed for 1 of 2 residents observed for urinary catheter care. The facility lacked preventative measures to keep legionella from forming in the water system for 3 of 3 halls. Gloves were not changed between dirty and clean tasks during catheter care. (Resident 16, Resident Halls[Wings] A, B, C) 1. During an observation on 11/16/23 at 10:42 A.M., urinary catheter care was performed by Certified Nurse Aide (CNA) 6 and CNA 8. CNA 6 failed to change gloves and sanitize or wash hands after catheter care was performed and Resident 16 was rolled to his side and CNA 6 used 2 washrags to wipe stool off of Resident 16. CNA 6 ran out of washrags and the Administrator brought in more washrags. At that time, CNA 6 washed hands and changed gloves. CNA 6 used the washrags and continued to wipe stool, then used another washrag to rinse his bottom, and then patted his bottom dry with another washrag. CNA 6 proceeded to place a clean brief under Resident 16 with the same soiled gloves. During an interview on 11/16/23 at 11:47 A.M., Licensed Practical Nurse (LPN) 3 indicated that during any kind of care, gloves should be changed and hands should be washed between dirty and clean tasks.	F 0880	F - 880 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 16 is now receiving urinary catheter care by staff members who are demonstrating appropriate infection control practices related to glove usage and hand hygiene. Staff members identified as CNA 6 and 8 have been re-educated on proper glove usage and hand hygiene in accordance with facility policy. *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a test on the facility's water supply for Legionella and other opportunistic waterborne pathogens and found the water supply to be free of these organisms. The facility will continue to conduct this test on the water supply in accordance with facility policy and regulations.	12/16/2023

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	155688	A. BUILDING 00 B. WING	11/16/2023

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	On 11/16/23 at 1:25 P.M., a current catheter care and glove use policy was requested, but not received. 2. On 11/13/23 at 1:00 p.m. the alphabetical listing of all residents was received from the Administrator, three resident units were identified Wing A, Wing B, and Wing C. On 11/16/23 at 11:00 A.M., the Maintenance Director indicated the maintenance department did not test for Legionella or other opportunistic waterborne pathogens. He indicated he thought dietary did the testing. He also indicated he did not have a description of the building water systems using text and flow diagrams where Legionella and other opportunistic waterborne pathogens could grow and spread. On 11/16/23 at 11:33 A.M., the Kitchen Manager indicated she did not and had never tested the water for Legionella. On 11/16/23 at 12:15 P.M., the Director of Nursing (DON) indicated there was not a current system in place to test the water for Legionella. She indicated a policy had been written, but the team had not put it in place yet. On 11/16/23 at 12:04 P.M., the DON provided a current Legionella Water Management Program policy, revised 9/2022, that indicated "The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk for Legionnaire's disease ... The water management program includes the following elements: ... A detailed description and diagram of the water system in the facility ... The identification of areas in the water system that could encourage the growth and spread of		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* infection control observations have been conducted related to urinary catheter care and no other residents have been identified. The facility has now conducted a test on the facility's water supply for Legionella and other opportunistic waterborne pathogens and found the water supply to be free of these organisms. The facility will continue to conduct this test on the water supply in accordance with facility policy and regulations. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policy and procedure related to infection control practices with a focus on glove usage and hand hygiene. All nursing staff has also been re-educated on urinary catheter care, with successful return demonstration demonstrated by each nursing staff member. In addition, a mandatory in-service has been provided for the Maintenance Supervisor on their responsibility to conduct the water supply testing per facility policy and maintaining documentation of the results. *The corrective action taken to monitor to ensure the deficient*	

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	Legionella or other waterborne bacteria ... Specific measures used to control the introduction and/or spread of Legionella" 3.1-18(b) 3.1-18(l)		*practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the infection control practices of the facility with a focus on urinary catheter care, glove usage and hand hygiene. This tool will be completed by the Infection Control Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. In addition, the Administrator will review monthly the Maintenance Supervisor's preventative maintenance binders to ensure that there is documentation to support the testing of the facility's water supply in accordance with the regulation. This will be an on-going review.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents. The water temperature was above 120 degrees Fahrenheit in 1 of 3 halls. Items were sitting on bathroom floors uncovered, a call light	F 0921	F - 921 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the water temperature has now been	12/16/2023

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	cord was resting on a resident's bathroom floor, a privacy curtain was hanging off of the track, and a resident's wall was scuffed with paint chipping in 2 of 3 halls observed. (A Hall, C Hall) Findings include: 1. On 11/14/23 from 10:06 A.M. through 10:18 A.M., the following resident bathroom temperatures were observed in A Hall: Bathroom between rooms 2 and 3: 124.1 degrees Fahrenheit. The resident in room 3 indicated she used the bathroom sink and it was sometimes hot. Bathroom between room 4 and the therapy room: 123.1 degrees Fahrenheit. Bathroom between rooms 6 and 7: 125.6 degrees Fahrenheit. Bathroom between rooms 9 and 10: 120.1 degrees Fahrenheit. On 11/14/23 from 11:08 A.M. through 11:10 A.M., the Maintenance Director was observed to obtain the following temperatures from resident bathrooms in A Hall: Bathroom between rooms 2 and 3: 123 degrees Fahrenheit. Bathroom between room 4 and the therapy room: 122 degrees Fahrenheit. Bathroom between rooms 6 and 7: 121 degrees Fahrenheit. Bathroom between rooms 9 and 10: 123.2 degrees Fahrenheit.		adjusted on hall A. Upon observation and checking of water temperatures, all water temps on hall A including the bathrooms between rooms 2 and 3, bathroom between room 4 and the therapy room, the bathroom between room 6 and 7, and the bathroom between 9 and 10 are being maintained at a safe and comfortable level in accordance with the regulations. (Between 100 degrees and 120 degrees Fahrenheit) *2. The corrective action taken for those residents found to have been affected by the deficient practice is that* all items that were identified to be on the floor of the bathroom between room 4 and the therapy room have been removed. No items are being left on the bathroom floor. The call light cord in the bathroom between room 4 and the therapy room has been shortened and no longer touches the floor. *3. The corrective action taken for those residents found to have been affected by the deficient practice is that* the uncovered bedpan on the floor behind the toilet in the bathroom between rooms 2 and 3 has been removed and no items have been left on that bathroom floor. *4. The corrective action taken for those residents found to have been affected by the deficient practice is that* the drain in the	

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	On 11/14/23 at 11:31 A.M., the weekly water temps log, dated from 8/20/23 through 11/23/23, indicated temperatures were checked in the visitor restroom, laundry room, and each hall's "sink" and shower. When asked, the Maintenance Director could not verbalize where exactly the temperatures were taken. 2. On 11/13/23 at 10:48 A.M., the bathroom between rooms 4 and the therapy room was observed with two buckets, 1 bedpan, and 3 washbasins on the floor under the sink uncovered. The call light cord was observed coiled up and resting on the floor between the wall and the toilet. The same was observed on 11/16/23 at 12:29 P.M. with the exception of the bedpan. 3. On 11/14/23 at 10:06 A.M., the bathroom between rooms 2 and 3 was observed with a bedpan on the floor behind the toilet uncovered. 4. On 11/14/23 at 10:04 A.M., the shower room sink on A Hall was observed 3/4 full of water. At that time, the Housekeeper 5 indicated it was clogged, and had done that before. 5. During an observation on Hall C on 11/15/23 at 7:35 A.M., the privacy curtain between Resident 33 and Resident 22's had 4 hooks that were not connected and the curtain hung down. At that time, the wall on the right of Resident 33's bed had 2 large oval areas of paint that peeled off and was hanging down. During an observation on 11/16/23 at 11:06 A.M., the privacy curtain between Resident 33 and Resident 22's had 4 hooks that were not connected and the curtain hung down. At that time, the wall on the right of Resident 33's bed had		sink in the shower room on Hall a has been unclogged and now drains freely. *5. The corrective action taken for those residents found to have been affected by the deficient practice is that* the divider curtain on Hall C that hung between the residents identified as resident 33 and 22 has been repaired and now hangs properly from the curtain rail. The wall on the right side of the resident identified as resident 33 has been repainted and there are no areas of peeled paint hanging down. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide environmental inspection was completed to identify any areas of concern. No additional concerns were identified. Water temperatures have been checked housewide and all water temperatures are being maintained in accordance with the regulations. No items are being stored on bathroom floors and all call light cords in bathrooms are not touching the floor surface. Upon observation of all wall surfaces, the wall surfaces are clean and free of chipped or peeling paint. All divider curtains are properly secured on the ceiling tracks.	

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	2 large oval areas of paint that peeled off and was hanging down. During an interview on 11/16/23 at 11:06 A.M., the Maintenance Director indicated the wheels must have been pulled out from the curtain and he was unaware of the paint that was peeled off of the wall. Staff would tell him if they notice a problem or they would submit a work order and he had not received one. On 11/14/23 at 11:15 A.M., the Maintenance Director indicated he was unsure of the appropriate water temperatures in resident bathrooms, and thought they could be as high as 124 degrees Fahrenheit. He indicated he had been told to check the water temperatures monthly, but he tried to check them weekly. He further indicated he did not check the water in resident bathrooms, but did from other areas of the building such as the hall bathroom and shower room. He indicated he was unable to adjust the water temperature on his own, and needed to call an outside company to come in and adjust the temperature. He indicated he was aware of the clogged sink in the A Hall shower room, and had to have a plumber out several times in the past for that sink. On 11/16/23 at 12:30 P.M., Licensed Practical Nurse (LPN) 3 indicated anything on a resident's bathroom floor should have been covered such as washbasins and bedpans. On 11/15/23 at 7:55 A.M., the Administrator provided a current Water Temperature Policy/Procedure, last reviewed 4/2023, that indicated "The hot temperature for all bathing and hand washing facilities shall be controlled by automatic control valves. The water temperature		F – 921 continued *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on appropriate water temperatures and weekly testing to include resident bathrooms and showers. The maintenance director was also re-educated on their responsibility to ensure wall surfaces remained clean and free of chipped or peeling paint. The maintenance director was also re-educated on their responsibility to ensure that all sink drains were maintained to function properly and to be free of clogs. In addition, a mandatory in-service was provided for all staff regarding their responsibility of maintaining a safe, sanitary, functional and comfortable environment for the residents as well as the process for reporting any environmental concerns to the maintenance supervisor in a timely manner. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's environment. This tool will monitor to ensure that safe water temperatures are maintained, bathrooms are clean including no	

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	at the point of use must be maintained between: (1) one hundred (100) degrees Fahrenheit; and (2) one hundred twenty (120) degrees Fahrenheit" On 11/15/23 at 11:56 A.M., the Administrator provided a current Maintenance/Housekeeping Policy, dated 6/2023, that indicated "It is the policy of facility to assure that the building is comfortable and clean in accordance with the regulation" 3.1-19(f) 3.1-19(r)		items being stored on the bathroom floors, call light chords are off of the floor surface and that there is no chipped or peeling paint on the wall surfaces. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 9999 Bldg. 00	16.2-7-4 Resident programs Sec. 4. (a) The facility shall provide a program for developmentally disabled individuals, which assures the following: (1) There is a designated staff member qualified by a minimum of two (2) years experience with developmentally disabled individuals, or through completion of the council approved training program on developmental disabilities, responsible for the program. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure implementation of a program for specialized populations served in the facility (intellectual and/or developmental disability) for 3 of 3 residents currently residing in the facility.	F 9999	9999 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the three residents with a diagnosis of intellectual and/or developmental disability have now been referred to a QIDP for the development of a specialized program that meets their needs. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide review was conducted and no other residents meet these criteria. *The measures that have been put*	12/16/2023

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	Finding includes: On 11/16/23 at 12:37 P.M., the Director of Nursing (DON) provided a list of three residents with a diagnosis of intellectual and/or developmental disability. On 11/16/23 at 1:37 P.M., the DON indicated the facility currently did not have a program for those residents with an intellectual and/or developmental disability. She indicated the facility did not have a designated Qualified Intellectual Disability Professional (QIDP) to head the program, and did not offer inservices to staff related to the specialized population of residents. The DON further indicated there was not a policy related to the QIDP, inservices, or program.		*into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the social service director on the QIDP program and the supportive services available for those residents who meet the intellectual and/or developmental disability qualifications. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor residents with intellectual and/or development disabilities to ensure that they are being provided the identified specialized services to meet their needs. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	