STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155856	A. BUILDING 00 B. WING	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAURELS OF GOSHEN, THE	1480 SANDPIPER LN GOSHEN, IN 46526

(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. This visit included the Investigation of Complaint IN00436069 and IN00435388 Complaint IN00435388 - Federal /State deficiencies related to the allegations are cited at F677. Complaint IN00436069 - No deficiencies related to the allegations are cited. Survey dates: June 17, 18, 19, 20 and 21, 2024 Facility number: 014141 Provider number: 155856 AIM number: 300012886 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 21 Other: 21 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 7/1/2024	F 0000	Laurels of Goshen does hereby request consideration for Paper Compliance for the Plan of Completion submitted for our complaint survey dated September 22, 2023. Attached with our plan of correction, which we believe responds to corrections and system implementation are documents that address education and audit materials used in attaining and maintaining substantial compliance with the findings. If you should need any further documentation or information, please do not hesitate to contact the facility Administration, phone # 574-536-9234 or through the Gateways system e-mail. Thank you, Carolyn Davidson, HFA	
F 0575 SS=C Bldg. 00	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Underly	Administrator	07/25/2024

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	(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. Based on observation and interview, the facility failed to ensure the current ombudsman's name was listed on their Resident Right's poster, in 4 of 4 houses. (Strawberry Fields, Blueberry Hill, Green Gables and Penny Lane) This deficient practice had the potential to affect all 46 residents and/or their family members and visitors. Finding includes: On 6/20/24 at 1:25 P.M., a Resident Rights' poster was observed hanging in the Penny Lane house, opposite of the Director of Nursing's office. The poster had the wrong local Ombudsman's name on it. There was no posting of the State Ombudsman information observed anywhere else in the house On 6/21/24 at 10:21 A.M., a Resident Rights'	F 0575	**F575** 1 It is the policy and practice of this facility to ensure the Resident Rights' poster located in the Penny Lane House, Blueberry Hill House, Strawberry Fields House, and the Green Gables House are accessible for all residents, staff and family members. The posters of the Resident Rights' were moved to a more visible site for viewing and were corrected to reflect the correct Ombudsman's name and correct telephone number. 2 There was no negative outcome as a result of the Resident Rights' Poster not being	07/22/2024

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	poster was observed hanging on the wall in the Blueberry Hill house. The poster had the wrong local Ombudsman's name on it. On 6/21/24 at 10:25 A.M. a Resident Rights' poster was observed hanging on the wall in the Strawberry Fields House. The poster was only partially visible due as it was hung behind a dry erase board. It had the wrong Ombudsman's name printed on it. On 6/21/24 at 10:34 A.M., a Resident Right's post was observed hanging on a wall in the Green Gables house. The poster had the wrong Ombudsman's name on it. There was no other posting of the State Ombudsman information located in the house. On 6/21/24 at 3:00 P.M., the Administrator indicated she had no policy regarding the displaying of the local or State Ombudsman information for resident's and/or family members. During an interview, on 6/21/24 at 3:30 P.M., the previous local ombudsman, whose name and phone number were printed on the Resident Right's posters, indicated she had retired from her position, as the local ombudsman, approximately 4 years ago. 3.1-4(J)(3)(C)		in the more visible area and the name and telephone of the Ombudsman being incorrect. 3 The facility Administrator was re-educated on policy and the requirement that they be posted in a form and manner accessible and understandable to residents and resident representatives (Exhibit 1). 4 Facility Administrator and/or designee during routine facility rounds will audit to ensure that required postings are completely visible and, in a form, and manner accessible and understandable to residents and resident representatives once a week x 8 weeks and monthly x 4 (Exhibit 2). Findings will be reported to the QAPI Committee for further review and/or recommendations. 5 7/22/24	
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			

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	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 ensure a Care Plan had been updated timely for 1 of 3 residents reviewed for care plans. (Resident 9) Findings include: 1. The record for Resident 9 was reviewed on 6/19/24 at 10:29 A.M. The resident's diagnoses included, but were not limited to; mild protein calorie malnutrition and impaired cognitive function. A Quarterly Minimum Data Set (MDS) Assessment, dated 5/5/24 indicated the resident was not receiving Hospice services.	F 0657	**F657** 1 The Care Plan for Resident #9 was updated by the Interdisciplinary Team (IDT) to reflect current treatment of care. 2 Residents residing within the facility have the potential to be affected. Care Plans were reviewed, concerns were addressed to ensure that Care Plans reflected resident's current treatment of care. 3 Care Planning Policy was reviewed by QAPI Committee and deemed appropriate. IDT was re-educated on the Care Planning Policy with emphasis on timely,	07/22/2024

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	A Dietary Progress Note, dated 6/7/24, indicated the resident's weight reflected a 9% significant weigh loss from three months ago and continued on a gradual trend down. His dietary interventions included, but were not limited ti, Boost, a nutritional supplement, twice a day. The dietary note, dated 6/7/2024, planned to increase the Boost supplement to three times a day and encourage good oral intakes. A Care Plan, dated 3/22/23 and revised on 5/8/24, indicated the resident was "...at risk for a decline in condition, pain, depression, weight loss and other symptoms related to terminal prognosis: PVD [peripheral vascular disease]...." A goal listed for the resident was to be accepting of end of life condition. The interventions included, but were not limited to: ·Assess resident's coping strategies and respect resident wishes. ·Hospice provided by (name and phone number of Hospice Care provider. Contact with condition changes or questions. ·Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. ·Observe for adverse reactions & symptoms of end of life such as nausea/vomiting, difficulty breathing, agitation; Report findings to Hospice and physician. ·Provide guest/family/legal representative with Hospice information as needed. During an interview on 6/19/24 at 2:38 P.M., the MDS Coordinator indicated Resident 9 was not currently on Hospice services and probably had not been on Hospice since August of 2023. She indicated she had not updated the care plan to remove interventions regarding hospice and the Hospice agency's contact information.		accurate review (Exhibit 3). 4 Director of Nursing and/or designee will audit care plans weekly x 8, monthly x 4 to ensure compliance with facility policy (Exhibit 4). Findings will be reported to the QAPI Committee for further review and/or recommendations. 5 7/22/24	

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	3.1-35(e)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide nail and hand hygiene and grooming assistance to a resident unable to complete care for themselves for 1 of 2 residents reviewed for activities of daily living. (Resident B). Findings include: During an observation, on 6/17/2024 at 2:26 P.M., Resident B was observed seated in her chair with a brown colored substance build up underneath her fingernails on both hands. In addition, she had long, dark brown whiskers noted above her lip and on left side of face. During an observation, on 6/18/2024 at 9:37 A.M., Resident B was observed seated her chair with a brown colored substance underneath her fingernails on both hands. She also had dark brown whiskers noted above her lip and on the left side of her face. A record review for Resident B was completed on, 6/18/2024 at 2:03 P.M. The resiident's diagnoses included, but were not limited to: hemiplegia and hemiparesis, affecting right dominant side, diabetes mellitus type 2, Dementia, ostoearthritis and weakness.	F 0677	**F677** 1 Resident B's fingernails were cleaned, trimmed and her facial hair removed. 2 Residents residing within facility have the potential to be affected. On 6/24/2024 all residents were visually inspected to ensure that personal hygiene was being maintained shaving, nail trimming, etc. Concerns were addressed immediately. 3 Activities of Daily Living (ADL) Program Policy was reviewed by QAPI Committee and deemed appropriate. Nursing Staff was re-educated on facility policy (Exhibit 5). 4 Director of Nursing and/or designee will monitor with Care Rounds weekly x 8 weeks, monthly x 4 months (Exhibit 6a). Residents will be visually observed to ensure that personal hygiene is being maintained. Findings will be reported to QAPI Committee for further review and/or recommendations. 5 7/22/24	07/22/2024

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	A Quarterly Minimum Data Set (MDS) assessment, dated 3/6/2024, indicated Resident B had moderate cognitive impairment and impaired Range of motion to one side of her upper extremities. She required substantial maximum assistance with grooming and personal hygiene needs. The Certified Nursing Assistant (CNA) documentation regarding manicures/nail care in the electronic health record from 6/1/2024-6/18/2024 indicated Resident B had no refusals of nail care. A Care Plan for late loss activities of daily living, dated 2/4/2024, indicated Resident B required maximum assistance with dressing, grooming and bathing. During an observation, on 6/19/2024 at 8:23 A.M., Resident B's fingernails remained dirty with brown debris under the nails, and her face remained unshaven with dark brown whiskers. During an interview, on 6/19/2024 at 8:49 A.M., CNA 5 indicated Resident B should have been shaved and her nails cleaned and trimmed when she had her shower and Resident B does not refuse care. During an interview, on 6/21/2024 at 1:56 P.M., the Director of Nursing indicated Resident B should have been shaved and her nails should have been trimmed on her shower day. On 6/21/2024 at 2:22 P.M., the Executive Director provided the policy titled, "Activities of Daily Living (ADL) Program", dated 4/5/2024, and indicated the policy was the one currently being used by the facility. The policy indicated,			

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	"...Bathing: Maintaining personal hygiene...vii. shaving, if applicable and x. trimming nails...." This citation relates to Complaint IN 00435388 3.1-38(a)(3)			
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, record review, and interview, the facility failed to obtain orders for wounds, change wound dressings as ordered, ensure recommended treatments for edema were completed and identify bruising for 2 of 15 residents reviewed for quality of care. (Residents 35 and 26) In addition, the facility failed to ensure a residents was free of medication errors for 1 of 5 residents reviewed for medication administration (Resident 18). Findings include: 1. During an observation, on 6/17/2024 at 9:40 A.M., Resident 35's left and right elbows were observed to have bandages, dated 6/9 and soilage could be seen seeping through the bandage on the left elbow. On 6/18/2024 at 12:35 P.M., the elbow bandages continued to have the date of 6/9 on them.	F 0684	**F684** 1 Resident #18's heart rate has been less than 50, thus Carvedilol was held but charted wrong. Resident #26 – orders received for ace wraps and Care Plan updated to reflect treatment plan. Resident #35 discharged from facility on 6/28/2024. 2 Residents residing within facility have potential to be affected. Audit of physician orders for residents were reviewed to ensure orders and recommended treatments were being followed. Concerns were addressed immediately. ADNS/Designee completed an audit of of all wounds and bruises by 7/22/24 to ensure skin issues had complete	07/22/2024

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	A record review for Resident 35 was completed on 6/18/2024 at 1:58 P.M. The resident's diagnoses included, but were not limited to, pneumonia and diabetes mellitus type 2. A Patient Discharge Instruction Sheet, dated 6/6/2024, and a Hospital Discharge Patient Health Summary, dated 6/13/2024, indicated an order to apply moisturizer to the resident's bilateral upper extremity's scabbed areas and the left scapula twice a day. A Nursing Comprehensive Evaluation, on 6/13/2024, indicated: - Left elbow scab 2.5 centimeters by 1.5 centimeters -Right elbow scab 1.3 centimeters by 1.1 centimeters and 2.2 centimeters by 1.5 centimeters A Nurse's Note, dated 6/6/2024 at 7:42 P.M., indicated Resident 35 had multiple scabbed wounds on her elbows, knees, and scattered bruising on her bilateral upper extremities from the elbows to her hands. A Physician's Order, dated 6/14/2024, indicated lotion was to be applied to Resident 35's bilateral upper extremities and left scapula scabbed areas two times a day for wound care. A Care Plan, dated 6/6/2024, indicated Resident 35 had an actual skin impairment related to closed wounds on her elbows, left shoulder, and left flank. The goal included having no complications related to the closed wounds with scabs. An intervention indicated to observe the location, size, and treatment of the skin injuries, and to report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the		assessments and physician orders for treatment. 3 Physician's Order Policy and Skin Management Policy were were reviewed by the QAPI Committee and deemed appropriate. Licensed Nurses were re-educated on facility policy for documentation, skin assessment and following physician orders (Exhibit 7). 4 Director of Nursing and/or designee to audit physician orders and all wounds and bruises weekly x 8 weeks, monthly x 4 months to ensure orders and recommended treatments are being followed (Exhibit 8). Findings will be reported to the QAPI Committee for further review and/or recommendations. 5 7/22/24	

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physician.

A Braden Scale (assessment to determine a resident's risk factor for developing impaired skin) assessment, dated 6/14/2024, indicated Resident 35 was at low risk for impaired skin development.

During an observation, on 6/19/2024 at 1:02 P.M., Resident 35's elbow bandages were still dated 6/9.

During an interview, on 6/20/2024 at 10:59 A.M., the Executive Director indicated the nursing staff should have pulled the dressing off to see what was underneath and should have applied the treatment orders for the elbow areas.

During an interview, on 6/20/2024 at 2:01 P.M., LPN 6 indicated he had received orders for the elbow wounds. The elbow wounds were observed, and described by LPN 6 as follows: "...1. The right elbow had a half centimeter diameter scabbed area, and had an opened area measuring ¾ centimeter by 1 centimeter, epithelialized, blanchable redness.
2. The left elbow had a shallow open area 2 inches by 1.5 inches with serous drainage...."

During an interview on, 6/20/2024 at 2:50 P.M., the Executive Director indicated Resident 35 should have had physician orders obtained for the elbow wounds.

2. During an interview, on 6/17/2024 at 2:10 P.M., Resident 26 complained of edema in her legs. Her legs were observed to be positioned flat on top of the mattress with no stockings or ace wraps on them. The ace wrap dressings were observed lying in the windowsill.

A record review for Resident 26 was completed on

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	6/18/2024 at 12:14 P.M. The resident's diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus type 2, edema, and morbid obesity. An Admission MDS (Minimum Data Set) assessment, dated 4/10/2024, indicated Resident 26 was cognitively intact and the primary medical condition category was medically complex conditions. A Care Plan, dated 1/11/2024, indicated Resident 26 was "...at risk for discomfort or adverse effects due to receiving diuretic therapy related to edema." The goal was for Resident 26 to be free of any discomfort or adverse side effects of the diuretic therapy. A Nurse Practitioner's Note, dated 6/1/2024 at 12:59 A.M., indicated the nursing staff were directed to apply ace wraps and elevate the resident's legs. Resident 26 was diagnosed with lymphedema in the left lower extremity which caused discomfort. During an observation on 6/18/2024 12:37 P.M., Resident 26 continued to complain of the edema to her legs. Her legs were observed to be positioned flat on the mattress with no stockings or ace wraps. Ace wraps were observed lying in the windowsill. Resident 26 indicated the staff used to wrap her lower legs. During an interview, on 6/20/2024 at 10:55 A.M., the Executive Director indicated Resident 26 could have been refusing (the application of the ace wraps), and the ace wraps may be a nursing measure. She indicated they should be completing the tasks unless Resident 26 was refusing.			

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	During an interview, on 6/21/2024 11:36 A.M., Resident 26 indicated she had not been refusing to have the ace wraps applied or to have her feet elevated. She indicated she felt the ace wraps would help her. A policy for following physician orders/recommendations was requested, on 3/21/2024 at 10:58 P.M. A policy was not provided for following physician recommendations and orders. 3. On 6/19/2024 at 3:30 P.M., a review of the clinical record was completed for Resident 18. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and sinus bradycardia. A Quarterly Minimum Data Set (MDS), dated 4/19/2024 indicated the resident's cognition was intact. The Physician's Orders for medications indicated the resient was to receive Carvedilol 6.25mg by mouth, twice per day, hold if heart rate is less than 50. A review of the resident's Medication Administration Record (MAR) indicated Carvedilol 6.25 mg was documented as given on the following dates and shifts, with the corresponding heart rates: Morning shift: - 5/3/2024 heart rate 36 - 5/6/2024 heart rate 32 - 5/11/2024 heart rate 45 - 5/19/2024 heart rate 33 - 5/27/2024 heart rate 35 - 5/29/2024 heart rate 39 - 6/11/2024 heart rate 35			

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(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
	- 6/12/2024 heart rate 34 - 6/15/2024 heart rate 34 - 6/19/2024 heart rate 33 Evening shift: - 5/3/2024 heart rate 36 - 5/11/2024 heart rate 42 - 5/19/2024 heart rate 45 - 5/20/2024 heart rate 32 - 5/21/2024 heart rate 32 - 5/28/2024 heart rate 35 - 6/11/2024 heart rate 35 - 6/15/2024 heart rate 34 - 6/18/2024 heart rate 35 A Care Plan, dated 7/12/2023, indicated the resident was at risk for cardiac complications related to multiple cardiovascular diseases. The residents goal included a goal for the resident to be free from signs and symptoms of cardiac complications through the review date. Interventions included: "... observe, document, and report to physician as needed any signs or symptoms of cardiac distress: chest pain or pressure, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in capillary refill, color/warmth of extremities, vital signs as ordered, and notify the physician of abnormal readings as needed...." A Physician's Note, dated 6/8/2024, indicated the patient was last seen on 5/23/2024. During an interview, on 6/19/2024 at 3:39 P.M., the Administrator and DON both indicated the resident should not have received the Carvedilol 6.5mg when his heart rate was less than 50. During an interview, on 6/20/2024 at 9:23 A.M.,			

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	155856	A. BUILDING 00 B. WING	06/21/2024

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	Resident 18 indicated he was unsure of what medications he was prescribed. He indicated he was prescribed a heart pill named Coreg but was unsure if the medication was being held if his heart rate was less than 50. He indicated some nurses would check his pulse before administering the medication and some nurses would not. On 6/20/2024 at 11:48 A.M., the Administrator provided the policy titled, "Medication Administration," dated 10/17/2023, and indicated it was the policy currently in use by the facility. The policy indicated: "...Procedure: 5. If applicable and/or prescribed, take vital signs or tests prior to administration of the dose, e.g, pulse with digitalis, blood pressure with anti-hypertensive, etc....." 3.1-37(a)			
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 unless the resident's clinical condition demonstrates that catheterization was necessary;			

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	(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 observation, record review, and interview, the facility failed to obtain a physician's order for an indwelling urinary (Foley) catheter for 1 of 2 residents reviewed for catheters. (Resident 35) Finding includes: During an observation on 6/17/2024 at 10:51 A.M., Resident 35 was observed to have a Foley catheter. A record review was completed for Resident 35 on 6/18/2024 at 1:58 P.M. Diagnoses included, but were not limited to, obstructive uropathy and diabetes mellitus type 2. An Admission MDS (Minimum Data Set) assessment had not yet been completed for Resident 35. A Care Plan, dated 6/14/2024, indicated Resident	F 0690	**F690** 1 Resident #35 discharged from facility on 6/28/2024. 2 Residents who have indwelling catheters have the potential to be affected. Nursing management audited treatment plans of residents with indwelling catheters to ensure compliance with facility policy. No concerns noted. 3 Bowel & Bladder Continence Program was reviewed by QAPI Committee and deemed appropriate. Licensed Nurses were re-educated on facility policy (Exhibit 7). 4 Director of Nursing and/or	07/22/2024

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	35 was a risk for a urinary tract infection and catheter related trauma. Interventions included, but were not limited to, provide catheter care per the policy. Resident 35 was seen by the physician on 6/15/2024. The Physician's Note did not reference the use of a Foley catheter. During an interview on 6/18/2024 at 2:27 P.M., Resident 35 indicated he had returned to the facility from his recent hospitalization with the Foley catheter. He indicated he had a prostate problem, and had completed self-catheterization at home prior to his admission to the facility. During an interview, on 6/20/2024 at 11:06 A.M., the Executive Director indicated Resident 35 should have had a physician's order for the Foley catheter and catheter care. A policy was provided, on 6/21/2024 at 1:41 p.m., by the Executive Director. The policy titled, "Indwelling urinary catheter [Foley} care and management", indicated there was no reference regarding the need to have physician's order in the policy for a Foley catheter. 3.1-41(a)		designee will audit admissions and new orders for catheters weekly x 8 weeks, monthly x 4 months to ensure that residents are screened upon admission for resident admitted with indwelling catheter is assessed to determine if the catheter may be discontinued (Exhibit 9). Findings will be reported to the QAPI Committee for further review and/or recommendations. 5 7/22/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure respiratory equipment was stored properly for 1 of 2 residents reviewed for respiratory care. (Resident 26) Finding includes: During an observation, on 6/17/2024 at 9:48 A.M., Resident 26's Bi-Pap (non-invasive ventilation therapy equipment) mask was observed hanging over bedside table. A record review was completed, on 6/18/2024 at 12:14 P.M., for Resident 26. Diagnoses included, but were not limited to, obstructive sleep apnea, edema, asthma, and morbid obesity. An Admission MDS (Minimum Data Set) assessment, dated 4/10/2024, indicated Resident 26 was cognitively intact and the primary medical condition category was medically complex conditions. The MDS did not indicate a Bi-Pap machine was in use for Resident 26. A Physician's Order, dated 1/4/2024, indicated Resident 26 was to wear a Bi-Pap mask at night while he was sleeping for sleep apnea. A Care Plan, dated 1/11/2024, indicated Resident 26 had the potential for difficulty breathing for respiratory complications related to asthma, obstructive sleep apnea, and morbid obesity. During an observation, on 6/18/2024 at 12:36 P.M., the BiPap mask for Resident 26 was observed on top of the bedside table.	F 0695	**F695** 1 The Bi-pap tubing for Resident #26 was placed in a bag. 2 Residents residing within facility requiring respiratory care have potential to be affected. Residents who require respiratory care were audited to ensure proper storage of respiratory equipment/supplies. No other concerns noted. 3 Use of Oxygen Policy was reviewed by QAPI Committee and deemed appropriate. Nursing staff re-educated on policy (Exhibit 7). 4 Director of Nursing and/or designee will complete Care Rounds weekly x 8 weeks, monthly x 4 months (Exhibit 6b). During Care Rounds staff will visually audit/observe to ensure that respiratory equipment is stored per facility policy. Findings will be reported to QAPI Committee for further review and/or recommendations. 5 7/22/24	07/22/2024

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	During an observation, on 6/19/2024 at 1:13 P.M., the BiPap mask for Resident 26 was observed on top of the bedside table. During an interview, on 6/20/2024 at 10:57 A.M., the Executive Director indicated the BiPap mask should be stored at the bedside in a respiratory bag or a bag. A policy was provided, on 6/21/2024 at 1:41 P.M., by the Executive Director. The policy, titled, "Noninvasive positive-pressure ventilation, respiratory therapy", did not include instructions regarding the storage procedure for the Bi-Pap mask. 3.1-47(a)(6)			
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 record review and interview, the facility failed to ensure the appropriate antibiotic was prescribed at the appropriate time for the appropriate duration for a skin infection for 1 of 4 residents reviewed for antibiotic stewardship. (Resident 26) Finding includes:	F 0881	**F881** 1 The Keflex for Resident #26 was discontinued. 2 Residents residing within facility with Antibiotic orders have the potential of be affected. Record review of resident's receiving antibiotics were reviewed to ensure compliance of antibiotic	07/22/2024

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	During an interview, on 6/17/2024 at 2:08 P.M., Resident 26 described an abdominal infection and a boil she had on her left thigh. A record review for Resident 26 was completed on 6/18/2024 at 12:14 P.M. The resident's diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus type 2, and morbid obesity. An Admission MDS (Minimum Data Set) assessment, dated 4/10/2024, indicated Resident 26 was cognitively intact and the primary medical condition category was medically complex conditions. A Physician's Order, dated 5/31/2024 at 12:30 P.M., indicated a wound culture was to be obtained. A Physician's Order, dated 5/31/2024 at 8:00 P.M., indicated the resident was to receive Keflex (cephalexin) (an antibiotic) 500 milligrams two times a day for a wound was to be administered. A Nurse Practitioner Note, dated 6/1/2024 at 12:59 A.M., indicated Resident 26 presented for a chronic care visit with concerns of a boil on her left inner side of her thigh. Resident 26 had a history of MRSA (Methacillan Resistant Staph Aureus) infection in 2004. The note indicated orders were given to culture the boil, complete lab tests and start the antibiotic, Keflex 500 mg twice a day for 7 days. The instructions indicated to change the antibiotic if the culture revealed a specific infection. A Care Plan, dated 6/3/2024, indicated Resident 26 had a wound to her left inner thigh. The interventions included, but were not limited to,		use and that system monitoring was occurring. No concerns noted. 3 Infection Control Antibiotic Stewardship & MDROs Policy was reviewed by QAPI Committee and deemed appropriate. Licensed Nurses re-educated on policy (Exhibit 7). 4 Director of Nursing and/or designee will audit antibiotic orders weekly x 8 weeks, monthly x 4 months to ensure proper antibiotic use and monitoring is occurring (Exhibit 10). Findings will be reported to the QAPI Committee for further review and/or recommendations. 5 7/22/24	

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	administering antibiotics as ordered, and updating the physician with changes as needed. The wound culture and sensitivity results , dated 6/7/2024 at 9:42 A.M., indicated a growth at 48 hours of 4 plus gram negative bacteria. The organism was identified as Myr. odoratus/odoratimimus. The following antibiotics were susceptible for treatment of the organism: -Amikacin -Ceftazidime -Cefepime -Gentamicin -Tobramycin -Trimethoprim/Sulfamethoxazole -Piperacillin/Tazobactam A Nurse's Note, dated 6/17/2024 at 9:23 P.M., indicated Keflex 500 milligrams was held for clarification of a stop date. There was no note the physician or nurse practioner was notified regarding the wound culture results and the need to alter the antibiotic treatment. During an interview, on 6/21/2024 at 1:17 P.M., the Executive Director indicated the Keflex should have been stopped after 7 days and the physician should have been notified of the culture results to see if the antibiotic should have been changed. A policy was provided, on 6/17/2024 at 1:45 P.M., by the Executive Director. The policy, titled, "Infection Control Antibiotic Stewardship & MRDOs [multidrug-resistant organisms]", indicated Antibiotic stewardship referred to: "...coordinated interventions designed to improve and measure the appropriate use of antimicrobials, by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration...."			

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