STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00366107, IN00367385, IN00367406, IN00367635, IN00367924, IN00368643, IN00368979, and IN00369014. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00366107 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00367385 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, and F684. Complaint IN00367406 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, and F684. Complaint IN00367635 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F880. Complaint IN00367924 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00368643 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, F684, and F697. Complaint IN00368979 - Substantiated. Federal/State deficiencies related to the allegations are cited at F698. Complaint IN00369014 - Substantiated.	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Federal/State deficiencies related to the allegations are cited at F755. Survey dates: December 14, 15, and 16, 2021 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF: 6 SNF/NF: 107 Total: 113 Census payor type: Medicare: 12 Medicaid: 72 Other: 29 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/22/21.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or			

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	psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

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	Based on record review and interview, the facility failed to promptly notify the resident's Physician and/or responsible party of a change in condition related to the onset of a red and swollen skin issue, and an allergy to an antibiotic medication for 1 of 3 residents reviewed for non-pressure skin issues. (Resident J) Finding includes: The record for Resident J was reviewed on 12/15/21 at 2:45 p.m. The resident was admitted on 10/22/21. Diagnoses included, but were not limited to, Parkinson's Disease, anxiety, osteoporosis, and major depressive disorder. An entry by Wound Nurse 1 in Nurses' Notes, dated 12/7/21 at 2:43 p.m., indicated "notified per nursing of lump to resident's back. Assessed area, noted firm bump to right lateral back, with redness to bottom right and swelling. No drainage or complaints of pain to area. Area covered with foam dressing. NP [Nurse Practitioner] notified. Responsible party notified. See wound rounds for assessment." The next documented note was on 12/9/21 at 1:08 p.m., which indicated an antibiotic was ordered for the resident related to the area on their back, however, the antibiotic ordered was identified as a possible drug allergy for the resident. The resident was allergic to Penicillin. A Physician Progress Note completed by the NP, dated 12/9/21 at 7:43 p.m., indicated the resident was being seen today by the request of the wound care nurse for a raised, reddened area to the lateral right side of the resident's back. They first noticed it two days prior. The resident was not able to say when it appeared.	F 0580	**1)Immediate actions taken for those residents identified:** Resident J received the antibiotic per physician order. As stated on page 5 of the 2567, resident's physician was aware of the allergy, and at the time chose to continue the medication. **2)How the facility identified other residents:** DON or designee will audit the EMR Clinical Dashboard for missed doses of ordered medications for all residents for the past thirty (30) days with necessary notifications made. DON or designee will review progress notes of residents for the last thirty (30) days to identify any changes of condition and validate physician and family notification of the same. DON or designee will review medication orders obtained in the past thirty (30) days to ensure that no medications listed on resident's allergy lists have been ordered, any identified concerns will be reported to physician. **3) Measures put into place/ System changes:** Licensed staff will be educated relative to notification of changes, including but not limited to, notifying physician of missed	01/14/2022

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	Physician's Orders, dated 12/9/21, indicated Cephalexin Capsule (an antibiotic) 250 milligrams (mg) give 250 mg by mouth every 6 hours for skin abscess for 7 Days. The order was discontinued on 12/10/21. Physician's Orders, dated 12/10/21, indicated Cephalexin Capsule 250 mg give 250 mg by mouth every 6 hours for skin abscess for 7 Days, ok to give, Physician aware of allergy. The Medication Administration Record (MAR) for the month of 12/2021, indicated the Cephalexin was scheduled to be administered at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. The first dose of the antibiotic was administered on 12/9/21 at 6:00 p.m. and then again on 12/10/21 at 12:00 p.m. The antibiotic was not administered on 12/10/21 at 12:00 a.m., 6:00 a.m., and 6:00 p.m. There was no documentation in Nurses' Notes indicating the Physician was again notified of the area to the resident's back, nor was there documentation regarding the allergy to the antibiotic. Interview with Wound Nurse 1 on 12/16/21 at 10:15 a.m., indicated she was informed by nursing staff on the unit the resident had a red and swollen area to her back. She assessed the area and texted the Nurse Practitioner. She worked every other day and Wound Nurse 2 worked the opposite days. They would leave notes for each other to follow up on new areas of concern. The NP was not notified again of the area until she was in the building on 12/9/21. She observed the area and ordered the antibiotics at that time.		medication doses, according to facility policy, promptly notifying responsible party and physician of resident changes of condition, and notifying physician of resident allergies when obtaining new medication orders. **4) How the corrective actions will be monitored:** DON, or designee, daily, on scheduled days of work, during clinical meeting, will review the EMR dashboard to identify any changes of condition, medications not administered, and new medication orders (to ensure resident is not allergic) to ensure physician/family notifications have been made, as necessary. These reviews will continue daily, on scheduled days of work, for 30 days, or until continued compliance has been achieved. Thereafter, these reviews will continue daily, on scheduled days of work, ongoing, during clinical meetings. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **January 14, 2022**	

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	Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the antibiotic was available in the EDK (Emergency Drug Kit) box. There was a delay in obtaining orders for treatment for the red raised area and in notifying the doctor of the allergy to the ordered antibiotic. This Federal tag relates to Complaints IN00367385, IN00367406, and IN00368643. 3.1-5(a)(3)			
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 ensure dependent residents received assistance with incontinence care, dressing, eating, grooming, and oral care for 2 of 3 residents reviewed for activities of daily living (ADL's). (Residents D and F) Findings include: 1. On 12/14/21 at 11:42 a.m., Resident D was observed in his geri chair recliner in the hallway of the 300 Unit. At 12:19 p.m., the resident was taken to the unit dining room by Agency CNA 2. The resident's lunch tray was on the table waiting for him and he was fed by the CNA. At 12:40 p.m., the resident was returned to the hallway and positioned across from the nurses' station. The resident was observed with dried food spillage on his shirt. The CNA indicated he was going to	F 0677	**The facility requests desk review for this citation.** **1)Immediate actions taken for those residents identified:** 1. Resident D's shirt was changed, and resident was checked for incontinence, by the DON at the time of identification. Resident D was shaved, and oral care performed as requested by resident at the time of survey. 2. Resident F was provided with incontinent care and necessary linen changes at the time of identification.	01/14/2022

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	check on another resident and then he would change the resident's shirt. At 1:56 p.m., the resident remained in the hall in his geri chair. He was still wearing the food stained shirt. At 3:34 p.m., a CNA was observed taking the resident into the shower room. The CNA was informed the resident was a bed bath and not a shower. She then positioned the resident across from the nurses' station in his geri chair. At 4:11 p.m., the resident was taken to his room by the Director of Nursing (DON) and she changed his shirt. At 4:21 p.m., the DON took the resident back out into the hallway until RN 1 indicated she needed him for his medications. The resident was in constant view from 1:56 p.m. until 4:21 p.m. He was not checked for incontinence during that time frame. On 12/15/21 at 10:35 a.m., the resident was observed in his geri chair in the hallway. At 10:52 a.m., QMA 1 took the resident to his room and fed him some ice cream. At 11:05 a.m., the resident was in his room in his geri chair watching television. At 12:17 p.m., the resident remained in his room watching television. His lunch tray was covered and located on the table next to the television. At 12:27 p.m., CNA 3 entered the resident's room to feed him lunch. On 12/16/21 at 9:57 a.m., CNAs 1 and 2 entered the resident's room to provide morning care. CNA 2 wiped the resident's face and she indicated that he needed a shave. When asked if he would like to be shaved, the resident indicated yes. After wiping the resident's face, the CNA washed the resident's arm pits, she changed the water and her gloves, and then proceeded to provide incontinence care. After discarding the water and changing her gloves, both CNAs put the resident's pants on and he was repositioned in		**2) How the facility identified other residents:** All residents currently residing in the facility have the potential to be affected. Thus, this plan of correction applies to all residents. **3) Measures put into place/ System changes:** Nursing staff will be educated on ADL Care Provided for Dependent Residents, including but not limited to, timely ADL care (incontinent care, dressing, eating, grooming, and oral care) and following the care plan for residents per resident Kardex. The wound nurse will be educated to perform ADLs as necessary and not leave resident with task undone. **4) How the corrective actions will be monitored:** DON, or designee, will conduct random visual observations of at least 7 residents per week, to ensure appropriate resident care has been provided, for 4 weeks and then random visual observations of at least 5 residents weekly for 8 weeks to ensure continued compliance is achieved. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make	

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	bed. CNA 2 then gathered her supplies and indicated she was done. The resident was not shaved and oral care was not provided. The record for Resident D was reviewed on 12/14/21 at 2:12 p.m. Diagnoses included, but were not limited to, Parkinson's, dementia without behavior disturbance, dysphagia (difficulty swallowing), and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/21, indicated the resident was cognitively impaired for daily decision making and was extensive assistance for transfers, dressing, eating, toilet use, and personal hygiene. The resident was always incontinent of urine and bowel. The Care Plan, dated 7/21/21 and reviewed 10/27/21, indicated the resident had an ADL self care performance deficit related to weakness and impaired mobility. The resident required staff assistance for bed mobility, eating, toileting, and transferring. Interventions included, but were not limited to, provide sponge bath when a full bath or shower can't be tolerated and the resident was totally dependent on 1 staff for eating. The Care Plan, dated 11/7/21, indicated the resident had bowel and bladder incontinence related to cognitive impairment, immobility, and Irritable Bowel Syndrome. Interventions included, but were not limited to, check resident every two hours and assist with toileting as needed. Interview with the Director of Nursing on 12/16/21 at 2:30 p.m., indicated the resident's shirt should have been changed in a more timely manner as well as checking him for incontinence.		recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 14, 2022**	

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	She also indicated oral care should have been provided and the resident shaved during AM care and a full bed bath provided. Interview at 6:10 p.m., indicated the resident should have been assisted with his meal in a more timely manner. 2. On 12/16/21 at 9:15 a.m., Resident F was observed in bed eating breakfast. He was dressed in a hospital gown and had an AFO (Ankle Foot Orthosis) boot noted to his left leg. There was nothing on his right leg or foot. On 12/16/21 at 9:45 a.m., the resident's treatment was observed with Wound Nurse 1. At the end of the treatment, the resident indicated his top sheet was wet. The Wound Nurse removed the sheet and asked him what had happened. He was not able to say what happened. The pad underneath the resident was slightly wet as well and she told the resident she was going to tell the CNA so they could change him and get him up. The Wound Nurse did not check or change the resident for incontinence at that time. On 12/16/21 at 11:07 a.m., Agency CNA 1 entered the resident's room to provide morning care and get him out of bed. She indicated at that time, she had started her shift at 6:00 a.m. that morning. She started to get residents up for breakfast and was working closely with CNA 1. The resident was not technically hers, but they were working together. At 11:25 a.m., the CNA removed the resident's incontinent brief which was heavily saturated with urine. When she rolled the resident onto to his left side the pad underneath him was saturated with urine and had dried yellow stains of urine noted. Interview with Agency CNA 1 at that time, indicated she did not check or change the resident at all since she had started work. She			

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	delivered his breakfast tray to him around 8:00 a.m. Interview with CNA 1 on 12/16/21 at 11:47 a.m., indicated she started her shift at 6:00 a.m. today. When she got to work, she started getting those residents up who needed to be up for breakfast, and whatever residents were not up she would get to after breakfast. CNA 1 indicated she going to take care of Resident F right after breakfast, however, the Wound Nurse needed to do his treatment. She was going in after that, but the nurse needed to change his IV bandage. She had not checked or changed the resident at all that morning. She stated, "To be honest I did not even know he was incontinent." The record for Resident F was reviewed on 12/15/21 at 10:45 a.m. Diagnoses included, but were not limited to, sepsis, non pressure chronic ulcer of the left lower leg, cellulitis of the left lower leg, type 2 diabetes, anemia, peripheral vascular disease, osteoarthritis, high blood pressure, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/25/21, indicated the resident was moderately impaired for decision making and needed extensive with 1 person physical assist for bed mobility, transfers, personal hygiene, and toilet use. The resident had no pain during the assessment. The Care Plan, revised on 11/4/21, indicated the resident had an Urinary Tract Infection. The approaches were to check at least every 2 hours for incontinence. A Care Plan, revised on 11/4/21, indicated the resident had bowel and bladder incontinence.			

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	The approaches were to check and change every 2 to 3 hours and as needed. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the resident should have been checked and/or changed since the start of the CNA's shift. This Federal tag relates to Complaints IN00366107, IN00367385, IN00367406, IN00367635, IN00367924, and IN00368643. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D)			
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 ensure treatments to skin tears were completed as ordered and a red raised area was assessed and monitored. The facility also failed to ensure pressure relieving devices were on the correct foot and dry scaly skin on the feet was treated for 3 of 3 residents reviewed for skin conditions (non-pressure related). (Residents D, F, and J) Findings include:	F 0684	**The facility requests desk review for this citation.** **1) Immediate actions taken for those residents identified:** 1. Resident D's dressing was changed and applied per physician's order. 2. Resident J received the antibiotic per physician order. As stated on page 5 of the 2567, resident's physician was aware of	01/14/2022

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	1. On 12/14/21 at 11:42 a.m., Resident D was observed seated in his geri chair recliner in the hallway. An adhesive dressing to the top of his left hand was dated 12/13/21. At 12:19 p.m., 1:56 p.m., 3:34 p.m., 4:11 p.m., and 4:21 p.m., the dressing dated 12/13/21 was observed on the resident's left hand. On 12/15/21 at 9:21 a.m., 10:35 a.m., 11:05 a.m., and 1:25 p.m., the adhesive dressing was observed on top of the resident's left hand. The dressing was dated 12/13/21. On 12/16/21 at 9:26 a.m., the resident was observed in his room in bed sleeping. A gauze dressing dated 12/15/21 was observed on the top of his left hand. The dressing was loose and lifting up in sections. At 9:57 a.m., CNAs 1 and 2 entered the room to provide morning care. CNA 1 indicated she would tell the Nurse about the resident's loose dressing. At 10:15 a.m., CNA 1 informed LPN 1 about the loose dressing to the resident's left hand. At 12:22 p.m., the resident was observed in his bed being fed lunch. There was no dressing on his left hand. The record for Resident D was reviewed on 12/14/21 at 2:12 p.m. Diagnoses included, but were not limited to, Parkinson's, dementia without behavior disturbance, dysphagia (difficulty swallowing), and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/21, indicated the resident was cognitively impaired for daily decision making and was extensive assistance for bed mobility and transfers. Nurses' Notes, dated 12/13/21 at 4:20 p.m., indicated notified per nursing of skin tear to		the allergy, and at the time chose to continue the medication. 3. Resident F had the appropriate device(s) placed at the time of survey. **2)How the facility identified other residents:** All residents currently residing in the facility have the potential to be affected. Thus, this plan of correction applies to all residents. **3)Measures put into place/ System changes:** Licensed staff will be educated relative to Quality of Care, including but not limited to, ensuring treatments/dressings are applied according to physician orders, ensuring changes of condition are followed up on with the physician, and notifying physician of resident allergies when obtaining new medication orders. **4) How the corrective actions will be monitored:** DON, or designee, daily, on scheduled days of work, during clinical meeting, will review the EMR dashboard to identify any changes of condition, treatments not administered, and new medication orders (to ensure resident is not allergic) to ensure physician/family notifications have been made, as necessary. These reviews will continue daily, on scheduled days of work, for 30 days, or until continued	

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	155156	A. BUILDING 00 B. WING	12/16/2021

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	resident's hand. Assessed left back of hand, noted skin tear with steri strips in place. No signs or symptoms of infection, scant amount of bleeding noted. The area was covered with a dry dressing, to be changed daily and as needed (prn). The Wound assessment, dated 12/13/21, indicated the skin tear to the resident's left hand measured 1.4 centimeters (cm) x 0.7 cm. A Physician's Order, dated 12/13/21, indicated the resident's left hand was to be cleansed with normal saline, patted dry, and a dry dressing was to be applied daily and prn each day shift for a skin tear. The December 2021 Treatment Administration Record (TAR), indicated the treatment to the resident's left hand was signed out as being completed on 12/14/21. Interview with the Director of Nursing on 12/16/21 at 2:30 p.m., indicated the treatment to the resident's left hand should have been completed as ordered. 2. The record for Resident J was reviewed on 12/15/21 at 2:45 p.m. The resident was admitted on 10/22/21. Diagnoses included, but were not limited to, Parkinson's Disease, anxiety, osteoporosis, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 10/29/21, indicated the resident was cognitively intact. An entry by Wound Nurse 1 in Nurses' Notes, dated 12/7/21 at 2:43 p.m., indicated "notified per nursing of lump to resident's back. Assessed area, noted firm bump to right lateral back, with redness to bottom right and swelling. No		compliance has been achieved. Thereafter, these reviews will continue daily, on scheduled days of work, ongoing, during clinical meetings. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 14, 2022**	

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drainage or complaints of pain to area. Area covered with foam dressing. NP [Nurse Practitioner] notified. Responsible party notified. See wound rounds for assessment."

The next documented note was on 12/9/21 at 1:08 p.m. which indicated an antibiotic was ordered for the resident related to the area on their back, however, the antibiotic ordered was identified as a possible drug allergy for the resident. The resident was allergic to Penicillin.

A Physician Progress Note completed by the NP, dated 12/9/21 at 7:43 p.m., indicated the resident was being seen today by the request of the wound care nurse for a raised, reddened area to the lateral right side of the resident's back. They first noticed it two days prior. The resident was not able to say when it appeared.

There was no follow up assessment or documentation of the red and raised area to the resident's back.

Physician's Orders, dated 12/10/21, indicated Cephalexin Capsule (an antibiotic) 250 milligrams (mg) give 250 mg by mouth every 6 hours for skin abscess for 7 days, ok to give doctor aware of allergy.

Nurses' Notes, dated 12/10/21 at 4:01 p.m., indicated a consult for the wound doctor to evaluate and treat the right lateral back abscess was obtained.

Nurses' Notes, dated 12/13/21 at 11:49 a.m., indicated the wound doctor assessed the area to the resident's back. The right lateral back hematoma measured 4.5 centimeters (cm) by 6.5 cm with 100% epithelial tissue. Further tests

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	needed to be performed to rule out an abscess. Physician's Orders, dated 12/14/21, indicated an ultrasound of the right lateral back abscess. Interview with Wound Nurse 1 on 12/16/21 at 10:15 a.m., indicated she was informed by nursing staff on the unit the resident had a red and swollen area to her back. She assessed the area and texted the Nurse Practitioner. She worked every other day and Wound Nurse 2 worked the opposite days. They would leave notes for each other to follow up on new areas of concern. Wound Nurse 2, or the nurses on the unit did not follow up with any assessments or treatments until the NP saw the resident on 12/9/21 and an antibiotic was started. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated there was no follow up assessment or treatments obtained for the area for 2 days after it was discovered. 3. On 12/15/21 at 2:30 p.m., Resident F was observed seated in his wheelchair in his room with his head low and eyes closed. At that time, he had a pressure relieving boot noted on his right foot and only a sock on his left foot. On 12/16/21 at 9:15 a.m., the resident was observed in bed eating breakfast. He was dressed in a hospital gown and had an AFO (Ankle Foot Orthosis) boot noted to his left leg. There was nothing on his right leg or foot. On 12/16/21 at 9:45 a.m., the resident's treatment was observed with Wound Nurse 1. The resident was observed in bed and wearing the AFO boot to the left leg and nothing was observed on the right leg/foot. After the Wound			

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	Nurse removed the bandages to the left leg and foot, the resident's feet were noted to be very dry with scaly and flaking skin. The resident had 2 open wounds to his left lower anterior lateral leg. The Wound Nurse described the areas as chronic arterial/vascular wounds. After the treatment was completed, she was asked to remove the resident's sock to the right foot. His right foot was observed with extremely dry, scaly and flaky skin on and in between his toes as well. Interview with the Wound Nurse at that time, indicated the AFO boot was only to be on the resident's left leg when he was up in the wheelchair. The pressure relieving boots were to be on him when he was in bed. She placed the left pressure relieving boot on his leg, however, she did not put the boot on the right leg. She was unsure if the resident had any medicated cream for his dry feet. The record for Resident F was reviewed on 12/15/21 at 10:45 a.m. Diagnoses included, but were not limited to, sepsis, non pressure chronic ulcer of the left lower leg, cellulitis of the left lower leg, type 2 diabetes, anemia, peripheral vascular disease, osteoarthritis, high blood pressure, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/25/21, indicated the resident was moderately impaired for decision making and needed extensive with 1 person physical assist for bed mobility, transfers, personal hygiene, and toilet use. The resident had no pain during the assessment. The Care Plan, updated 11/4/21, indicated the resident had peripheral vascular disease. The approaches were to keep toenails cut and inspect			

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	feet daily. CNAs and LPN to keep skin on extremities well hydrated with lotion in order to prevent dry skin and cracking of the skin. A Care Plan, updated on 11/22/21, indicated the resident had an arterial/ischemic ulcer of the left medial lower leg and left dorsal foot related to peripheral vascular disease. The approaches were to don the AFO to the left lower leg while up and soft boots while in bed and keep the feet clean and dry. Physician's Orders, dated 12/10/21, indicated AFO boot or soft boot to left lower leg while up in chair and may remove for hygiene. Pressure relieving boots while in bed and may remove for hygiene. Interview with LPN 1 on 12/16/21 at 11:44 a.m., indicated the resident's feet were very dry with scaly skin. There were no Physician's Orders for the type of cream or ointment ordered for his feet. The CNAs had no care cards or care sheets for information about each resident. She indicated the resident was to have on his pressure relieving boots in bed and the AFO boot when up in the wheelchair. There were many Agency CNAs working all the shifts and better communication was needed. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the boots were to be on as ordered by the Physician and there should have been something ordered for the resident's dry skin. This Federal tag relates to Complaints IN00367385, IN00367406, and IN00368643. 3.1-37(a)			

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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident was free from pain related to throat and mouth pain for 1 of 3 residents reviewed for pain. (Resident F) Finding includes: The record for Resident F was reviewed on 12/15/21 at 10:45 a.m. Diagnoses included, but were not limited to, sepsis, non pressure chronic ulcer of the left lower leg, cellulitis of the left lower leg, type 2 diabetes, anemia, peripheral vascular disease, osteoarthritis, high blood pressure, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/25/21, indicated the resident was moderately impaired for decision making and needed extensive with 1 person physical assist for bed mobility, transfers, personal hygiene, and toilet use. The resident had no pain during the assessment. A pain assessment, dated 11/8/21, indicated the resident had osteoarthritis and had Tylenol for pain. A Care Plan, revised on 11/4/21, indicated the resident had pain related to an ischemic wound to the left lower leg, osteoarthritis, cervical stenosis and peripheral vascular disease. The	F 0697	**The facility requests desk review for this citation.** **1) Immediate actions taken for those residents identified:** Resident F no longer resides at this facility so no further corrective action could be taken for this resident. **2) How the facility identified other residents:** This plan of correction applies to all residents with orders for PRN analgesic medication. **3)Measures put into place/ System changes:** Licensed staff will be educated relative to Pain Management, including but not limited to, assessing residents for presence/absence of pain, and administering pain medication as necessary. **4) How the corrective actions will be monitored:**	01/14/2022

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	approaches were to administer analgesia as per orders. Nurses' Notes, dated 11/28/21 at 1:49 p.m., indicated the writer observed the resident not eating well and when asked, he complained of a sore throat. The resident was observed with numerous white patches to his cheeks and throat. The Nurse Practitioner (NP) was called and notified and a new order for Nystatin (an antifungal) swish and swallow was ordered for thrush. The next documented Nursing Note was by the NP on 11/29/21 at 7:27 p.m., which indicated she assessed the resident for thrush. Physician's Orders, dated 5/17/21, indicated Acetaminophen 325 milligrams (mg) give 2 tabs every 6 hours as needed (prn) pain. Pain assessment every shift. The Medication Administration Record (MAR) for the month of 11/2021, indicated on 11/27/21 for the evening shift the pain assessment was blank. On 11/27/21 for the midnight shift the resident had a pain level of a 4 out of 10. The pain assessment for 11/28/21 for all 3 shifts was a score of "0". The medication of Acetaminophen was not signed out for the entire month of 11/2021. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated if the resident had something ordered for pain, then it should have been administered for any complaints of pain. This Federal tag relates to Complaint IN00368643.		DON, or designee, daily, on scheduled days of work, during clinical meeting, will review pain assessments completed to ensure pain medication was administered as ordered. Any identified concerns will be promptly addressed with the responsible individual(s). These reviews will continue daily, on scheduled days of work, for 30 days, or until continued compliance has been achieved. Thereafter, these reviews will continue at least weekly, ongoing, during clinical meetings. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 14, 2022**	

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	3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to provide the necessary care and services for a resident who received hemodialysis related to not having Physician's orders for the resident to receive dialysis and not assessing and monitoring the resident's dialysis access site for 1 of 1 residents reviewed for dialysis. (Resident K) Finding includes: Resident K's record was reviewed on 12/16/21 at 4:15 p.m. Diagnoses included, but were not limited to, chronic kidney disease, renal failure, and dependence on renal dialysis. The resident was admitted to the facility on 11/12/21. The Admission Minimum Data Set (MD'S) assessment, dated 11/19/21, indicated the resident was cognitively intact for daily decision making and she was receiving dialysis. The Care Plan, dated 11/16/21, indicated the resident received hemodialysis 3 times a week for end stage renal failure (ESRD). Interventions included, but were not limited to, check bruit (a swishing sound) and thrill (gentle vibration) every shift and record.	F 0698	**1) Immediate actions taken for those residents identified:** Resident K had appropriate orders received for Dialysis, and for monitoring of Dialysis site. **2) How the facility identified other residents:** All residents currently receiving Hemodialysis have the potential to be affected. Thus, this plan of correction applies to all residents receiving Hemodialysis. **3)Measures put into place/ System changes:** Licensed nursing staff will be educated relative to Dialysis, including but not limited to obtaining physician orders for resident to receive dialysis, obtaining physician orders to assess and monitor dialysis access sites, and proper assessment and monitoring of	01/14/2022

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	The December 2021 Physician's Order Summary (POS), indicated there were no orders for dialysis and there were no orders to monitor the resident's dialysis access site. There was also no documentation indicating what type of access site the resident had. Nurses' Notes, dated 11/17/21 at 6:47 p.m., indicated the resident's skin was assessed, she had a nonfunctional left upper arm fistula and a permacath to the right chest (dialysis access sites). Nurses' Notes, dated 11/19/21 at 3:40 p.m., indicated the dialysis center had called the facility concerning the resident's port not functioning properly. Dialysis put in an order to schedule an appointment for replacement. Interview with LPN 1 on 12/15/21 at 9:30 a.m., indicated the resident had dialysis on Monday, Wednesday, and Friday. To her knowledge, the resident had not missed any dialysis appointments since being admitted. Interview with RN 1 on 12/16/21 at 5:11 p.m., indicated she was unaware where the resident went to receive dialysis. She also indicated there was no binder for communicating with the dialysis center. Interview with the Director of Nursing on 12/16/21 at 5:25 p.m., indicated there should have been a Physician's order for the resident to receive dialysis and to monitor the resident's dialysis access site. This Federal tag relates to Complaint IN00368979.		dialysis access sites. **4) How the corrective actions will be monitored:** DON, or designee, daily, on scheduled days of work, during clinical meeting, will review physician orders of those residents receiving Hemodialysis to ensure orders for Dialysis and assessing/monitoring Dialysis access sites are in place. Any identified concerns will be promptly addressed with the responsible individual(s). These reviews will continue daily, on scheduled days of work, for six (6) weeks, or until continued compliance has been achieved. Thereafter, these reviews will continue at least weekly, ongoing, during clinical meetings. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 14, 2022**	

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	3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

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	Based on record review and interview, the facility failed to ensure medications were obtained timely from the pharmacy related to admission and readmission medications for 2 of 3 residents reviewed for medications. (Residents L and M) Findings include: 1. The closed record for Resident L was reviewed on 12/15/21 at 2:11 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes, and high blood pressure. The resident was admitted to the facility on 11/19/21. There was no admission assessment or admission nursing progress note indicating what time the resident arrived at the facility. The November 2021 Medication Administration Record (MAR) indicated the resident did not receive the following medications on 11/20/21 upon rising and/or 7:00 a.m. as scheduled: - Amiodarone HCl (a medication used to treat an irregular heartbeat) 200 milligrams (mg) - Cymbalta HCl (an antidepressant) 60 mg - Prednisone (a steroid) 20 mg - Spironolactone (a diuretic) 25 mg - Allopurinol (a medication for gout) 100 mg - Bumetanide (a diuretic) 1 mg - Coreg (a blood pressure medication) 6.25 mg - Entresto (a blood pressure medication) 24-26 mg - Senexon-S (a medication to treat constipation) 8.6-50 mg - Gabapentin (a medication to treat nerve pain) 300 mg - Midodrine HCl (a blood pressure medication) 10 mg	F 0755	**The facility requests desk review for this citation** **1) Immediate actions taken for those residents identified:** 1. Resident L no longer resides at this facility; therefore, no further corrective action could be taken for this resident. 2. Resident M finished medication as ordered after missed doses on 12/12/21 and 12/13/21. Physician was notified of the missed doses. **2) How the facility identified other residents:** DON, or designee, will audit the charts of admissions for the past thirty (30) days to ensure medications were delivered timely. **3)Measures put into place/ System changes:** Licensed staff will be educated relative to Pharmacy Services/Procedures/Pharmacist/ Records, including but not limited to, medications available in the EDK and procedure for obtaining them. **4) How the corrective actions will be monitored:** DON, or designee, daily, on	01/14/2022

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	155156	A. BUILDING 00 B. WING	12/16/2021

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	Nurses' Notes, dated 11/20/21 at 1:25 p.m., indicated the above medications were waiting to be delivered from the pharmacy. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the pharmacy delivered to the facility once a shift and the resident should have received his medications in a more timely manner. 2. The record for Resident M was reviewed on 12/15/21 at 3:01 p.m. Diagnoses included, but were not limited to, urinary tract infection and neurogenic bladder. The resident was readmitted to the facility on 12/12/21. The Quarterly Minimum Data Set (MDS) assessment, dated 10/21/21, indicated the resident was cognitively impaired for daily decision making, had an indwelling foley catheter and had received antibiotics during the assessment reference period. A Physician's Order, dated 12/12/21, indicated the resident was to receive Amoxicillin-Pot Clavulanate (an antibiotic) Tablet 500-125 milligrams (mg). Give 1 tablet by mouth three times a day related to urinary tract infection. The December 2021 Medication Administration Record (MAR), indicated the resident did not receive his Amoxicillin on 12/12 at 10:00 p.m. and on 12/13/21 at 6:00 a.m. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the medication was available in the EDK (Emergency Drug Kit) and the medication should have been given.		scheduled days of work, during clinical meeting, will audit new admission charts to ensure medications have been received timely. Any identified concerns will be promptly addressed with the responsible individual(s). These reviews will continue daily, on scheduled days of work, for 30 days, or until continued compliance has been achieved. Thereafter, these reviews will continue at least weekly, ongoing, during clinical meetings. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: January 14, 2022**	

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	This Federal tag relates to Complaint IN00369014. 3.1-25(a)			
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 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			

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	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. 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, record review, and interview, the facility failed to ensure infection control guidelines were in place and	F 0880	**F 880 Infection Prevention and Control** **The facility requests desk**	01/14/2022

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	implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed before and after glove removal for 3 of 3 observations of staff testing and incomplete monthly infection control logs for random observations for infection control. Findings include: 1. On 12/14/21 at 10:09 a.m., Lab Tech 1 was observed testing facility staff for COVID-19. The Lab Tech was wearing a face shield and a KN95 mask. She was not wearing a gown over her clothing. The Lab Tech donned a pair of gloves and inserted a nasal swab into the staff member's nares. She removed her gloves when she was done. She did not hand sanitize before or after she removed her gloves. Another staff member entered the testing area. The Lab Tech donned a pair of gloves and proceeded to test the staff member. She removed her gloves when she was done. Again, she did not hand sanitize before or after she removed her gloves. A third staff member entered the area to be tested, the Lab Tech donned a pair of clean gloves without hand sanitizing prior. She tested the staff member and then removed her gloves. She did not perform hand hygiene when she was done. Interview with the Lab Tech at that time, indicated she was out of hand sanitizer and she needed to get more out of the crate she brought with her. After looking in the crate, the Lab Tech indicated she didn't have any extra hand sanitizer and she would have to ask the facility for more. Interview with the Director of Nursing on 12/16/21 at 2:00 p.m., indicated the lab tech should have been wearing a gown and should have performed hand hygiene before and after glove		**review for this citation** **1) Immediate actions taken for those residents identified:** 1. Lab Tech was addressed at the time of the survey. No residents were adversely affected by this practice. 2. The Infection Preventionist was addressed at the time of survey. No residents were adversely affected by this practice. 3. LPN #1 was addressed at the time of survey. No resident was adversely affected by this practice. 4. CNA #1 was addressed at the time of survey. No resident was adversely affected by this practice. **2) How the facility identified other residents:** All residents currently residing in the facility have the potential to be affected. Thus, this plan of correction applies to all residents. The facility infection control self-assessment will be reviewed to ensure accuracy and will be revised, as necessary. **3) Measures put into place/system changes:** Root Cause Analyses (RCA) were conducted. As a result of the RCA, facility staff will be educated relative to infection control	

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	use. A restroom was located across the hall from the testing area for handwashing and the lab tech should have asked facility staff for more hand sanitizer as soon as she ran out. The updated 7/8/21 CDC guidance for "Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing," indicated "For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown." 2. The Infection Control binder was reviewed on 12/16/21 at 2:30 p.m. For the months of September, October and November 2021, the binder contained pharmacy and laboratory reports. The monthly logs were incomplete as well as the mapping data and the monthly infection rate. There was no way to determine how patterns and trends were being monitored. Interview with the Infection Preventionist on 12/16/21 at 3:30 p.m., indicated she had the data but the sheets had not been completed. 3. During a random observation on 12/16/21 at 10:28 a.m., LPN 1 was observed to don a clean isolation gown and a pair of clean gloves to both hands. No hand hygiene was performed. She proceeded to walk into a resident's room who was in contact isolation for a wound infection. She was then observed to change the resident's PICC (peripherally inserted central catheter - IV access) line bandage. Interview with LPN 1 on 12/16/21 at 10:38 a.m.,		guidelines, including but not limited to, COVID transmission, infection control measures to be implemented during COVID testing, and proper hand hygiene technique and when to perform hand hygiene by 1/14/22. Additionally, as a result of the RCA, the facility Infection Preventionist (IP) will be re-educated relative to monthly infection control responsibilities, including but not limited to, updating the monthly infection logs, mapping of infectious processes, and calculating monthly infection rates by 1/14/22. **4) How the corrective actions will be monitored:** The IP nurse/DON/designee will complete random visual rounds daily, on scheduled days of work, for 6 weeks, and until continued compliance is maintained, to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, infection control measures utilized during COVID testing and proper performance of hand hygiene, at the proper times. The DON/designee will conduct weekly audits, for 6 weeks, of the IP's records to ensure timely documentation, or until continued compliance is maintained with updating of infection logs, mapping infectious processes,	

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	indicated she performed hand hygiene at her medication cart which was at the nurses' station prior to walking over to the room. She did not perform hand hygiene before donning gloves. 4. On 12/16/21 at 11:07 a.m., Agency CNA 1 donned an isolation gown and clean gloves to both hands without performing hand hygiene. She walked into the resident's room, who was in contact isolation for a wound infection. She was unable to find any clothes for the resident, so she removed all of the personal protective equipment (PPE) and left the room. She did not perform hand hygiene. She walked down the hallway to the nursing station and proceeded to touch the counter and then walked down the hall to the resident's other room and picked up some clothing for him. She walked back to where the resident was and donned the PPE once again and did not perform hand hygiene. Interview with the Infection Preventionist on 12/16/21 at 2:00 p.m., indicated hand hygiene was to be performed before and after glove use. The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "Hand hygiene [use of alcohol-based hand rub (ABHR) is preferred]: · Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. ABHR >60% are preferred unless hands are visibly soiled or when handwashing is advocated by CDC guidance." This Federal tag relates to Complaint IN00367635. 3.1-18(b)		and calculation of infection rates. Once continued compliance is achieved, the DON/designee will conduct monthly audits, ongoing, of the IP's records to ensure logs are updated timely, infectious processes are mapped, and monthly infection rates are calculated. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months, or until 100% compliance is achieved for 3 consecutive months. The QA Committee will review, update, and make changes, as necessary, to this plan of correction to ensure substantial compliance for no less than 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months.	

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