DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 1, 2, 3, 6, 7, and 8, 2023. Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 83 SNF: 12 Residential: 26 Total: 121 Census Payor Type: Medicare: 27 Medicaid: 55 Other: 13 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2023	F 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Ross	RN/HFA	03/29/2023

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	Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 2 of 3 residents reviewed for accommodation of needs. (Residents 37 and 243) Findings include: 1. On 3/1/2023 at 12:32 p.m., Resident 37's call light was observed out of her reach on her bed, as she sat in a recliner at the foot of her bed, about 4 feet from the call light. Resident 37 said she doesn't know why it wasn't put where she can reach it today. During an observation, on 3/1/23 at 2:29 p.m., Resident 37's call light was lying on her bed, about 4 feet out of her reach. On 3/1/2023 at 2:31 p.m., CNA 1 was questioned about the call light, and she went in and placed Resident 37's call light where she could reach it. CNA 1 the nurses had just changed shifts, she had to assist a resident, had 2 others wanting her and she isn't on this unit very often. Resident 37's record was reviewed on 03/03/2023 at 2:07 p.m. and had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, weakness, left hand contracture, unsteady on feet, gait and mobility abnormalities, rheumatoid arthritis, and dementia. An Annual Minimum Data Set assessment, dated 12/13/2022, indicated Resident 37 was cognitively intact, was understood and understands others. A care plan, last reviewed and revised on 12/4/2022, indicated a problem for: "Resident is unable to independently perform late loss ADLs	F 0558	**F558 Reasonable Accommodations Needs/ Preferences CFR(s): 483.10 (e) 3)** **I. Call lights were placed within reach for resident 37 and 243.** **II. All residents that use call lights have the potential to be affected by the alleged deficient practice.** **III. Education will be provided to all staff related to placing call lights within reach of a resident. The systemic change includes the charge nurse will be responsible to ensure the call lights are in place and accessible for all residents when they are in their bed or chair.** **IV. The DON/Designee will randomly audit 5 residents to ensure call lights are in reach of the resident. This will occur 7 days per week on all shifts for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 4/7/2023**	04/07/2023

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(activities of daily living) dementia and weakness; requires mostly extensive assistance of one, at times needs 2 staff for bed mobility, transfers, toileting and independent, with set up help, for eating. Long Term Goal Target Date: 04/09/2023. Goal: Resident will experience no declines in level of participation of late loss ADLs...5/09/2018: Keep call light within reach...."

A care plan, last reviewed and revised on 12/14/2022, indicated: "Resident has been evaluated by PT (Physical Therapy) and has been determined to be a RED SHOE: resident is unsafe to walk independently and should only be walked with staff assistance." Goal date: 4/9/2023. Interventions included, but were not limited to, "Keep call light in reach at all times", dated 12/29/2021.
2. The clinical record for Resident 243 was reviewed on 3/7/2023 at 11:53 a.m. The medical diagnosis included dementia.

A care plan, dated 12/31/2018, indicated for resident to have her call light kept within reach.

An Quarterly Minimum Data Set Assessment, dated 2/16/2023, indicated Resident 243 needed extensive assistance with activities of daily living.

An interview and observation on 3/1/2023 at 01:44 p.m., indicated resident 243 laying in bed at this time with her call light hanging off the top of the bed, out of her reach. Resident indicated she could not reach it. She stated she often doesn't have it, but she'll have her roommate turn it on for her.

An observation on 3/1/2023 at 2:35 p.m., indicated Resident 243 was still in bed with her call light over the top of the bed. She again indicated she

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	could not reach it. A policy entitled "Answering the Call Light", was provided by the Director of Nursing on 3/7/2023 at 9:30 a.m. The policy indicated, "...When the resident is in bed or confided to a chair be sure the call light is within each reach of the resident..." 3.1-3(v)(1)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview and record review the facility failed to accurately code a Minimum Data Set (MDS) assessment for dental and status and restraint use for 3 of 32 residents reviewed for MDS assessments (Resident 55, Resident 35 and Resident 8). Findings include: 1. During an interview with Resident 55 on 3/01/2023 at 11:54 a.m., indicated she walked with a walker and did not have anything that restricted her movement. The resident indicated she was able to get out of her recliner with no difficulties. The resident indicated she had never had anything constricting her movement that she would consider a restraint. The Quarterly Minimum Data Set (MDS) assessment for Resident 55, dated 1/7/2023, indicated the resident was cognitively intact for daily decision making. The resident had a restraint of bed rails that were used daily. During an interview with the MDS Coordinator on	F 0641	**F641 Accuracy of Assessments CFR(s): 483.20(g)** **I. Resident 55 has never had a restraint. Her MDS was modified to reflect the change. Resident 35 has had a new dental assessment and her MDs has been modified.** **Resident 8 has had a new dental assessment and her MDS has been modified. She has a care plan in place for her dentures.** **II. All residents have the potential to be affected by the alleged deficient practice. All residents have had their dental status reassessed and any identified issues have been corrected. Any identified issues have had a modification to the MDS.** **No other residents have**	04/07/2023

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	3/07/2023 at 12:39 p.m., indicated Resident 55 had never had a restraint and the Quarterly MDS for Resident 55, dated 1/7/23, was marked incorrectly for Restraint use. 2. During an interview and observation on 3/02/2023 at 10:53 a.m., Resident 35 was missing upper left teeth broke. The resident indicated she had not seen a dentist and her teeth were in bad shape. The resident indicated she would like to see a dentist. The Admission Minimum Data (MDS) assessment for Resident 35, dated 9/10/2022, indicated the resident was cognitively intact for daily decision making. The resident's oral status was not marked for obvious or likely cavity or broken natural teeth. During an interview on 3/03/2023 at 1:20 p.m., the Minimum Data Set (MDS) Coordinator indicated the resident's MDS assessment did not capture Resident 35's broken/missing teeth was because when the admission assessment was completed on 9/6/22 it was marked there were no dental problems. During an interview with the Director Of Nursing (DON) on 3/3/2023 at 1:55 p.m., indicated she talked to Resident 35's daughter and her broken teeth are from at least eight years ago. 3. The clinical record of Resident 8 was reviewed on 3/3/2023 at 11:43 a.m. The diagnoses included, but were not limited to, acute kidney failure, chronic respiratory failure with hypoxia, dysphagia, congestive heart failure, and chronic pain. An Admission MDS assessment, dated 9/20/2022,		**restraints coded on their MDS.** **III. Education has been provided the nursing staff on assessing dental status upon admission and with any significant change. Education has been provided to the MDS staff regarding coding dental status and restraint use correctly. The systemic change includes the nursing administration team will audit all new admissions to determine their dental assessment is completed correctly and the MDS is coded correctly for restraints and dental status.** **IV. The DON/Designee will review all new admissions to determine their dental assessments are accurate and the Admission MDS is coded correctly for dental status and restraint use. This will occur 5 days per week during morning clinical meeting for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary** **COMPLIANCE DATE: 4/7/2023**	

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	indicated Resident 8 had no concerns with her dental status. A Quarterly MDS assessment, dated 12/14/2022, indicated Resident 8 had no concerns with her dental status. An observation was conducted of Resident 8, on 3/1/2023 at 12:09 p.m., to where she did not have any upper teeth and indicated she had an upper denture. There were no care plans regarding Resident 8's dental status nor the use of dentures. An interview conducted with the MDS Coordinator, on 3/7/2023 at 3:35 p.m., indicated the facility codes the MDS assessments to the latest version of the MDS RAI (resident assessment instrument) Manual.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to complete an accurate dental assessment and failed to ensure a readmission assessment was completed fully and timely for 2 of 2 residents reviewed for quality of care (Resident 35 and resident 45).	F 0684	**F684 Quality of Care CFR(s): 483.25** **I. Resident 35 has had a new dental assessment. Her MDS has been modified. She has**	04/07/2023

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	Findings include: 1. During an interview and observation on 3/02/2023 at 10:53 a.m., Resident 35 was missing upper left teeth broke. The resident indicated she had not seen a dentist and her teeth were in bad shape. The resident indicated she would like to see a dentist. Review of the record of Resident 35 on 3/7/2023 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, asthma, pulmonary fibrosis, allergies and hypertension. The Admission assessment for Resident 35, dated 9/6/2022, indicated the resident did not have any obvious or likely cavity or broken teeth. The Admission Minimum Data (MDS) assessment for Resident 35, dated 9/10/2022, indicated the resident was cognitively intact for daily decision making. The resident's oral status was not marked for obvious or likely cavity or broken natural teeth. The care plan meeting for Resident 35, dated 12/13/2022, indicated the resident wished to receive all ancillary services. Resident wishes to receive all ancillary services. New consent form completed by the resident. The physician order for Resident 35, dated February 2023, indicated the resident may receive Podiatry/Optometry/Audiology/Dentistry Services as needed. During an interview with the Social Service Director (S.S.D.) on 3/3/2023 at 12:30 p.m., unable to find where Resident 35 had seen a dentist.		**enrolled in the Ancillary Dental Service and will be seen on their next visit to the facility. Resident 45 no longer resides in the facility.** **II. All new admissions have the potential to be affected by the alleged deficient practice. All residents have had their dental status reassessed and any identified issues have been corrected. Any identified issues have had a modification to the MDS.** **All new admissions within the past 30 days have been audited to determine their admission assessment was completed timely. Any identified issues have been corrected.** **III. Education has been provided the nursing staff on assessing dental status upon admission and with any significant change. Education has been provided to the MDS staff regarding coding dental status and restraint use correctly. Education has been provided regarding accurately completing the admission assessment timely. The systemic change includes the nursing administration team will audit all new admissions to determine their admission assessment is completed correctly/timely and the MDS is**	

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	During an interview on 3/03/2023 at 1:20 p.m., the Minimum Data Set (MDS) Coordinator indicated the resident's MDS assessment did not capture Resident 35's broken/missing teeth was because when the admission assessment that was completed on 9/6/2022 was marked there were no dental problems. During an observation and interview with Resident 35 on 3/3/2023 at 1:25 p.m., Resident 35 showed the MDS Coordinator her missing teeth, one on the upper right side and one on the right lower and two on the Right top. The resident indicated she broke them when she fell. The resident indicated it was hard for her to eat but staff were good to cut up her food. The resident indicated her teeth did not hurt her "they just hurt her spirit." During an interview with the DON on 3/3/2023 at 1:55 p.m., indicated she talked to Resident 35's daughter and her broken teeth were from at least eight years ago. During an interview with the Director Of Nursing (DON) on 3/7/2023 at 2:10 p.m., the facility did not have a policy related to the nursing admission assessment. The admission assessment completed on 9/6/2023 for Resident 35, if the nurse asked the resident if she had any pain or problems with her teeth and the resident denied she did, the DON would not expect the nurse to conduct a visual assessment. 2. The clinical record for Resident 45 was reviewed on 3/3/2023 at 12:41 p.m. The diagnoses included, but were not limited to, heart failure, pressure ulcer of sacral region, diabetes mellitus, and open wound, unspecified foot. Resident 45 was hospitalized from 2/21/2023 and returned to the facility on 2/24/2023.		**coded correctly for dental status.** **IV. The DON/Designee will review all new admissions to determine their admission assessments are accurate, completed timely and the Admission MDS is coded correctly for dental status. This will occur 5 days per week during morning clinical meeting for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary** **COMPLIANCE DATE: 4/7/2023**	

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	An assessment titled "Admission/Readmission Assessment", dated 2/24/2023, was initiated but was left blank when reviewed on 3/3/2023 at 12:41 p.m. This included a skin assessment that was left blank. An interview conducted with the Director of Nursing (DON), on 3/7/2023 at 10:08 a.m., indicated the readmission assessment was not completed until 3/3/23 because the nurse who had started the assessment on 2/24/2023 did not complete it until 3/3/2023. Resident 45 does not currently have any wounds. A policy titled "Pressure Ulcers/Skin Breakdown - Clinical Protocol", revised April 2007, was provided by the DON on 3/6/2023 at 11:15 a.m. The policy indicated the following, " ...Assessment and Recognition ...3. The physician and staff will examine the skin of a new admission for ulcerations or indications of a Stage I pressure area that has not yet ulcerated at the surface ...." 3.1-37(a)			
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 comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record	F 0695	**F695 Respiratory**	04/07/2023

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	review the facility failed to store oxygen nasal cannula and C- PAP mask in a bag for infection control purposes and failed to date oxygen tubing for 2 of 2 residents reviewed for respiratory care (Resident 55 and Resident 35). Findings include: 1. During an observation on 3/01/2023 at 11:55 a.m., Resident 55 Bipap mask was laying on bedside table not in a bag. Review of the record of Resident 55 on 3/7/2023 at 1:30 p.m., indicated the resident's diagnosis included, but were not limited to, congestive heart failure, allergic rhinitis, asthma, weakness, diabetes, anxiety and hypertension. The physician order for Resident 55, dated February 2023, indicated the resident was ordered Bipap/Cpap per home settings at bedtime. The plan of care for Resident 55, dated 3/2/2023, indicated the resident had asthma and required a Bipap, the resident was at risk for respiratory distress. The Quarterly Minimum Data Set (MDS) assessment for Resident 55, dated 1/7/2023, indicated the resident was cognitively intact for daily decision making. During an interview with the Director Of Nursing (DON) on 3/7/2023 at 2:14 p.m., yes it would the facilities expectation be that Bipap mask would be stored in a plastic bag for infection control purposes. 2. During an observation on 3/01/2023 at 12:02 p.m., Resident 35's oxygen tubing on portable or		**/Tracheostomy Care and Suctioning CFR(s): 483.25(i)** **I. Resident 55 BiPap mask has been bagged. Resident 35 oxygen tubing has been changed and a bag provided for storage. Her nebulizer mask has been changed and is bagged when not in use. Neither resident have had any new signs or symptoms of any infection.** **II. All residents with oxygen needs/equipment have the potential to be affected by the alleged deficient practice. All residents at risk have been reviewed to determine their oxygen supplies are in good repair , dated and stored in a bag when not in use.** **III. Education will be provided to all nursing staff regarding changing O2 equipment if it is solied, dating O2 equipment when it is placed and bagging equipment for infection control when not in use. The systemic change includes the charge nurse will be responsible to ensure O2 equipment is clean, dated and bagged when not in use.** **IV. The DON/Designee will**	

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	concentrator were not dated. The resident's portable oxygen tubing was laying in a chair, not in a bag. During an observation on 3/02/2023 at 10:57 a.m., Resident 35's nebulizer mask was not in a bag and was visibly dirty. The resident indicated there is a bag but staff do not always put the mask in the bag. The bag was on the table with a date of 3/1/2023. Review of the record of Resident 35 on 3/7/2023 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, asthma, pulmonary fibrosis, allergies and hypertension. The physician order for Resident 35, dated February 2023, indicated oxygen 2-4 liters/minute to maintain saturations greater than 90% continuous per nasal cannula. 3.1-47(6) .		**audit 5 random residents with Oxygen needs to ensure the supplies are clean, in good repair, dated and bagged if not in use. This will occur 7 days per week on all shifts for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 4/7/2023**	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to ensure individualized approaches to care for a resident with dementia by continuing with care for a resident exhibiting refusal of care for 1 of 5 residents reviewed for dementia care.	F 0744	**F744 Treatment/Service for dementia CFR(s): 483.40 (b)(3)** **I. The allegations Resident 19 made during the survey were investigated and reported to**	04/07/2023

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	(Resident 19) Findings include: The clinical record for Resident 19 was reviewed on 3/3/2023 at 2:11 p.m. The diagnoses included, but were not limited to, dementia with other behavioral disturbance, altered mental status, weakness, and pain. A Quarterly MDS (Minimum Data Set) assessment, dated 2/14/2023, indicated Resident 19 had moderate cognitive impairment. A Mini-Mental State Examination (MMSE), dated 3/1/2023, indicated Resident 19's score was documented as "moderate dementia". A care plan for memory impairment, edited 2/17/2023, indicated Resident 19 had a memory problem due to short term memory loss. The approach was listed to include, but not limited to, provide cues and supervision when needed, provide verbal reminders when needed, and structure daily programs around the physical aspects of the resident's life ((e.g., cognitive, exercise, ADLs (activities of daily living), eating, etc.)). An interview conducted with Resident 19, on 3/1/2023 at 2:31 p.m., indicated the evening staff from the previous day, 2/28/23, just "threw her in bed and took her clothes off". The allegation was reported to the Executive Director (ED) after the interview was conducted with Resident 19. An interview conducted with the Executive Director (ED), on 3/2/2023 at 12:30 p.m., indicated there were 3 Certified Nursing Assistants (CNAs) involved in putting Resident 19 to bed the		**The Indiana State Board of Health. She was assessed for pain or skin injuries with no findings for either. She was followed by social services and the nursing department for any changes in mood and behavior. She continued with normal activities, eating and sleeping habits. The staff involved were educated on approach and completed dementia training prior to returning to duty.** **II. All residents with dementia have the potential to be affected by the alleged deficient practice. There have been no other allegations of care concerns involving direct ADL care since the annual survey.** **III. Education will be provided to staff regarding dementia care in Relias. Education also includes reporting specific behaviors to the charge nurse and social services for follow up. The systemic change includes Dementia training on hire and annually for all staff.** **IV. The DON/Designee will review through the medical record any progress notes related to behaviors during care for follow up to include**	

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	evening of 2/28/2023. Resident 19 became combative, but the 3 CNAs proceeded to put her in bed. Education was provided to the staff members about approach, leaving when a resident is upset, and then reapproach the resident. The investigative file for the allegation was reviewed on 3/3/2023 at 2:11 p.m. A statement from CNA 20, dated 3/1/2023, indicated the following, " ...On Tuesday February 28th me and 2 other coworkers went into room [Resident 19's room number] and helped her get ready for bed. Me and the other coworker 2 person assisted her to stand the resident became aggressive and combative [sic]. Stating that she already called the cops and saying wee were trying to kill her. We got her transferred to the w/c [wheelchair] and started to put her night gown on. The resident was getting combative so I held her forearm away from her body with little to no pressure and the coworker held the other forearm so the other coworker could get her gown pulled down. We then 2 person assisted her to stand again. The coworker pulled her pants down and we layed her in bed [sic] ...She was continuously hitting, scratching, and kicking the whole time, we were trying to be as gentle and patient while getting her to bed. When we were finished we told 2 nurses about what had happened and how aggressive she was getting [sic]". A statement from CNA 22, dated 3/1/2023, indicated the following, "" ...[Name of CNA 24] the CNA asked [name of CNA 20] and I [CNA 22] to help get [Name of Resident 19] in bed...After we got into the resident's room we had explained to her that we needed to get in bed and she said "ok"...After we had her w/c [wheelchair] pulled up to her recliner we told [Resident 19] that we were		**dementia care services were provided for resident. Social Services will be notified of any behaviors related to dementia for follow up also. This auditing will occur daily in clinical stand up 5 days per week for 4 weeks then monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 4/7/2023**	

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	going to help her in her w/c and she was starting to refuse. [CNA 20] asked [Resident 19] if we could change her in her recliner and she said no that she wanted to change in the bathroom and we told her "ok". [CNA 24] and I had placed our inner elbow under [Resident 19's] armpit and grabbed the back of her pants to stand her up while [CNA 20] made sure that w/c wouldn't move or she could move it if needed be [sic]. Once we stood [Resident 19] up she started yelling "help" and we told her that we were putting her in her w/c again and we gently sat her down. We started wheeling her to the bathroom to be changed and she told us that she didn't want to go to the bathroom now. So we proceeded to wheel her. [CNA 20] and I [CNA 22] were going to stand her up to turn her around. [CNA 24] was going to pull her pants off her bottom and sit her down on her bed. We did this gently and quickly as possible but [Resident 19] started to yell help again and after we set her on the side of her bed [CNA 24] started to take her pants the rest of the way off but before she could take [Resident 19's] shoes off, [Resident 19] said that [CNA 24] was going to rape her and this all shocked us. We reassured her that no that we not going to happen and started yelling help again we told her that she was ok. That we weren't trying to hurt her. She tried to kick at [CNA 24] and [CNA 20] explained to her that if she kept trying to kick we weren't going to be able to take off her pants and she stopped...Once she did that, I had [Resident 19's] top half of her body and [CNA 20] had her bottom half and we laid her down...."" A statement from CNA 24, dated 3/1/2023, indicated the following, "" ...I [CNA 24] went into ask her about getting her ready for bed and [Resident 19] said "no, not ready for bed". So I left the room. Then later [CNA 22] and [CNA 20]			

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	came to me and said they were going to help me get [Resident 19] to bed. [CNA 20] and me [CNA 24] were on each side of [Resident 19] who was in her chair. [Resident 19] went to go grab at [CNA 20] and so [CNA 20] switched spots with [CNA 22]. Me [CNA 24] and [CNA 22] got [Resident 19] into the w/c after we got the gown on her [CNA 20] pushed the w/c up to the bed and [CNA 22] and [CNA 20] stood her up and pulled the pants down and we laid her down and [Resident 19] tried to kick [CNA 20] so [CNA 20] helped me get the pants off. I took the brief off and wiped and put a new brief on her. [Resident 19] was trying to grab and scratch us while getting her ready for bed. She was not naked. We had her PJ [pajama] gown on. When I pulled down the pants, [Resident 19] yelled "I'm going to get you for rape". "Help". "Police are going to come and get you three girls". I told [Resident 19] "I just needed to pull down your pants to get your brief changed". [CNA 20] had her legs held down. [Resident 19] called [CNA 20] (red head) and [CNA 22] (pigtails) and me [CNA 24] (mohawk). [CNA 22] held her arms/hands as I changed her brief. I talked to [Resident 19] nice and calmly."" A progress note, dated 3/1/2023 at 2:50 p.m., indicated the following, " ...Received a report the resident made an allegation someone threw her in bed last night. This writer went to talk to her. She stated three people came to her room and pestered her all night. She stated the one that threw her in the bed had red hair and a pony tail ...." The progress note was signed by the ED. A progress note, dated 3/1/2023 at 4:56 p.m., indicated the following, "" ...SSD [Social Services Director] was notified of statements made by resident regarding wanting to be killed due to resident reporting problems the night before. SSD			

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	followed up with res [resident] and asked res if res has had thoughts about harming res self. Res stated, "oh on, I am not that crazy yet." SSD informed res of plan to continue to follow up with res [sic] ...."" A policy titled, "Care Plans, Comprehensive Person-Centered", revised December 2016, was provided by the Director of Nursing (DON) on 3/7/2023 at 9:30 a.m. The policy indicated the following, " ...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ...8. The comprehensive, person-centered care plan will ...b. Describe the services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment ...j. Reflect the resident's expressed wishes regarding care and treatment goals ...." 3.1-37(a)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and			

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	(ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview and record review the facility failed to provide routine dental services for 2 of 9 residents reviewed for dental status (Resident 7 and Resident 25). Findings include: 1. During an interview with Resident 7 on 3/01/2023 at 11:27 a.m., indicated she had not seen	F 0791	**F791 Routine/Emergency Dental Services in NFs CFR(s): 483.55(b)(1)-5** **I. Residents 7 and 25 have dental visits scheduled. Their weights have been reviewed**	04/07/2023

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	a dentist in a long time and would like to see a dentist. The resident indicated she had her own teeth and they were "wearing out". The resident indicated she reported to nursing staff that she wanted to see a dentist. Review of the record of Resident 7 on 3/6/2023 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, low back pain, unspecified,major depressive disorder, recurrent, moderate, generalized anxiety disorder and exudative age-related macular degeneration. The consent for ancillary services for Resident 7, dated 11/28/2017, indicated the resident had signed up for dental services. The Quarterly Minimum Data Set (MDS) assessment for Resident 7, dated 12/20/2022, indicated the resident was cognitively intact for daily decision making. During an interview with Social Service Director (S..S.D.) on 3/6/2023 at 12:30 p.m., the resident had requested to see the dentist in Feb 2023. Nursing staff had left me a note that she had been requesting dental services. During an interview with the S.S.D. on 3/06/2023 at 2:39 p.m., indicated Resident 7 had not received routine dental services. The S.S.D. indicated the facility had contacted the facility to set up dental appointment. 2. The clinical record for Resident 25 was reviewed on 3/7/2023 at 11:55 a.m. The medical diagnoses included chronic kidney disease and diabetes.		**and there are not weight loss concerns.** **II. All residents had the potential to be affected by the alleged deficient practice. The social services department has audited all in house residents to determine they are receiving dental services per their request. Any identified issues have been corrected.** **III. Education was provided to the Social Service Director to obtain a consent or refusal for all dental needs upon admission. The systemic change includes the social service department will review in each quarterly care plan dental needs and services needed.** **IV. The Social Service Director /Designee will audit all new admissions weekly to determine dental service needs were addressed. The Social Service Director/Designee will also audit 5 random long term care residents with quarterly care plans to determine if their dental service needs were reviewed in the care plan. This audit will occur weekly for 4 weeks; then, monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the**	

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	An Annual Minimum Data Set Assessment, dated 2/24/2023, indicated Resident 25 was cognitively intact. An interview with Resident 25 on 3/2/2023 at 10:32 a.m., indicated she had multiple broken teeth that need removed due to them being broken and she would like see the dentist. The broken teeth did not cause her pain at the time, but had been in a state of poor repair for at least a year. A social service note, dated 2/1/2023, indicated Resident reported needing teeth pulled and would like to see the dentist. No indication of Resident 25 seeing a dentist in the last 12 months was provided. A policy entitled, "Dental Services", was provided by the Executive Director on 3/7/2023 at 10:30 a.m. The policy indicated, "...Routine and emergency dental services are provided...Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary." 3.1-24(a)(1)		**monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 4/7/2023**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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

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	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 interview, observations, and record review, the facility failed to utilize contact/droplet precautions for a resident on contact/droplet isolation for Covid-19 when serving a meal tray in the resident's room (Resident 59) and placing the meal tray on the floor on the ground prior to serving it to Resident 259 for consumption for 2 of 7 people reviewed for infection control. Findings include: 1. The clinical record for Resident 59 was reviewed on 3/1/2023 at 1:20 p.m. The medical diagnoses included, Covid-19 infection and heart failure. A Quarterly Minimum Data Set Assessment, dated 1/22/2023, indicated that Resident 59 was cognitively intact.	F 0880	**F880 Directed POC** **The directed plan of correction (DPOC) is to serve as Arbor Trace Health and Living Community's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision**	04/07/2023

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	A physician order, dated 2/23/2023, indicated that Resident 59 was on droplet/contact isolation with all meals, activities, therapy and services must be provided in room with isolation precautions followed. An observation on 3/1/2023 at 12:05 p.m. indicated CNA 2 going into Resident 59's room using only a standard surgical mask. She set the tray in front of Resident 59, touched the Resident's shoulder, and asked if she needed anything before she left the room. An interview with Resident 59 on 3/1/2023 at 12:07 p.m., indicated that staff do not always wear a gown, glove, or face shield when they come in her room. Contact/droplet signaled was provided by the Director of Nursing on 3/2/2023 at 10:30 a.m., that indicated appropriate personal protective equipment (PPE) would be eye protection, gowns, MN-95 (a higher quality face mask), and gloves. An interview with the Infection Preventions Nurse and Director of Nursing on 3/2/2023 at 3:41 p.m., indicated staff should utilize a gown, gloves, face shield and MN-95 when they are entering a room for a resident with Covid-19 even if they were just dropping off a meal tray. 2. An observation on 3/1/2023 at 12:36 p.m. indicated CNA 24 placed a meal tray on the ground to their don PPE for Resident 295's room. CNA 24 then picked the tray up from the ground to then station in the room for Resident 295 to consume. An interview with Executive Director on 3/1/2023 at 12:45 p.m., indicated that it is not acceptable to		**constitute an agreement or admission of the survey allegations.** **The facility respectfully requests desk review for the following citation.** **F880 Infection Prevention and Control** **S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** **There were no residents harmed by the alleged practice. The staff members found to have deficient practices were immediately educated on proper PPE usage for contact/droplet isolation for Covid-19 and proper handling of meal trays prior to serving them to residents.** **II. The facility will identify other residents that may potentially be affected by practice.** **Any residents in droplet/contact isolation for Covid-19, or other residents cared for by staff that enter and exit droplet/contact isolation for Covid-19 may be affected by the deficient**	

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	place a meal tray on the ground and then serve it to a resident. 3.1-18(a)		**practice. Rounds were immediately made to ensure staff were donning proper PPE prior to entering droplet/contact isolation for Covid-19 rooms and maintaining proper infection control practices when passing meal trays in isolation rooms.** **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · **Root Cause Analysis (RCA) with facility consultant Infection Preventionist, including input from the facility Medical Director/DON/IP was completed (Attachment A)** · **Consultant Infection Preventionist educated IDT/Nursing Leadership team on proper PPE usage in droplet/contact isolation for Covid-19 and proper infection control practices for passing meal trays in isolation rooms. (Attachment B)** · **All staff who enter droplet/contact isolation for Covid-19 rooms and those who pass meals in isolation rooms were educated by IDT/Nursing Leadership team on proper PPE usage in droplet/contact isolation for Covid-19 and proper infection control**	

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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
			practices for passing meal trays in isolation rooms. (Attachment C) **IV. The facility LTC Infection Control Self-assessment was reviewed with the consulting Infection Preventionist resulting in an updated LTC Infection Control assessment being completed with input from the Consultant IP/Medical Director and DON (Attachment D)** **V. The facility will monitor the corrective action by implementing the following measures.** · **The IP/DON or designee will observe the staff to ensure proper PPE is worn into droplet/contact isolation for Covid-19 rooms daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit tool. (Attachment E)** · **The IP/DON or designee will observe the staff to ensure proper infection control practices are maintained while passing meal trays in isolation rooms daily for 6 weeks, then weekly for 8 weeks, then**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	03/08/2023

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			monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit tool. (Attachment F) · **The IP/DON or designee, will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with proper PPE utilization daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit tool (Attachment G)** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.** **VI. Plan of correction completion date.** **Date of compliance: April 7, 2023**	

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			The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Arbor Trace Health and Living Community's credible allegation of compliance.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 1, 2, 3, 6, 7, and 8, 2023. Facility number: 000455 Residential: 26 Arbor Trace Health & Living Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 14, 2023	R 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	03/08/2023

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