| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155486 | A. BUILDING 00<br>B. WING | 08/05/2022 |

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| MIDDLETOWN NURSING AND REHABILITATION CENTER | 131 S 10TH ST<br>MIDDLETOWN, IN 47356 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: August 2, 3, 4, and 5, 2022.<br><br>Facility number: 000343<br>Provider number: 155486<br>AIM number: 100289600<br><br>Census Bed Type:<br>SNF/NF: 11<br>Total: 11<br><br>Census Payor Type:<br>Medicaid: 7<br>Other: 4<br>Total: 11<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on August 8, 2022 | F 0000 | F 0000<br>This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law. | |
| F 0563<br>SS=D<br>Bldg. 00 | 483.10(f)(4)(ii)-(v)<br>Right to Receive/Deny Visitors<br>§483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.<br>(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;<br>(iii) The facility must provide immediate | | | |

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

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

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| | access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;<br>(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and<br>(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. | | | |
| | Based on interview and observation, the facility failed to provide visitation between the hours of 6 p.m. and 9 a.m. for 1 of 1 resident reviewed for visitation. (Resident 12)<br><br>Findings include:<br><br>An interview with family member of Resident 12 indicated that in the middle of July 2022, she attempted to visit Resident 12 at 5:55 p.m. A staff member answered the door and told her visiting hours were over and she could not visit.<br><br>A Center Medicare and Medicaid Services Memorandum, revised on 3/10/2022, with a Reference of QSO-20-39-NH indicated, " ...Visitation is allowed for all residents at all times ..." | F 0563 | **Tag 563**<br>**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>All residents have to right to receive visitors at any time as long as the visit does not contradict the rights or safety of other visitors. The “Visitation Policy” indicated that visitations were allowed between the hours of 9am and 6pm, allowing for 9 hours of visitation previously required. Visits were never declined if the Administrator was notified prior to a later visit. Visits will be offered 24 hours in the Facility. Doors will | 08/19/2022 |

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| | And interview with the Administrator on 8/5/2022 at 10:11 a.m. indicated that visitation is from 9 a.m. to 6 p.m. If a visitor comes before 5:55 p.m., they are welcome to stay longer, but they do not have the staffing to screen at the door after 6 p.m.<br><br>A policy entitled, "Visitation", was provided by the Administrator on 8/4/2022 at 2:15 p.m. The policy indicated, " ...Visiting hours are 9a - 6 p due to Covid-19 restrictions ..."<br><br>3.1-8(b)(7) | | be unlocked 9a-7p and locked the remaining hours to maintain safety of the residents and staff. (See attachment #1)<br>**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>Residents could be affected if they only wanted visits outside the hours of 9am and 6pm. To avoid any complaints or concerns with visitation times; the Facility will offer 24 hour visits with the front door unlocked 9am-7pm and locked during the remaining hours. Visitors visiting before 9am or after 7pm will have to ring the doorbell and let in by the staff. Visitors will be required to self-screen for Covid-19.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>The Facility will offer 24 hour visits with the front door unlocked 9am-7pm and locked during the remaining hours. Visitors visiting before 9am or after 7pm will have to ring the doorbell and let in by the staff. Visitors will be required to self-screen for Covid-19.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED** | |

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| | | | **TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The Administrator will monitor that the new policy change is being followed correctly. The Charge nurse per shift is responsible for visitation requirements to be adhered. The Administrator will monitor daily (Monday-Friday) that all visitations protocols are being followed. Family's will also be informed that if there is a problem with a visit that the Administrator must be notified. We will discuss any problems with visitation during our next 2 quarterly QA meetings.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>Changes were made Friday, August 19.<br>We respectfully request paper compliance for Tag F 563. | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's | | | |

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| | comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>Based on observation, interview, and record review, the facility failed to keep Resident 7's urinary catheter bag free from the floor for 1 of 1 residents reviewed for indwelling urinary catheters.<br><br>Findings include:<br><br>The medical record for Resident 7 was reviewed on 8/3/2022 at 11:09 a.m. The medical diagnoses included, but were not limited to, urinary retention, urinary tract infection, and chronic kidney disease. | F 0690 | **Tag 690**<br>**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>Catheter bags should never be found on the floor. When proper care is not being done, it may cause an Infection Control problem. Proper catheter care will be monitored by the Charge nurse and all nursing staff will be re-educated by the Director of Nursing on proper Catheter care. | 08/26/2022 |

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| | A Quarterly Minimum Data Set Assessment, dated 6/15/2022, indicated that Resident 7 was cognitively intact, needed assistance with hygiene activities of daily living, and utilized and indwelling urinary catheter.<br><br>An observation on 8/2/2022 at 1:12 p.m., indicated Resident 7 was lying in bed with his urinary catheter bag off the left side of his bed. The bottom of the bag was in contact with the floor.<br><br>An observation on 8/2/2022 at 1:50 p.m., indicated Resident 7 was lying in bed with his urinary catheter bag off the left side of his bed. The bottom of the bag was in contact with the floor.<br><br>An observation on 8/3/2022 at 2:52 p.m., indicated Resident 7 was lying in the bed with his urinary catheter bag off the right side of the bed. The bottom of the bag was laying on the bottom bar of the bedside table.<br><br>An interview with LPN 2 on 8/3/2022 at 2:53 p.m., indicated the urinary catheter bag should not be making contact with the bottom of the bedside table and she would change the catheter bag.<br><br>A urinary tract infection care plan, dated 1/8/2020, indicated to provide catheter care every shift and check the tubing every shift for Resident 7.<br><br>A policy entitled, "Catheter Care", was provided by the Administrator on 8/4/2022 at 2:12 p.m. The policy indicated, " ...Keep drainage bag of [sic, off] floor at all times ..."<br><br>3.1-41(a)(2) | | **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>Currently we only have 1 resident that has a catheter. The deficiency will be corrected quickly and all nursing staff will be re-educated on proper catheter care. The Director of Nursing and Infection Preventionist will continue to monitor any other possible infection control issues.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>The deficiency will be corrected quickly and all nursing staff will be re-educated on proper catheter care. The Director of Nursing and Infection Preventionist will continue to monitor observe any other possible infection control issues. If there is a concern the DON or IP will immediate educate the staff member involved.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The charge nurse will monitor that | |

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| | | | the catheter bag is secured properly per shift for the next 30 days and then daily after that, and the Director of Nursing and Infection Preventionist will make daily rounds for the next 30 days, and then weekly rounds for the next 60 days to ensure catheter care is being done properly. We will monitor and discuss any issues during our quarterly QA meetings as well as during our morning meetings.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>Systemic changes have already been made, but re-educated for all nursing staff will be completed by August 26.<br>We respectfully request paper compliance for Tag F 960 | |
| F 0727<br>SS=D<br>Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or | | | |

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| | fewer residents.<br><br>Based on interview and record review, the facility failed to provide 8 hours of consecutive registered nurse (RN) coverage for 2 of the last 30 days reviewed.<br><br>Findings include:<br><br>Nursing schedules for 7/10/2022 though 8/6/2022 were reviewed on 8/3/2022 at 10:55 a.m. The scheduled indicated that on 7/16/2022 and 7/30/2022, Licensed Practical Nurses (LPNs) were scheduled from midnight until 11 p.m. then RN 6 was scheduled from 11 p.m. Saturday until 7 a.m. on Sunday.<br><br>An interview with Administrator on 8/4/2022 at 1:51 p.m. indicated that he had overlooked those dates but would get it fixed going forward.<br><br>An interview with Administrator on 8/5/2022 at 12:54 p.m. indicated they did not have a specific policy for RN coverage but would follow the Center for Medicare and Medicaid regulation.<br><br>3.1-17(b)(3) | F 0727 | **Tag F 727**<br>**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>All residents could be affected by this deficiency. There will be 8 continuous hours of RN coverage every day. The Administrator will ensure that RN hours are met per IDOH regulation.<br>**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>The Administrator creates the nursing schedule. The Administrator will ensure that 8 hours of continuous RN coverage will be present. In the event that the scheduled RN is unable to cover their shift, the DON will cover shift if another RN is unavailable.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>The Administrator will ensure that 8 hours of continuous RN coverage will be present. In the event that the scheduled RN is unable to cover their shift, the | 08/19/2022 |

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| | | | DON will cover shift if another RN is unavailable. The DON will help review the schedule to ensure all shifts are covered.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The schedule is done every 2 weeks. The Administrator and DON will ensure all shifts are covered as well as proper RN coverage. RN coverage will be monitored by the Administrator daily, and reviewed every 2 weeks when the schedule is made. We will discuss any issues with RN coverage during our quarterly QA meetings and daily if necessary.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>RN coverage was assigned immediately, and the next 2 week nursing schedule will be posted Friday, August 19. (See attachment #2)<br>We respectfully request paper compliance for Tag F 727 | |
| F 0880<br>SS=E<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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 | | | |

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| | the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident | | | |

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| | under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>Based on interview and observation, the facility failed to adhere to their mitigation strategy by having unvaccinated staff members wear a face shield or eye protection during resident care for 1 of 5 staff members effecting 3 residents reviewed for infection control. (Resident 3, 5, and 7)<br><br>Findings include:<br><br>The Staff Vaccination Matrix was provided by the Business Office Manager on 8/3/2022 at 11:05 a.m. This form indicated Staff 2 was unvaccinated.<br><br>On 8/3/2022 at 2:20 p.m. Staff 2 was observed | F 0880 | **Tag 880**<br>**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>All residents could have been affected by any staff not following proper Covid-19 procedures. According to the CDC up-to-date vaccination states one must be vaccinated and at least one booster. Anyone that is not vaccinated must wear proper PPE while caring for the residents to | 08/26/2022 |

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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 |
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| | going into and out of residents' rooms on the green zone (zone utilized for residents that do not have Covid-19 and have not been identified as being a risk for exposure for Covid-19) with just an N-95 face mask on. (Resident 5 and Resident 7)<br><br>On 8/3/2022 at 2:55 p.m. Staff 2 was observed going into and out of residents' rooms on the green zone. She then donned personal protection equipment to go onto the red zone (area where residents with active Covid-19 were residing). (Resident 5 and Resident 3)<br><br>An interview with Staff 2 on 8/3/2022 at 2:55 p.m. indicated they did not need to wear eye protection on the green zone, only in red or yellow rooms.<br><br>An interview with the Administrator on 8/4/2022 at 2:20 p.m. indicated that the policy provided was the most up to date and that unvaccinated staff should be wearing approved eye protection or glasses.<br><br>A policy entitled, "Employee Infection, Vaccination Status and Covid-19 staff vaccination requirements", was provided by the Administrator on 8/4/2022 at 2:15 p.m. The policy indicated, " ...Any employee (direct hire or contracted) that is unvaccinated and has been granted an exemptions ...must comply with the following: ...Wear an N-95 mask with an approved face-shield or glasses ..."<br><br>3.1-18(a) | | help prevent the spread of Covid-19, regardless of the resident's vaccination status. All staff will be re-educated on the meaning of "up-to-date", and proper use; donning and doffing of PPE.<br>**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>The Administrator and Infection Preventionist will re-educate all staff on proper PPE per vaccination status. When proper PPE is not worn properly, contagious illnesses are much easier transmitted amongst the staff and residents. The Facility will continue to provide all PPE to the staff.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>Up-to-date signage will be posted in the designated areas stating what the proper PPE is per zone. The Infection Preventionist with the help of the DON and Administrator will monitor that all staff are following the Policy and Procedures.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED** | |

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| | | | **TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The Administrator and Infection Preventionist will continue to follow the updates guidelines provided by IDOH pertaining to Covid-19 in order to keep our policy up-to-date and all staff continue to follow the right protocols. The Administrator will monitor all vaccination status. Department Heads will meet weekly to discuss any new changes that need to be made to follow CDC guidelines. We will discuss any new changes during our quarterly QA meetings as well.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>Corrections and Systems have already been implemented, but all corrections and re-education will be completed by August 26.<br>We respectfully request paper compliance for Tag F 880. | |
| F 0886<br>SS=D<br>Bldg. 00 | 483.80 (h)(1)-(6)<br>COVID-19 Testing-Residents & Staff<br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including<br>individuals providing services under arrangement and volunteers, for COVID-19. At a minimum,<br>for all residents and facility staff, including individuals providing services under | | | |

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| | arrangement<br>and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for<br>conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate<br>to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with | | | |

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| | symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing<br>services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state<br>and local health departments to assist in testing efforts, such as obtaining testing supplies or<br>processing test results.<br><br>Based on interview and observation, the facility failed to assure a staff member that was not up-to-date on their covid-19 vaccination tested at least weekly for 1 of 5 staff reviewed for infection control. (Staff 4)<br><br>Findings include:<br><br>The Staff Vaccination Matrix was provided by the Business Office Manager on 8/3/2022 at 11:05 a.m. This form indicated Staff 4 was not up-to-date on their vaccination.<br><br>Testing logs for Staff 4 indicated that between 7/1/2022 and 7/30/2022 had tested for Covid-19 on:<br><br>7/11/2022<br>7/29/2022<br>7/30/2022 | F 0886 | **Tag 886**<br>**WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>Middletown Nursing and Rehabilitation Center prides ourselves on having early detection of Covid-19. We have gone above and beyond on testing and in most cases have kept Covid-19 out of the building and away from our residents. The facility's "Covid-19" policy will be updated to indicate and clarify the procedures for testing depending on both vaccination status and community's positivity rate (Attachment #3). The county positivity rate will be posted at the | 08/26/2022 |

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| | A time sheet for Staff 4 indicated from 7/1/2022 to 7/30/2022 they had worked on:<br><br>7/2/2022<br>7/4/2022<br>7/7/2022<br>7/8/2022<br>7/9/2022<br>7/10/2022<br>7/11/2022<br>7/14/2022<br>7/16/2022<br>7/17/2022<br>7/21/2022<br>7/22/2022<br>7/23/2022<br>7/24/2022<br>7/28/2022<br>7/29/2022<br>7/30/2022<br><br>And interview with the Administrator on 8/4/2022 at 2:20 p.m., indicated he had not been tracking the county level, but that staff were to be testing every day before their shift since 6/26/2022.<br><br>Center for Disease Control and Prevention Covid-19 Community Level logged the historical values for Henry County, Indiana as:<br><br>6/23/2022 - Medium (Yellow)<br>6/30/2022 - High (Red)<br>7/7/2022 - Medium (Yellow)<br>7/14/2022 - Medium (Yellow)<br>7/21/2022 - High (Red)<br>7/28/2-2022 - Medium (Yellow)<br><br>An interview with the Business Office Manager on 8/5/2022 at 11:01 a.m. indicated that Staff 4 had missed testing in July 2022. | | staff entrance and testing area.<br>**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>Staff members not following protocol could unknowingly bring Covid-19 into the facility, affecting both staff and residents. Even though it has been proven that vaccinations and boosters will not stop or prevent Covid-19, the more immunity a person may have is still a step forward to protecting oneself and everyone around. Staff must be aware of the positivity rate and their own vaccination status. Staff must understand “up-to-date” with vaccination or order to know when to test.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>A new sign in sheet has been created to help monitor everyone is properly testing for Covid-19 when it is applicable (attachment #4). In this specific deficiency it would have made it easier to see that the employee was not testing properly, especially since all employees were to be testing daily no matter vaccination status. The sign-in sheet will be monitored | |

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| | A Center Medicare and Medicaid Services Memorandum, revised on 3/10/2022, with a Reference of QSO-20-38-NH indicated that for a level of yellow to test once a week and red to test twice a week. The memorandum indicated that facilities should monitor their level of community transmissibility at least every other week.<br><br>A policy entitled, "Employee Infection, Vaccination Status and Covid-19 staff vaccination requirements", was provided by the Administrator on 8/4/2022 at 2:15 p.m. The policy had not been updated to reflect guidance for staff that were not up-to-date.<br><br>An interview with the Administrator on 8/4/2022 at 2:20 p.m. indicated that the policy provided was the most up to date. | | by the Administrator.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The Infection Preventionist will post the community positivity rate at the employee entrance, and the staff will be responsible to test accordingly. The Administrator and IP will both monitor the new testing sheet to ensure compliance is being met. (See attachment #3). The Infection Preventionist will post the community positivity rate weekly and the Administrator and IP will review the new staff testing sheet daily to ensure everyone is testing properly. All testing for the quarter will be reviewed during QA meeting.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>The Facility has already implemented changes to correct this deficiency. Further changes will be completed by August 26. We respectfully request paper compliance for Tag F 886. | |
| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL | F 9999 | **Tag F 9999** | 08/26/2022 |

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| | (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees Specific inquiries shall be made for prospective employees...<br>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:<br>(1) Residents' rights.<br>(5) Needs of specialized populations served.<br>(6) Care of cognitively impaired residents.<br>(p) Initial orientation of all staff must be conducted and documented ans shall include the following:<br>(1) Instructions on the needs of the specialized population or populations served in the facility, for example:<br>(A) aged;<br>(E) care of cognitively impaired residents.<br>(2) A review of the residents's rights and other pertinent portions of the facility's policy manual.<br>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read and by whom administered. The tuberculin skin test must be read prior to the employee starting work.<br>(1) At the time of employment, or within 1 (one) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For | | **WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**<br>All residents could be affected by this deficiency when the Facility does not conduct proper screenings and training on time. Even though the staffing situation had become so chaotic, it is the Facility's responsibility to hire well educated and healthy individuals to provide care and safety to the residents. The Administrator and office manager will oversee that all department heads complete their employee's personnel files on time.<br>**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:**<br>In the event that the Facility fails to have completed personnel files prior to starting their first shift, the facility unknowingly could hire someone that is ineligible for criminal reasons, TB could be brought into the building or the employee may just be physically unable to do the job. It is the Facility's responsibility to provide great care and safety to all the residents. Department Heads will manage the personnel files for all new employees with the | |

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| | health care workers who have not had a documented negative tuberculin skin test result in the last 12 (twelve) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed 1 (one) to 3 (three) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(3) The facility shall maintain a health record of each employee that include:<br>(A) a report of the preemployment physical examination<br>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.<br><br>This rule was not met as evidenced by:<br><br>Based on interview and record review, the facility failed to maintain personnel records in a manner consistence with regulatory guidelines, specific to new employee and annual training for resident's rights, including abuse and neglect education, timely physical examinations and tuberculosis (TB) screening for new employees, education regarding dementia training for new employees and long-term employees and timely criminal background checks, for 8 of 10 employee files reviewed. (Director of Nursing [DON], RN 5, RN 6, RN 7, CNA 8, CNA 9, Dietary Staff 10 and CNA 11.) | | Administrator and Office manager oversee the process.<br>**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**<br>Any new hire, the Administrator will verify and assist the Department Heads on completing personnel files prior to starting their first shift. The Facility is looking into an online training software that will help maintain all staff annual training as well as new hire training.<br>**HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:**<br>The Administrator, Office manager and Infection Preventionist will do quarterly audits on current employee files to ensure all employees are up-to-date. Department Head will audit employee file prior to start date. Office Manager will audit employee file within 1 week of start date and assist the Department Head to get file complete. Administrator with audit files within 30 days to ensure everything is complete. All new hires will be audited quarterly during QA meetings. Administrator | |

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| | Findings include:<br><br>The employee files were reviewed on 8-5-22 at 11:45 a.m. The following concerns were identified:<br>- The file of the DON indicated he began employment with the facility on 1-31-22. His criminal background check was not conducted until 8-4-22, 6 months after beginning employment. His pre-employment physical exam was dated 4-5-22, 2 months after beginning employment. His pre-employment TB screening was not conducted until 3-28-22, nearly 2 months after beginning employment. As of 8-5-22, he had received only 3 hours of dementia-related education since his employment began 6 months prior.<br>-The file of RN 5 indicated she began employment with the facility on 11-18-21. Her criminal background check was not conducted until 8-4-22, 9 months after beginning employment. Her pre-employment physical exam was dated 11-23-21, 2 days after beginning employment. Her pre-employment TB screening was not conducted until 11-19-21, 1 day after beginning employment. As of 8-5-22, she had received only 3 hours of dementia-related education since her employment began 9 months prior.<br>-The file of RN 6 indicated she began employment in 2018. Her record indicated she had not received any annual training for resident's rights, including abuse and neglect education for this year. As of 8-5-22, she had received only 1.5 hours of dementia-related education for her annual training.<br>-The file of RN 7 indicated she began employment with the facility on 2-22-22. Her pre-employment physical exam was dated 4-12-22, 1.5 months after beginning employment. Her pre-employment TB screening was not conducted until 2-28-22, 6 days after beginning employment. As of 8-5-22, she | | and Office Manager will audit files annually to ensure all insensitivity, TB, and certifications are up to date. Office Manager will create a new employee file audit tool to ensure everyone is completing each task on time.<br>**BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:**<br>Systemic Changes have already begun. All personnel files will be completed prior to hire and all current employee files will be completed by August 26.<br>We respectfully request paper compliance for Tag F 9999. | |

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| | had received only 3 hours of dementia-related education since her employment began 5 months prior.<br>-The file of CNA 8 indicated she began employment on 7-18-22. It indicated her pre-employment physical exam was conducted on 7-19-22, 1 day after beginning employment.<br>-The file of CNA 9 indicated she began employment on 11-19-21. As of 8-5-22, she had received only 3 hours of dementia-related education since her employment began 8 months prior.<br>-The file of Dietary Staff 10 indicated she began employment on 6-20-22. Her pre-employment physical was conducted 7-21-22, one month after her employment began.<br>-The file of CNA 11 indicated she began employment in 2017. As of 8-5-22, her annual dementia-related training was indicated as 0.0 hours.<br><br>In an interview with the Business Office Manager (BOM) on 8-5-22 at 12:30 p.m., she indicated her official office duties do not include over-seeing the employee files. However, when a vacancy in that position became available, she has since been over-seeing this task, "but I really never was trained for this position and am not really sure what needs to be in the records or the timing of getting things done." She indicated, to the best of her knowledge, the facility did not encounter any shortage of tuberculin/Mantoux solution during the last year.<br><br>3.1-14(a)<br>3.1-14(k)(1)<br>3.1-14(k)(5)<br>3.1-14(k)(6)<br>3.1-14(p)(1)(A)<br>3.1-14(p)(1)(E)(2) | | | |

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