STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00368350, IN00368995, IN00372360, IN00374545, and IN00375472. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00368350 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00368995 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F690, and F694. Complaint IN00372360 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F880. Complaint IN00374545 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F697. Complaint IN00375472 - Substantiated. Federal/State deficiencies related to the allegations are cited at F554 and F676. Unrelated deficiencies cited at F583, F726, F773, and F888. Survey dates: March 14, 15, 16, and 17, 2022 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 92 Total: 92	F 0000		

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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	Census Payor Type: Medicare: 5 Medicaid: 67 Other: 20 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 23, 2022.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self administer their own medications for 1 of 15 residents reviewed for self administration of medication. (Resident R) Finding includes: During a random observation on 3/14/22 at 12:15 p.m., Resident R was observed in bed in his room. At that time, there was a plastic cup of medications filled to the top on his over bed table in front of him. He indicated the nurse (name) just gave them to him about a couple of minutes ago. Interview with RN 1 on 3/14/22 at 12:20 p.m., indicated she swears she stayed with the resident and he took all of his medications. She was aware she needed to stay with the resident to make sure they took their medications.	F 0554	**F554** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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.* **1) Immediate actions taken for**	04/01/2022

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	The record for Resident R was reviewed on 3/16/22 at 10:44 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing), dementia with behaviors, stroke, hemiplegia, high blood pressure, and convulsions. The Quarterly Minimum Data Set (MDS) assessment, dated 2/16/22, indicated the resident was cognitively intact and able to make decisions. There was no Care Plan or Physician's Orders to self administer medications. There was no self administration of medication assessment for the resident. Interview with RN 1 on 3/15/22 at 9:04 a.m., indicated she went back to Resident R's room yesterday and did confirm he had not taken all of his medications. The Federal tag relates to Complaint IN00375472. 3.1-11(a)		**those residents identified:** Resident R self-medication administration assessment completed. RN #1 was educated on the importance of monitoring resident during medication administrator to ensure all medication are taken as prescribed. **2) How the facility identified other residents:** All residents may have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Nursing staff will be re-educated on the importance of following physician orders when completing medication administration. If a resident requests to self-administer medication(s), nurse must immediately notify the director of nursing and/or administrator. The IDT team will complete assessment and will determine if it is safe for the resident to self-administer. No medications should be left at bedside without prior approval from the IDT team. DON/Designee will complete med pass observations audits on 2 nurses per week for 4 weeks then	

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			monthly thereafter to ensure nurses are not leaving medication unattended. Social Services and Director of Nursing will review daily documentation to ensure assessment were completed if change of condition is noted. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 4/01/2022**	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.			

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	§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, record review and interview, the facility failed to ensure privacy was provided during care for 1 of 3 residents reviewed for pressure ulcers (Resident F) and for 1 of 3 residents reviewed for tube feeding. (Resident G) Findings include: 1. On 3/15/22 at 8:30 a.m., Resident G was observed in her room in bed. RN 1 was observed in the resident's room. The RN was administering the resident's medications by the way of a gastrostomy tube (a tube in the stomach). The curtain was not pulled between the resident and her roommate.	F 0583	**F583** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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*	04/01/2022

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	The record for Resident G was reviewed on 3/16/22 at 10:29 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), altered mental status, dysphagia (difficulty swallowing), and gastrostomy status. The Admission Minimum Data Set (MDS) assessment, dated 2/3/22, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 1/27/22, indicated the resident could receive her medications through the gastrostomy tube as needed. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the RN should have pulled the privacy curtain between the resident and her roommate while giving the resident her medication. 2. During a random observation on 3/14/22 at 3:38 p.m., CNA 2 was asked to observe Resident F's skin on her legs. She entered the room and did not close the door. She started to pull back the resident's linens exposing her legs and incontinent brief. At that time, she was asked to pull the privacy curtain, however, there were no privacy curtains in the room. The CNA continued to remove the bed linens so her legs could be observed. The resident's roommate was in her bed, awake, and watching the CNA move the resident's legs so her skin could be observed. On 3/15/22 at 9:45 a.m., CNA 1 was observed to check the resident for incontinence. The resident was seated in her room in a broda chair. The resident's roommate was in her bed and watching television. The CNA leaned back the broda chair and pulled down her pants so the incontinent brief could be viewed. The CNA indicated if there		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Privacy was provided to Resident F and Resident G during care and treatments. RN1, CNA2 and Wound Nurse were educated regarding the importance of providing privacy to residents by closing the resident's door, privacy curtains or room dividers when providing care and treatments. **2) How the facility identified other residents:** All residents may have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Nursing staff will be re-educated on the importance of following physician orders when completing medication administration, treatments, and ADL care. Privacy must be always provided to all residents. In the absence of privacy curtains, staff must use room divider screens. Screens must be clean before and after each use in between residents	

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	was a blue stripe, she would be in need of a change. The resident's roommate watched the entire observation. There was no privacy curtain or a screen in the room. Interview with CNA 1 on 3/15/22 at 1:00 p.m., indicated the facility only had a couple of privacy screens, so she had to borrow them from other rooms. On 3/15/22 at 2:58 p.m., the Wound Nurse was going to perform the treatments to the resident's pressure and non pressure sores. After obtaining all of her supplies and getting the material ready, she pulled back the resident's bed linens to remove the bandages on her feet. There was no privacy provided for the resident. There was no screen in the room or a privacy curtain pulled around the resident. The resident's roommate was observed in her bed, watching and talking to the Wound Nurse during the treatment. Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated they realized they only had a couple of screens and more have been ordered. The screens could be reused, however, they needed to be cleaned in between residents. 3.1-3(p)(4)		with approved EPA disinfectant. An audit tool will be developed to ensure that weekly observation is completed during resident's care and treatments to ensure privacy is provided to the residents. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks, then 2x weekly for 6 months. Director of Nursing or designee is responsible for compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless			

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	circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			
	Based on observation, record review, and interview, the facility failed to provide timely assistance with meals for 1 of 4 residents reviewed for activities of daily living. (Resident Q) Finding includes: On 3/14/22 at 11:48 a.m., Resident Q was observed	F 0676	**F676** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	04/01/2022

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	in the dining room. She was served her lunch at that time which consisted of lasagna and broccoli. At 11:58 a.m., CNA 3 sat down to assist the resident. The resident indicated she did not want the food she was served. The Assistant Director of Nursing (ADON) went to the kitchen and got the resident a peanut butter and jelly sandwich. The record for Resident Q was reviewed on 3/16/22 at 9:22 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/22/21, indicated the resident was cognitively impaired for daily decision making and needed supervision with eating. The Care Plan, dated 6/9/21 and reviewed 12/2021, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, during meals place resident with peers and with those who had similar cognition. The March 2022 Physician's Order Summary (POS), indicated the resident was to receive a regular diet. Interview with the ADON on 3/17/22 at 8:35 a.m., indicated the resident should have been assisted in a more timely manner. This Federal tag relates to Complaint IN00375472. 3.1-38(a)(2)(D)		*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.* **1) Immediate actions taken for those residents identified:** Resident Q was assisted with meals. **2) How the facility identified other residents:** Residents requiring assistance with ADL's have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Staff will be re-educated regarding the importance of providing adequate supervision and timely assistance during mealtimes. **4) How the corrective actions will be monitored:**	

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			Director of Nursing or designee will complete rounds at least once a day 5 times per week to ensure proper monitoring, assistance, and supervision of residents during mealtimes. **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: 04/01/2022**	
F 0684 SS=E 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 medications were administered as ordered and communication was completed between the on-site dialysis staff and facility nursing staff related to infections and	F 0684	**F684** The facility requests paper compliance for this citation.	04/01/2022

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	monitoring of perma catheter sites for 2 of 4 residents reviewed for infections. (Residents L and E) The facility also failed to ensure treatments were applied as ordered, preventative measures were in place and skin tears and rashes were assessed and monitored for 2 of 3 residents reviewed for skin conditions non-pressure related. (Residents F and D) Findings include: 1. On 3/14/22 at 2:00 p.m., Resident L was observed in his room seated on the side of his bed. The resident had a peripherally inserted central catheter (PICC) line to his left upper arm. His intravenous (IV) antibiotic was infusing at that time. The record for Resident L was reviewed on 3/15/22 at 3:25 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), malignant neoplasm of bronchus or lung, and sepsis due to methicillin susceptible staphylococcus aureus (MSSA). The resident was admitted to the facility on 2/18/22. The Admission Minimum Data Set (MDS) assessment, dated 2/25/22, indicated the resident was cognitively intact and he had received antibiotics during the assessment reference period. The Care Plan, dated 2/21/22, indicated the resident was at risk for complications secondary to being diagnosed with infection of sepsis. Interventions included, but were not limited to, administer antibiotic per Physician's Order. A Physician's Order, dated 2/18/22, indicated the resident was to receive Nafcillin Sodium (an		*This Plan of Correction is the center's credible allegation of compliance.* *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.* **1) Immediate actions taken for those residents identified:** · Resident L medication order was clarified and updated. · Resident F skin was assessed. Treatments and interventions are in place per physician orders. Plan of care updated. · Resident E no longer resides in the facility. · Resident D no longer resides in the facility. · Dialysis Staff communication education completed. · Hospice staff in-service regarding notification of treatment orders and skin areas found completed. **2) How the facility identified**	

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	antibiotic) in dextrose solution 2 grams (GM)/100 milliliters (ML), use 2 GM intravenously (IV) six times a day for sepsis for 6 weeks. The resident was also receiving dialysis at an off site dialysis center three times a week. The February 2022 Medication Administration Record (MAR), indicated the resident did not receive his IV antibiotic on 2/21 at 10:00 a.m. and 2:00 p.m., 2/22 at 2:00 p.m., 2/23 at 10:00 a.m. and 2:00 p.m., and 2/25/22 at 10:00 a.m. and 2:00 p.m. The March 2022 MAR, indicated the resident did not receive his IV antibiotic on 3/1 at 10:00 p.m., 3/2 at 10:00 a.m. and 2:00 p.m., 3/4 at 6:00 p.m. and 10:00 p.m., 3/7 at 10:00 a.m. and 2:00 p.m., 3/8 at 10:00 a.m., 3/9 at 10:00 a.m. and 10:00 p.m., 3/11 at 10:00 p.m., 3/12 at 10:00 a.m. and 2:00 p.m., and 3/14/22 at 10:00 a.m. Nurses' Notes, dated 3/9/22 at 1:05 p.m., indicated the resident returned at that time from dialysis. His morning IV was restarted and his afternoon medications were given. There was no documentation indicating the Physician had been contacted to clarify the medication order since the resident attended dialysis three times a week. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the Physician should have been contacted to clarify the antibiotic order since the resident attended dialysis three times a week and the antibiotic was for every 4 hours.2. The closed record for Resident E was reviewed on 3/14/22 at 10:45 a.m. The resident was admitted on 2/17/22 and expired in the facility on 2/26/22. Diagnoses included, but were not limited to, stroke, diabetes, chronic		**other residents:** All residents receiving dialysis services have the potential to be affected by the allege deficiency. An audit was completed of all residents receiving dialysis services to ensure all treatments were applied as ordered, preventative measures were in place and skin tears and rashes were assesses and monitored. Additional audit was completed to ensure all medications and treatments were administered per physician orders. In-house dialysis communication tool was audited to ensure information related to infections, labs orders and monitoring of perma catheter sites was completed, documented, and related to facility staff. Plan of care were reviewed and updated as needed. Skin assessment was completed on all residents to ensure skin areas were assessed, reported, documented, treated, and monitored per physician order. **3) Measures put into place/ System changes:** Staff will be re-educated regarding importance of completing permacath site assessment,	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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	kidney disease, vascular dementia, high blood pressure, osteoarthritis right hip, and pneumonia. The 2/22/22 Admission Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. She needed extensive assist with 1 person physical assist for bed mobility. Routine pain medication was coded as "none" and the resident had no pain present at the time of the assessment. The resident had a transfusion and received dialysis while a resident. The Admission Nursing assessment, dated 2/17/22, indicated the resident had an AV (Arteriovenous) fistula graft to the right shoulder. There was no dialysis Care Plan for the resident. There were no Physician's Orders to monitor or assess the dialysis access site at least daily or every shift for signs and symptoms of infection from admission to 2/26/22. Nurses' Notes, dated 2/17/22 at 1:30 p.m., indicated the resident had arrived to the facility. The resident was confused and oriented to self only. An assessment revealed a port cath to the right shoulder for dialysis on Tuesday, Thursday, and Saturday. A dialysis communication report sheet, dated 2/18/22, indicated there were no issues during dialysis. Nurses' Notes, dated 2/18/22 at 3:52 p.m., indicated the resident was observed pulling on the right chest catheter. The bandage was removed and replaced. A dialysis patient access note, dated 2/21/22,		identification, reporting, documentation, and weekly monitoring of skin conditions. Completing medication and treatments administration per Physician order and completing proper notification and documentation. Importance of communication with in-house dialysis RN to ensure all ordered are received and followed. An audit tool will be developed to ensure that a weekly skin assessment is performed on all residents. This will be completed two times weekly for 4 weeks the 1x weekly for 6 months. The Director of Nursing or designee will review at least 3 residents dialysis resident per week to ensure all order received are followed, skin conditions are identified, documented, and monitored weekly as indicated. Any deficiencies will be corrected immediately. **4) How the corrective actions will be monitored:** **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**	

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	indicated the CVC (central venous catheter) access exit site was noted with scant serosanguinous secretions. MD (name) paged with order to culture swab from the exit site. The site was swabbed for culture sensitivity. A dialysis communication report sheet, dated 2/21/22, indicated the resident was agitated the entire treatment and was trying to pull the lines. There was no documentation to let the facility know they had cultured the access site for a possible infection. A CBC (Complete Blood Count) lab result, dated 2/21/22, indicated the residents WBC (white blood cells) was 8.08 normal. Nurses' Notes, dated 2/22/22 at 7:20 p.m., indicated the resident's hemoglobin lab result was low at 6.3 and hematocrit was low at 19.7. The Physician was notified and new orders were obtained to send the resident to the hospital for a blood transfusion. The resident left at 9:38 p.m. Nurses' Notes, dated 2/23/22 at 4:45 a.m., indicated the resident returned from the hospital after the blood transfusion. New orders for a CBC this upcoming Friday 2/25/22. A HD (hemodialysis) treatment flowsheet, dated 2/23/22, indicated there was no drainage at the site, but the same redness continued. A dialysis communication report sheet, dated 2/23/22, indicated the resident was agitated the whole time. Needs medication prior to treatment. Nurses' Notes, dated 2/25/22 at 1:00 p.m., indicated the resident hollered out when repositioned. Dressing in place to right upper		**will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 04/01/2022**	

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	chest. Resident transferred to front of facility for dialysis. A HD treatment flowsheet, dated 2/25/22, indicated CVC exit site with serosanguinous scant amount of secretions noted. The preliminary culture showed staph aureus in moderate amount. The doctor was paged twice awaiting response. The dialysis communication report sheet, dated 2/25/22, indicated the resident was moaning the whole time. There was no documentation on the sheet for the facility to know the resident had an infection at the access site. Nurses' Notes, dated 2/25/22 at 8:19 p.m., indicated the resident's family felt the resident was not feeling well. The resident's temperature was assessed and was found to be normal at 97.2. Will continue to monitor. The CBC lab result, dated 2/25/22 and reported to facility at 2:27 p.m., indicated the WBC was 13.87 a high count (normal 4.8-10.8). There was no documentation the doctor was notified of these labs. Nurses' Notes, dated 2/26/22 at 3:45 a.m., indicated the resident was found not breathing. Immediately a code blue was called and compressions were started. EMS were called and arrived after 20 minutes to assess the resident. The EMS pronounced the resident dead at 4:02 a.m. The resident's daughter and the doctor were both notified. Nurses' Notes, dated 2/28/22, indicated the doctor was notified of the 2/25/22 CBC lab results.			

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	Interview with the dialysis RN on 3/16/22 at 9:15 a.m., indicated the first time the site was red, she did not know if that could have been from the sutures from the hospital. The second time she came there the cover was off of the site and they saw drainage and swabbed it and sent it out to the lab. The culture came back as a staph infection. A follow up interview with the dialysis RN on 3/16/22 at 12:55 p.m., indicated she did not document any information on the communication form regarding the site, drainage or that she took a culture on 2/21/22. She did not document any information on the communication form regarding the results of the culture. Interview with the Assistant Director of Nursing (ADON) on 3/16/22 at 12:21 p.m., indicated she was unaware the dialysis center took a culture of the site or that it had an infection. She indicated the doctor was not notified timely of the CBC drawn on 2/25/22. There was no assessment or monitoring of the dialysis access site the entire time she was at the facility. The current 2/15/21 "Hemodialysis" policy, provided by the ADON on 3/16/22 at 12:00 p.m., indicated staff will monitor the catheter insertion site every shift. Document any redness, swelling, pain or drainage. 3. The closed record for Resident D was reviewed on 3/15/22 at 11:58 a.m. The resident was admitted to the facility on 1/31/22 and discharged home on 2/16/22. Diagnoses included, but were not limited to, diabetes, fractured femur, and dementia. The Admission Minimum Data Set (MDS) assessment, dated 2/7/22, indicated the resident was moderately impaired for decision making.			

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Physician's Orders, dated 1/31/22, indicated skin assessments weekly. Document new skin issues per protocol. Peri area/Buttock May apply moisture barrier with each incontinent episode. May keep barrier cream at bedside for CNA to apply as needed.

Physician's Orders, dated 2/7/22, indicated Calmoseptine Ointment 0.44-20.6 % (Menthol-Zinc Oxide) apply to buttocks topically every shift for excoriation.

The Treatment Administration Record (TAR) for 2/2022, indicated the ointment was not signed out as being completed on day shift: 2/10 and 2/11, evening shift: 2/8, 2/10, 2/16, and midnight shift: 2/10 and 2/16/22.

There was no documentation in nurses' notes of any excoriation to the buttocks.

There was no Care Plan for excoriation.

Nurses' Notes, dated 2/8/22 at 12:10 p.m., indicated skin assessment done, no skin issues noted.

The Point of Care charting indicated there were no skin issues noted on 2/3-2/5, 2/8, 2/10-2/12 and 2/15/22.

Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated there was no documentation of any excoriation in the record. The treatment should have been signed out as ordered by the doctor.

4. On 3/14/22 at 9:00 a.m., Resident F was observed sitting in a broda chair by the nurses'

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	station. There were 2 skin tears observed on her right and left arms that were dried with bloody drainage noted. There were multiple areas of red and purple bruising noted to both arms. The resident was wearing short sleeves. On 3/14/22 at 10:25 a.m. and 1:56 p.m., the resident was observed in her room wearing short sleeves and the skin tears were still open and not bandaged. The resident's feet were extremely dry and scaly as well. On 3/14/22 at 3:38 p.m., CNA 2 removed the resident's bed linens from on top of her. She was observed lying in bed with no pillow between her legs and a heel boot to the right foot only. There were no bandages on her legs and both skin tears were still uncovered. On 3/15/22 at 2:58 p.m., the Wound Nurse performed the treatments for the resident's pressure ulcers. She pulled back the bed linens and there were no bandages on the resident's lower legs for non pressure areas of shearing. Interview with the Wound Nurse at that time, indicated the only non pressure area was on the left shin and a dry bandage was to be placed on it daily. The record for Resident F was reviewed on 3/14/22 at 3:05 p.m. Diagnoses included, but were not limited to, stroke, heart failure, dementia, high blood pressure, peripheral vascular disease, and Alzheimer's disease. The 2/5/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident was			

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	totally dependent on staff with a 2 person physical assist for bed mobility and transfers. The resident had unstageable and stage 2 and 4 pressure ulcers. The Care Plan, revised on 2/25/22, indicated the resident had fragile skin and was noted with discolorations. There were no Physician's Orders for geri sleeves or any other protectant for the resident's arms and fragile skin. Physician's Orders, dated 12/31/21, indicated Eucerin lotion to torso, arms, and legs every night shift. Physician's Orders dated 3/14/22, indicated cleanse left lower medial shin with normal saline and cover with dry dressing daily. There was no documentation in Nurses' Notes from 3/1-3/13/22 regarding any skin tears the resident had sustained. A skin note, dated 3/14/22 at 9:48 p.m., indicated all wounds were assessed by the Wound Doctor. The resident was noted to have a wound to the right forearm which remained stable. Skin tear with flap in place present, no drainage noted. Wound to left forearm remained stable. Skin tear with flap in place present, no drainage noted. Interview with CNA 1 on 3/15/22 at 12:50 p.m., indicated the resident used to have geri sleeves but she had not seen them for awhile. Interview with the Wound Nurse on 3/15/22 at 4:00 p.m., indicated the skin tears to both arms were noted on Monday and looked like they were			

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	old. She went through her orders on Monday and discontinued many treatments that were old. She indicated she brought tubigrips in for her today and was going to apply them to her arms. Her arms should be covered due to the fragile skin. Hospice nurses come in and do her treatments on Wednesdays and Fridays. They were always changing the treatments and the communication with nursing staff and hospice was not clear all the time. Interview with the resident's daughter on 3/15/22 at 3:47 p.m., indicated a male hospice nurse had called last week and notified of her a skin tear on her arm. A hospice note, dated 3/10/22 by the LPN indicated wound care completed. "I did note 1 new pressure area and 1 skin tear. Treatment obtained. POA notified." There were no treatments obtained in the resident's clinical record on 3/10/22 from hospice. Interview with the Assistant Director of Nursing (ADON) on 3/16/22 at 12:21 p.m., indicated treatments were to be done as ordered and she informed the Wound Nurse to provide the resident with geri sleeves. Hospice was to communicate with facility staff regarding any new areas of concern. The current 9/1/20 "Skin Condition Assessment and Monitoring" policy, provided by the ADON on 3/15/22 at 2:05 p.m., indicated non pressure skin conditions will be assessed for healing progress and signs of complications or infection weekly. This Federal tag relates to Complaints IN00368350,			

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	IN00372360, and IN00374545. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services for wound healing related to applying heel boots, pillows between legs, and covering pressure sores for 1 of 3 residents reviewed for pressure sores. (Resident F) Finding includes: On 3/14/22 at 9:00 a.m., Resident F was observed sitting in a broda chair by the nurses' station. She was wearing a heel boot to the right foot. There was nothing on the left foot. On 3/14/22 at 10:25 a.m. and 1:56 p.m., the resident was observed in her room wearing a heel boot to her right foot. There was nothing on the left foot.	F 0686	**F686** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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*	04/01/2022

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	On 3/14/22 at 3:38 p.m., CNA 2 removed the resident's bed linens from on top of her. She was observed lying in bed with no pillow between her legs and a heel boot to the right foot only. On 3/15/22 at 8:32 a.m., 9:45 a.m., and 11:45 a.m., the resident was observed sitting in the broda chair wearing a heel boot to her right foot and nothing on her left foot. At 12:50 p.m., the resident was observed in bed. CNA 1 indicated she had just put the resident to bed 10 minutes ago. The CNA provided incontinence care and while doing so, the bandage on the right ankle fell off and onto the floor. The CNA did not place a pillow in between the resident's legs when she was finished. At 2:58 p.m., the Wound Nurse performed the treatments for the resident's pressure ulcers. She pulled back the bed linens and there were no heel boots observed to either foot nor was there a pillow between her legs. The right ankle had no bandage noted over it. The pressure ulcer was red with no drainage noted. Interview with the Wound Nurse at that time, indicated no one had told her the bandage had fallen off of the right ankle. The resident was to have heel boots to both feet at all times and a pillow between her legs when she was in bed. The record for Resident F was reviewed on 3/14/22 at 3:05 p.m. Diagnoses included, but were not limited to, stroke, heart failure, dementia, high blood pressure, peripheral vascular disease, and Alzheimer's disease. The 2/5/22 Quarterly Minimum Data Set (MDS)		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F treatment to right ankle, heel boots to both feet and preventative measures such as pillow between legs are in place per physician orders. **2) How the facility identified other residents:** All residents may have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Staff will be re-education on ensuring treatment for pressure ulcer wounds are in place as ordered by physician. Staff will also be in-services on weekly monitoring of resident's skin condition during routine care and skin check schedule. Any abnormalities noted will be assessed, referred to MD/NP for interventions. An audit tool will be developed to ensure that weekly skin treatments for residents is in place. At least five random	

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	assessment, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident was totally dependent on staff with a 2 person physical assist for bed mobility and transfers. The resident had unstageable and stage 2 and 4 pressure ulcers. The Care Plan, revised on 2/25/22, indicated the resident had potential impairment to skin integrity related to immobility, incontinence, unstageable to left foot and stage 4 to right ankle. The resident was also receiving hospice services. Physician's Orders, dated 1/3/22, indicated bilateral heel floats on at all times. Physician's Orders, dated 1/25/22, indicated cleanse right ankle with normal saline and pat dry. Apply Medihoney to wound bed, abd pad, and wrap with kerlix daily. Cleanse left lateral foot with normal saline and pat dry. Apply Medihoney to wound bed and skin prep to peri wound. Cover with abd pad and wrap with kerlix daily. These orders were discontinued on 3/14/22. Physician's Orders, dated 2/9/22, indicated keep a pillow between legs when in bed as tolerated every shift. Physician's Orders, dated 2/16/22, indicated betadine to left lateral foot at night time. Apply gauze and cover with gauze island and wrap in gauze wrap. The order was discontinued on 3/14/22. Physician's Orders, dated 2/25/22, indicated right medial ankle apply leptospermum honey (Medihoney) with gauze island border dressing		residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	

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	every night shift. Physician's Orders, dated 3/4/22, indicated right medial ankle apply leptospermum honey with gauze island border dressing every day shift. Betadine moistened gauze to left distal lateral foot every day shift for wound. Apply to gauze and cover with gauze island and wrap in gauze wrap. These orders were discontinued on 3/14/22. The Wound Physician progress notes, dated 2/15/22, indicated the plan for treatment for the left lateral foot and the right ankle was betadine and gauze bandage and wrap in kerlix for the next 30 days. The Wound Physician's progress notes, dated 2/22/22 and 3/1/22, indicated to continue the betadine to the left lateral foot and apply leptospermum honey to the right ankle and cover daily. The Wound Physician's progress notes, dated 3/8/22, indicated to add Metronidazole gel and mix with Lidocaine 4% 1:1 cover with gauze island border dressing. Discontinue betadine. The right ankle treatment stayed the same. There was no Physician's Order for the Metronidazole gel and lidocaine mixture from 3/8-3/14/22. The 2/2022 Treatment Administration Record (TAR), indicated the Betadine to the left lateral foot was not signed out as being completed on 2/23/22. The TAR for 3/2022, indicated the Betadine to the left lateral foot was not signed out as being competed on 3/1, 3/3, 3/4, and 3/10/22. The			

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	leptospermum honey was not signed out as being completed to the right ankle on 3/3, 3/5, and 3/6/22. The Medihoney to the left lateral foot was also being signed out as completed on 3/2, 3/4, and 3/7-3/14/22 even though the Wound Physician had discontinued the treatment on 2/15/22 Interview with the Assistant Director of Nursing on 3/16/22 at 12:21 p.m., indicated Physician's Orders were to be followed for the treatments and the preventative measures such as the pillow and heel floats. This Federal tag relates to Complaint IN00368995. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter			

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	155469	A. BUILDING 00 B. WING	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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	as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure urine samples were collected for residents with a history of a urinary tract infection (UTI), catheter care was signed out as completed, and antibiotics were started timely after being diagnosed with a UTI for 3 of 3 residents reviewed for urinary catheters. (Residents N, C, and P) Findings include: 1. On 3/16/22 at 9:01 a.m., Resident N was observed in his room in bed sleeping. His foley catheter drainage bag was on the floor. The drainage bag was not covered with a dignity bag. The record for Resident N was reviewed on 3/16/22 at 9:04 a.m. Diagnoses included, but were not limited to, urinary tract infection, end stage renal disease, and benign prostatic hyperplasia (BPH) without lower urinary tract symptoms. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and had an indwelling	F 0690	**F690** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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.* **1) Immediate actions taken for those residents identified:** Resident N drainage bag was	04/01/2022

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	catheter. The March 2022 Physician's Order Summary (POS), indicated the resident had a 14 french/10 cubic centimeter (cc) Coude foley catheter for the diagnosis of neurogenic bladder. Catheter care was to be completed every shift. The February 2022 Treatment Administration Record (TAR), indicated catheter care had not been signed out as completed for the day shift on 2/22, evening shift 2/3, 2/9, 2/14, 2/20, and night shift on 2/9 and 2/14/22. The March 2022 TAR, indicated catheter care had not been signed out as completed for the day shift on 3/15 and the evening shift on 3/1, 3/9, and 3/11/22. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the resident's catheter bag should not have been on the floor and catheter care should have been signed out as being completed every shift. 2. On 3/14/22 at 2:06 p.m., Resident C was observed in her room in bed. The resident's foley catheter was draining clear yellow urine. There was no documentation on the door indicating the resident was in contact isolation. The record for Resident C was reviewed on 3/15/22 at 9:32 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and sepsis. The Significant Change Minimum Data Set (MDS) assessment, dated 2/8/22, indicated the resident's cognitive status had not been assessed and she was always incontinent of bladder. The resident's		covered, and catheter care was completed per physician order. Resident N urine sample was obtained, contact isolation and antibiotic regimen was completed. Resident P urinalysis and culture obtained. Antibiotic regimen completed. **2) How the facility identified other residents:** All residents with orders for IV antibiotics and indwelling/ suprapubic catheters have the potential to be affected by this alleged deficient practice. Audit of current residents with indwelling catheters was completed to ensure appropriate treatment and services are provided. Audit of residents receiving IV antibiotics was completed to ensure medication was obtained and administered per physician order. **3) Measures put into place/ System changes:** Nurses re-educated on catheter care and proper documentation to comply with Physician order and	

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	indwelling catheter had not been coded. The Care Plan, dated 11/11/21, indicated the resident was at risk for a UTI related to the use of an indwelling catheter. She had recurrent urinary tract infections and a neurogenic bladder. Interventions included, but were not limited to, observe, record, and report to Physician for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. A Physician's Order, dated 1/25/22, indicated the resident was to have an 18 french/30 milliliter (ml) balloon foley catheter. Catheter care was to be completed every shift. A Physician's Order, dated 1/30/22, indicated the resident was to have a straight catheter urine culture to rule out ESBL (extended spectrum beta-lactamase) one time a day every Monday and Wednesday. A Physician's Order, dated 2/21/22, indicated the resident was to be in contact isolation for ESBL. An entry completed by the Infectious Disease Nurse Practitioner (NP), on 1/26/22 at 6:32 p.m., indicated the resident was being followed for Pseudomonas/ESBL UTI. The resident was not receiving antibiotic therapy and urine cultures were ordered. He consulted with nursing and the resident had no fever, altered mental status or any worsening urinary issues. The resident was asymptomatic and isolation was to be maintained. Urine cultures were ordered times two 48 hours apart to rule out ESBL. When two negative cultures were obtained, isolation could be		plan of care. Nurses will also be re-educated on IV antibiotic regiment and completion, notification of labs orders. The director of nursing or designee will complete weekly audits on all residents with catheters to ensure orders are in PCC and on the MAR. A weekly audit of all residents with IV antibiotics and labs orders will be completed to ensure orders are followed and documented. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	

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discontinued.

An entry completed by the Infectious Disease NP, on 2/4/22 at 6:07 p.m., indicated he educated staff on the importance of obtaining the urine cultures and they understood when two consecutive negative cultures were obtained, then isolation could be discontinued.

The Infectious Disease NP again educated the staff about the importance of obtaining the urine cultures on 2/9, 2/16, and 2/23/22.

Nurses' Notes, dated 2/25/22 at 10:31 a.m., indicated the resident's urinary catheter was not draining. The balloon was deflated and then reinflated with 10 ml of normal saline. A scant amount of urine was drained and irrigation was attempted, but unsuccessful. The catheter was removed and a new one was inserted by the NP.

Nurses' Notes, dated 3/6/22 at 12:09 p.m., indicated the resident's husband stated the foley catheter was not functioning properly and the resident's bed sheets were wet. The catheter balloon was deflated, the catheter was advanced an inch, and then the balloon was inflated with 10 ml of water. The catheter continued to leak and a new catheter was inserted per the husband's request.

The resident was seen by the Infectious Disease NP on 3/2 and 3/9/22 and he again indicated isolation could be discontinued after two consecutive negative cultures within 48 hours.

Nurses' Notes, dated 3/14/22 at 6:00 a.m., indicated the resident's Physician requested for the resident's foley catheter to be changed and a urinalysis with a urine culture was to be obtained

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	and sent to the lab today. The urine sample was obtained and the sample was placed in the refrigerator for laboratory pickup. The final urine culture result, dated 3/16/22, indicated the urine contained 10-50,000 colonies/ml of Proteus Mirabilis. There were no other urine cultures available for review between 1/30 and 3/14/22. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the urine cultures should have been obtained as ordered. 3. On 3/14/22 at 9:07 a.m. Resident P was observed in bed. At that time, a foley catheter drainage bag was hanging on the side of the bed. The record for Resident P was reviewed on 3/16/22 at 8:50 a.m. Diagnoses included, but were not limited to, stroke, heart failure, high blood pressure, obstructive and reflux uropathy, hydronephrosis with ureteral stricture, urine retention, history of kidney stones and blood in the urine, and dementia without behaviors. The Significant Change Minimum Data Set (MDS) assessment, dated 2/8/22, indicated the resident had an indwelling catheter. The Care Plan, revised on 11/29/21, indicated the resident had potential for complications and infection related to having a suprapubic catheter. Nurses' Notes, dated 1/20/22 at 3:22 p.m., indicated the resident was having nephrolithotomy surgery (a procedure used to remove kidney stones from the body when they can't pass on their own) on 1/27/22 at 10:30 a.m.			

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Nurses' Notes, dated 1/25/22 at 5:08 a.m., indicated the resident's urine bag was replaced in an attempt to collect a urine sample. No urine output was noted in the bag for the past 3 hours. Resident made aware by CNA that during incontinence care, there was urine coming from suprapubic catheter entrance and the resident's brief was wet. The Nurse Practitioner was notified.

The resident was sent to the hospital and admitted with a complicated Urinary Tract Infection.

The resident was readmitted to the facility on 2/1/22 with ESBL (extended spectrum beta-lactamase) in the urine. The resident had a picc (peripherally inserted central line) line and was to receive Intravenous (IV) antibiotics.

The discharge instructions from the hospital, dated 2/1/22, indicated last dose of Piperacillin (an antibiotic medication) was administered on 2/1/22 at 10:09 a.m. The orders were Piperacillin 4.5 (4-0.5) GM Use 4.5 gram intravenously every 8 hours for 7 days.

Physician's Orders, dated 2/3/22, indicated Piperacillin 4.5 (4-0.5) GM Use 4.5 gram intravenously daily.

Physician's Orders, dated 2/3/22 at 4:00 p.m., indicated Piperacillin 4.5 (4-0.5) GM Use 4.5 gram intravenously every 8 hours.

The Medication Administration Record (MAR) dated 2/2022, indicated the first dose administered was on 2/3 at 9:55 a.m. and the next dose was administered at 12:00 a.m. on 2/4/22.

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	The Infectious Disease (ID) Nurse Practitioner (NP) progress notes, dated 2/16, 2/23, 3/2 and 3/9/22, indicated consulted with nursing and the resident presented with no fevers, altered mental status, or any worsening urinary issues outside of the normal. Isolation should be maintained. The resident had completed Zosyn as ordered. Urine cultures times 2 (48) hours apart to rule out ESBL were ordered and were pending. Educated staff on importance of obtaining cultures. When two consecutive negative cultures 48 hours apart were obtained then isolation can be discontinued. Will proceed based on next weeks assessment and response to treatment. Physician's Orders, dated 2/23/22, indicated Urinalysis with Reflex Culture to rule out ESBL one time a day every Monday and Thursday for ESBL of the urine. Will be reviewed by ID NP. There was no urinalysis obtained since the resident had finished the IV antibiotics. Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated the urinalysis nor the cultures were obtained. This Federal tag relates to Complaint IN00368995. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and			

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	preferences. Based on observation, record review and interview, the facility failed to ensure intravenous flush orders were obtained for 2 of 4 residents reviewed for infections. (Residents L and K) Findings include: 1. On 3/14/22 at 2:00 p.m., Resident L was observed in his room seated on the side of his bed. The resident had a peripherally inserted central catheter (PICC) line to his left upper arm. His intravenous (IV) antibiotic was infusing at that time. The record for Resident L was reviewed on 3/15/22 at 3:25 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), malignant neoplasm of bronchus or lung, and sepsis due to methicillin susceptible staphylococcus aureus (MSSA). The resident was admitted to the facility on 2/18/22. The Admission Minimum Data Set (MDS) assessment, dated 2/25/22, indicated the resident was cognitively intact and he had received antibiotics during the assessment reference period. The Care Plan, dated 2/21/22, indicated the resident required IV medication and had a peripherally inserted central catheter (PICC) required for sepsis. He had a potential for catheter related bloodstream infection, phlebitis, deep vein thrombosis, catheter occlusion, and catheter migration. Interventions included, but were not limited to, assess site during continuous infusion, before and after each intermittent use, and at least every shift when not in use.	F 0694	**F694** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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.* **1) Immediate actions taken for those residents identified:** Resident L and Resident K intravenous flush orders are in PPC and on the MAR. Orders are followed per Physician orders **2) How the facility identified other residents:** All residents with orders for IV antibiotics have the potential to be affected by this alleged deficient practice.	04/01/2022

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	A Physician's Order, dated 2/18/22, indicated the resident was to receive Nafcillin Sodium (an antibiotic) in dextrose solution 2 grams (GM)/100 milliliters (ML), use 2 GM intravenously (IV) six times a day for sepsis for 6 weeks. A Physician's Order, dated 3/8/22, indicated the resident was to receive a saline flush, 10 ml IV every shift for PICC line. There were no PICC line flush orders prior to 3/8/22. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the resident should have had IV flush orders upon admission. 2. On 3/15/22 at 8:30 a.m., Resident K was observed in his room seated in a wheelchair. The resident had a picc (peripherally inserted central catheter) line in his right upper arm. The bandage over the top of the picc line was dated 3/15/22. The record for Resident K was reviewed on 3/15/22 at 10:55 a.m. The resident was admitted on 3/10/22 from the hospital. Diagnoses included, but were not limited to, diabetes, stroke, end stage renal dialysis, partial traumatic amputation of the right great toe, and peripheral vascular disease. Nurses' Notes, dated 3/10/22 at 4:41 p.m., indicated, the resident arrived to the facility accompanied by two EMT's. The resident was alert and indicated "my mind is right." The resident was to receive dialysis in the facility on Monday, Wednesday, and Fridays at 1:50 p.m. The resident had an AV fistula to the left forearm. He was to receive two Intravenous (IV) antibiotics and 1 antifungal related to the surgical wound site on the right foot. The right great toe was amputated and the wound was open with the		Audit of residents receiving IV antibiotics was completed to ensure flush orders were completed and documented. **3) Measures put into place/ System changes:** Nurses will also be re-educated on IV antibiotic regiment and flush orders completion, notification, and documentation. The director of nursing or designee will complete weekly audits on all residents with IV antibiotics to ensure orders are properly entered in PCC, followed, and documented. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	

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	bone exposed. Physician's Orders, dated 3/10/22 , indicated Cefepime HCl Solution 1 gram/50 milliliters. Use 1 gram intravenously one time a day every Monday, Wednesday, and Friday for 15 administrations to be given at dialysis. Daptomycin Solution Reconstituted 350 milligrams (mg), use 450 mg intravenously one time a day every Monday, Wednesday, and Friday to be given after dialysis. Nurses' Notes, dated 3/11/22 at 12:45 p.m., indicated vascular access solutions here at this time to place midline for IV antibiotic for right foot. Access placed in right upper arm. Nurses' Notes, dated 3/11/22 at 12:47 p.m., indicated both IV antibiotics were not administered due to resident did not have IV access site. Midline inserted to right upper arm. In house dialysis stated they were unable to hang it today after dialysis. Physician notified. Physician's Orders, dated 3/11-3/14/22, indicated there were no orders to flush the picc line ports every shift for patency. Interview with RN 1 on 3/15/22 at 11:30 a.m., indicated the resident arrived at the facility on Thursday night and the orders indicated he was to receive the antibiotic on Monday, Wednesday and Fridays in dialysis. The RN indicated on 3/11/22 she took the IV's to dialysis and they told her they cannot and will not hang IV antibiotics during dialysis. She had to call the pharmacy to have someone come out and put a picc line in. She also notified the doctor the antibiotics were not administered in dialysis as ordered. The picc line was inserted on Friday. RN 1 indicated she did not work the weekend so she had no idea if			

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	the ports were flushed with saline. Interview with the Assistant Director of Nursing (ADON) on 3/16/22 at 12:30 p.m., indicated she saw the resident had no orders for saline flushes after the picc line was inserted, so she put the orders into the computer so they would be done. The current 2/15/21 "PICC Line Flush" policy, provided by the ADON on 3/14/22 at 2:05 p.m., indicated to flush and lock the peripheral catheter used for intermittent infusion at least every 12 hours. This Federal tag relates to Complaint IN00368995. 3.1-47(a)(2)			
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 not providing a prn (as needed) pain medication for a pain level of 5 for 1 of 3 residents reviewed for pain. (Resident E) Finding includes: The closed record for Resident E was reviewed on 3/14/22 at 10:45 a.m. The resident was admitted on 2/17/22 and expired in the facility on 2/26/22. Diagnoses included, but were not limited to, stroke, diabetes, chronic kidney disease, vascular	F 0697	**F697** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	04/01/2022

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	dementia, high blood pressure, osteoarthritis right hip, and pneumonia. The 2/22/22 Admission Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. She needed extensive assist with 1 person physical assist for bed mobility. Routine pain medication was coded as "none" and the resident had no pain present at the time of the assessment. The resident had a transfusion and received dialysis while a resident. A Care Plan, dated 2/17/22, indicated the resident was at risk for pain. The nursing approaches were to administer analgesics per orders and monitor and report non verbal signs of pain. A pain assessment was completed on the nursing admission assessment dated 2/17/22. Information related to pain came from the resident and nurse. If the resident was experiencing pain it was unknown or unable to determine. An acceptable level of pain, what makes the pain worse or what helps, and when the resident was experiencing pain were documented with "n/a." Physician's Orders, dated 2/17/22, indicated Tylenol Extra Strength Tablet 500 milligrams (mg) (Acetaminophen). Give 1 tablet by mouth every 6 hours as needed for pain. Physician's Orders, dated 2/18/22, indicated Tylenol Extra Strength Tablet 500 mg, give 1 tablet by mouth in the morning for pain. Pain scale/evaluation every shift. The Medication Administration Record (MAR) for the month of 2/2022, indicated the resident's pain level was a 5 on the day and evening shifts on 2/24/22. The prn Tylenol was not signed out on		*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.* **1) Immediate actions taken for those residents identified:** Resident E no longer resides in the facility. **2) How the facility identified other residents:** All residents receiving PRN pain medications have the potential to be affected by this alleged deficient practice. An audit was completed on all residents with PRN pain medication to ensure assessments and plan of care were up to date. **3) Measures put into place/ System changes:** Staff education was provided on medication administration and assessment of residents that exhibit change of condition. Staff was also educated on the importance of monitoring, assessing, documenting, and providing PRN pain medication	

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	2/24/22, nor had it been signed out the entire time the resident resided in the facility. There was no documentation in nursing progress notes to indicate the resident was having pain. Interview with the Assistant Director of Nursing on 3/16/22 at 12:21 p.m., indicated the resident's pain should have been assessed further and documented when their pain level was a 5 and the prn Tylenol should have been administered. This Federal tag relates to Complaint IN00374545. 3.1-37(a)		according to physician's order and resident plan of care. **4) How the corrective actions will be monitored:** Director of Nursing or designee will review daily documentation to ensure assessments were completed and PRN pain medication was administered and documented. **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: 04/01/2022**	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each			

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	resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, record review, and interview, the facility failed to ensure a CNA did not provide care outside of their scope of practice related to turning on tube feeding pumps for 1 of 3 residents reviewed for tube feeding. (Resident C) Finding includes: On 3/15/22 at 11:20 a.m., Resident C was in her room in bed. The head of the bed was flat and the resident's tube feeding pump had been placed on hold. Interview with the resident's husband at that time, indicated he put the feeding pump on hold.	F 0726	**F726** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *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*	04/01/2022

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	CNA 5 entered the room to provide incontinence care for the resident. After the completion of incontinence care, the resident's husband asked the CNA to turn the feeding pump back on. The CNA hesitated and then resumed the feeding pump. Interview with the CNA after she exited the room, indicated instead of turning the feeding pump back on per the husband's request, she should have told him she needed to get a nurse to do it. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the CNA should have gotten a nurse to turn the tube feeding back on because that was not within her scope of practice. She also indicated the resident's husband would be counseled about putting the pump on hold. 3.1-35(g)(2)		*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.* **1) Immediate actions taken for those residents identified:** Resident C was assessed by attending nurse and remain within baseline. CNA#5 was educated regarding importance of not providing services outside the scope of practice. Resident C husband educated regarding requesting assistance from attending licensed nurse for management of feeding pump equipment. **2) How the facility identified other residents:** All residents with feeding pump have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Staff education was provided on the importance of not incurring on out-of-scope practices. C.N.A's and/ or unlicensed personnel are not allowed to operate tube feeling machines. C.N.A or any other	

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			unlicensed personnel must notify the attending nurse if when entering a room, equipment alarm sound is on or family request assistance with the equipment. **4) How the corrective actions will be monitored:** An audit tool will be developed to ensure that weekly observation rounds are completed at least 5 times weekly for 4 weeks the 2x weekly for 6 months to ensure CNA is not performing tasks out of their scope of practice related to tube feeding machines. **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: 04/01/2022**	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse			

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	specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure stool specimens were collected as ordered for 1 of 4 residents reviewed for infections. (Resident U) Finding includes: The record for Resident U was reviewed on 3/17/22 at 9:00 a.m. Diagnoses included, but were not limited to, sepsis and clostridium difficile (c-diff). The resident was admitted to the facility on 2/28/22. A Nurse Practitioner progress note, dated 3/2/22 at 10:57 a.m., indicated the resident was currently reporting diarrhea for a "few days." The resident was unable to tell how many times per day. Will obtain stool for c-diff due to intravenous antibiotic use while hospitalized. A Physician's Order, dated 3/2/22, indicated the resident was to have a stool sample collected to rule out c-diff due to diarrhea status post antibiotic therapy. The order end date was 3/12/22. A Physician's Order, dated 3/9/22, indicated the resident was to have a stool sample collected to rule out c-diff due to diarrhea and recent antibiotic therapy.	F 0773	**F773** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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.* **1) Immediate actions taken for those residents identified:** Resident U antibiotic regiment was completed per physician order. **2) How the facility identified other residents:**	04/01/2022

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	The stool specimen was collected on 3/10/22. On 3/11/22 it was reported the resident was positive for c-diff. The bowel and bladder sheets indicated the resident had large/loose stools on 3/5, 3/7, and 3/8/22. Interview with the Assistant Director of Nursing on 3/17/22 at 12:42 p.m., indicated the stool specimen should have been collected prior to 3/10/22. 3.1-49(f)(1)		All residents with laboratory orders have the potential to be affected by this alleged deficient practice. Audit of all lab orders was completed to ensure samples were collected timely, results were received and promptly notification of results were given to ordering Physician. New orders were completed and documented as needed. **3) Measures put into place/ System changes:** Staff was re-educated on the importance of timely collection of samples for lab services. Once results are received, the nurse must immediately notify the ordering physician of the results. Any new orders received must be document on resident clinical record. The director of nursing or designee review daily documentation five days per week to ensure all labs orders were properly entered in PCC, followed, Physician notification was completed and documented. **4) How the corrective actions will be monitored:**	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	
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			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	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 implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed after leaving isolation rooms, masks worn incorrectly, not wearing the correct personal protective equipment in isolation rooms, staff unaware of why residents were in isolation, not monitoring for COVID-19 signs and symptoms, disinfecting of multi-use equipment, incomplete staff screening sheets and staff with long fingernails for 1 of 3 staff reviewed and for 2 of 2 residents reviewed for COVID-19. (Residents B, C, S, T, F, and Employee 3) Findings include: 1. On 3/14/22 at 10:27 a.m., LPN 1 was observed in the doorway of Resident U's room. The LPN had a cup of water and the resident's medications in each hand. She stopped in the doorway and removed a gown from the personal protective equipment (PPE) supply hanging from the door frame. The LPN put on the gown while holding the items in her hands and then she retrieved a pair of gloves and carried them into the room. A sign on the door indicated the resident was in contact isolation. Upon exiting the room, the LPN had the rolled up gown in her hands and she discarded the gown in the trash can on the side of her medication cart.	F 0880	**F880** **The facility requests paper compliance for this citation***This Plan of Correction is the center's credible allegation of compliance. 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.***1)** **Immediate actions taken for those residents/staff identified:**Resident B no longer resides in the facility. Resident C orders for vital sign monitoring reinstated. Resident F was provided a clean pillow. LPN #1, Social Services Designee, CNA #1, Housekeeper #1, Therapy Employee, CNA #4, Dietary employee #1, QMA #1, CNA #3, were re-educated on Infection control policy. Awareness of current residents in isolation. Competency with return demonstration was given on proper use of PPE, hand hygiene, proper	04/01/2022

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	Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the LPN should have discarded the gown in the resident's room. 2. On 3/14/22 at 10:32 a.m., the Social Service Designee (SSD) was observed in Resident S's room. The SSD was seated on a bed across from the resident. The SSD was wearing a surgical mask and no other PPE. There was a yellow sign on the resident's door which indicated he was in contact/droplet precautions. A PPE container was hanging from the resident's door frame. The sign on the door indicated an N95 mask, eye protection, a gown, and gloves were to be worn while in the room. Upon exiting the room, the SSD's phone rang, she took the call and did not perform hand hygiene when exiting the room. There was a hand sanitizing station outside of the resident's door in the hallway. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the SSD should have worn full PPE while in the room and she should have sanitized her hands upon exiting the room. 3. On 3/14/22 at 11:50 a.m., CNA 1 entered Resident S's room to deliver his lunch tray. A yellow sign on the door indicated he was in contact/droplet precautions. Prior to entering the room, the CNA donned a gown and gloves. She did not switch out her surgical mask for a N95 mask nor did she put on any type of eye protection. At 11:54 a.m., the CNA entered Resident T's room to deliver his lunch tray. A yellow sign on the door indicated he was in contact/droplet precautions. Prior to entering the room, the CNA donned a gown and gloves. She did not switch		discard of gowns, different types of isolation, residents door signage, required PPE based on type of ISO and recommended eye protection related to properly prevent and/or contain Covid-19. CNA#2 was re-educated on facility policy regarding fingernails, infection control policy, proper use of PPE and hand hygiene. CNA #4 was re-educated on facility infection control policy related to immediate disinfection of multi-use equipment between resident use. Emergency Medical Staff was contacted, and education was provided regarding facility infection control practices related to the use of facial covering while in the facility. **2) How the facility identified other residents:**All residents have the potential to be affected by the alleged deficiency. Audit of new admission over the last 30 days was completed to ensure monitoring order for sign and symptoms of COVID-19 were in place and COVID-19 rapid test was performed if resident exhibited flu-like symptoms. Proper notification, interventions in place and documentation completed. Audit of staff COVID-19 screening sheet was completed ensure staff are being properly screening prior to starting their shift.Observation audit was completed on all staff to ensure facility policy regarding fingernails its been followed. **3)**	

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	out her surgical mask for a N95 mask nor did she put on any type of eye protection. At 12:24 p.m., Housekeeper 1 entered Resident T's room and removed his lunch tray. She was not wearing a gown, gloves, N95 mask, or eye protection. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated the CNA and the Housekeeper should have worn an N95 mask, gown, gloves, and eye protection while in the rooms. 4. On 3/15/22 at 9:04 a.m., Housekeeper 1 and Therapy Employee 1 were observed inside the doorway of Resident S's room. A yellow sign on the door indicated the resident was in contact/droplet precautions. The Housekeeper was wearing a surgical mask and a pair of disposable gloves. She was not wearing a gown or eye protection. The Therapy Employee had his surgical mask pulled down below his chin and he was not wearing a gown, gloves, or eye protection. Interview with the Housekeeper at that time, indicated she did not know why the resident was in isolation and she went by what was on the door. She also indicated as far as PPE, she would put on whatever was in the container hanging from the door. There were no N95 masks in the PPE supplies hanging from the door. Interview with the Assistant Director of Nursing on 3/16/22 at 1:00 p.m., indicated both staff members should have been wearing an N95 mask, gown, gloves, and eye protection while in the resident's room.		**Measures put into place/ System changes** Staff will be re-educated regarding infection control guidelines, PPE utilization, proper hand hygiene, different types of isolation, how to identify residents on isolation, proper use of face covering, disinfection of multi-use equipment, staff proper completion of COVID-19 screening sheet. Residents monitoring and testing to prevent and/or contain COVID-19. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete daily care rounds on at least 5 staff members 5 times per week at varied times/shifts to ensure proper infection control techniques are followed. The ICP or designee will review daily staff COVID-19 screening sheets to ensure accurate completion.The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 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: 04/01/2022**	

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	5. On 3/15/22 at 9:34 a.m., CNA 4 entered a resident room with the sit to stand lift. At 9:40 a.m., the CNA exited the room and positioned the lift next to the wall outside of the room. The CNA then went back inside the room. At 9:46 a.m., the CNA exited the room and then entered another room on Apple Lane. After exiting the room on Apple Lane, interview with the CNA at that time, indicated lifts were to be cleaned with bleach wipes after each use. She indicated she hadn't had a chance to clean the lift yet, but she would do so before she used it on someone else. At 9:56 a.m., the CNA was observed cleaning the sit to stand lift. Interview with the Assistant Director of Nursing on 3/17/22 at 8:35 a.m., indicated the lift should have been cleaned when the CNA brought it out of the room in case someone else needed to use it before she got the chance to clean it. 6. On 3/15/22 at 1:59 p.m., an Emergency Medical Staff Person was observed walking from the Nurses' Station down the Cherry Court hallway with no mask on. At 2:01 p.m., Dietary Employee 1 was observed walking down the Cherry Court hallway with her mask pulled down below her chin. On 3/17/22 at 8:30 a.m., Dietary Employee 1 was observed in the dining room. Her mask was pulled down below her nose. Interview with the Assistant Director of Nursing on 3/17/22 at 8:40 a.m., indicated EMS should have been wearing a mask and the Dietary Employee shouldn't have had her mask pulled down.			

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	155469	A. BUILDING 00 B. WING	03/17/2022

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	7. The closed record for Resident B was reviewed on 3/14/22 at 2:15 p.m. Diagnoses included, but were not limited to, stroke, end stage renal disease, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus. The resident was admitted to the facility on 11/16 and discharged on 11/28/21. The Admission Minimum Data Set (MDS) assessment, dated 11/23/21, indicated the resident was cognitively intact and she required extensive assistance with bed mobility, transfers, and toilet use. The Care Plan, dated 11/21/21, indicated the resident was at risk for psychosocial well being concerns related to medically imposed restrictions related to COVID-19 precautions. Interventions included, but were not limited to, follow facility protocol for COVID-19 screening/precautions and observe for signs and symptoms of COVID-19, document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, or respiratory issues. A Physician's Order, dated 11/16/21, indicated observe resident for flu-like symptoms, including cough, fatigue, shortness of breath, sore throat, headache, nasal congestion, or fever. For positive, flu-like symptoms, immediately place resident in droplet and contact isolation. Place a mask on the resident and ensure their door is closed. Document: + if symptoms are present; - if symptoms not present every shift. Nurses' Notes, dated 11/27/21 at 10:49 a.m., indicated a telephone call was received from the dialysis nurse who stated, "pt [sic] has forty minutes left on dialysis machine and pt states			

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	she's not feeling well and her stomach is cramping, can someone come and pick her up early?" The dialysis nurse was informed transportation was provided by a transportation service. The dialysis nurse was informed the resident was not complaining of any pain or discomfort prior to leaving the facility. At 11:37 a.m., the resident returned from dialysis, she appeared moderately tired. She consumed 50% of her lunch and then she was assisted to bed to rest. At 8:15 p.m., the resident was noted to be very weak, lethargic, and moaning. The resident indicated she was fine and just tired. The resident had an elevated temperature of 101.8 with an oxygen saturation level of 85% on room air. Writer spoke with Physician and orders were received for Tylenol for the elevated temperature. The resident was also provided with an as needed (prn) Albuterol inhaler. At 11:50 p.m., the resident's oxygen saturation was 90% on room air and her temperature was 98.1 and she was resting comfortably. Nurses' Notes, dated 11/28/21 at 4:20 a.m., indicated the resident's oxygen saturation was 84% on room air and she had a temperature of 100.7. At 4:50 a.m., the resident's Physician was notified and orders were obtained for oxygen at 2 liters per nasal cannula and send to the emergency room for evaluation. The resident was admitted to the hospital with COVID-19. There was no documentation of a rapid COVID-19 test being completed at the facility when the resident started exhibiting flu-like symptoms. There was also no documentation indicating if the resident was placed in contact/droplet precautions. Interview with the Assistant Director of Nursing			

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	on 3/16/22 at 1:00 p.m., indicated the resident should have received a rapid COVID test when she started having flu like symptoms and she should be have been placed in contact/droplet precautions. 8. The record for Resident C was reviewed on 3/15/22 at 9:32 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and sepsis. The resident was readmitted to the facility on 1/25/22. The Significant Change Minimum Data Set (MDS) assessment, dated 2/8/22, indicated the resident's cognitive status had not been assessed and she was always incontinent of bladder. The resident's indwelling catheter had not been coded. A Physician's Order, dated 1/25/22, indicated observe resident for flu-like symptoms, including cough, fatigue, shortness of breath, sore throat, headache, nasal congestion, or fever. For positive, flu-like symptoms, immediately place resident in droplet and contact isolation. Place a mask on the resident and ensure their door is closed. Document Y if symptoms are present. The resident did not have a Physician's Order to monitor vitals upon her hospital return on 1/25/22. The resident's oxygen saturation was being monitored each shift due to her receiving oxygen, however, the resident's temperature was not being documented daily. The last documented temperature in the "weights/vitals" section was dated 3/2/22. Interview with the Assistant Director of Nursing on 3/17/22 at 12:30 p.m., indicated the orders for vital sign monitoring needed to be reinstated.			

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	9. The COVID-19 screening sheets for Employee 3 were reviewed on 3/17/22 at 12:45 p.m. No temperature was documented for the employee on 3/1, 3/3, 3/4, 3/5, 3/7, and 3/8/22. Interview with the Administrator on 3/17/22 at 12:55 p.m., indicated all questions on the screening sheet should be answered along with a temperature documented. 10. During a random observation on 3/14/22 at 9:20 a.m., QMA 1 was observed sitting behind the nurses' station on the Bakersfield unit. At that time a resident was directly across from her and within 6 feet. QMA 1 had her face mask below her nose and mouth and she was speaking to him. Interview with QMA 1 at that time, indicated she was aware her mask was supposed to be over her mouth and nose at all times. 11. During a random observation on 3/14/22 at 1:50 p.m., CNA 3 was observed to call out to Resident S from the hallway. The sign on the resident's door indicated he was in Transmission Based Precautions (TBP). The resident came to the door and CNA 3 escorted him down the hallway to the dialysis room. The CNA was wearing a regular surgical face mask over her nose and mouth and was not wearing any eye protection as she walked with him down the hall. Interview with CNA 3 at that time, indicated she had no idea why the resident was in isolation. She thought the resident was in isolation for something in his "stool." Interview with LPN 1 at that time, indicated she was unaware why the resident was in isolation and she had been taking care of him all day. The			

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	LPN was wearing a pair of safety glasses with large gaps at the sides. She indicated she had worn them all day and while she was in the room with Resident S. Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated staff were to be aware of why the resident's were isolation. 12. During a random observation on 3/14/22 at 3:38 p.m., CNA 2 was observed with approximately 3 inch fingernails to both hands. She walked into Resident F's room so her skin on her legs could be observed. The CNA did not donn a pair of gloves and pulled back the linens. At that time, she moved the resident's arms. The resident had 2 open skin tears on each arm with multiple bruises on each arm as well. The CNA donned a pair of clean gloves to both hands and did not perform hand hygiene. She moved her legs so the resident's skin could be observed. She then placed a dirty pillow with dried brown stains and no pillow case between the resident's legs. Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated she saw the CNA's fingernails and she told her to cut them. The facility's current guidance in the handbook indicated long fingernails were not appropriate for healthcare environment and may interfere with employee and/or resident safety. Fingernails must be clean and neatly trimmed. 13. During a random observation on 3/15/22 at 12:50 p.m., Resident F was observed in bed. At that time, CNA 1 was going to provide incontinence care. She left the room briefly and walked to the room next door and obtained a privacy screen. She did not clean or sanitize the			

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	screen and placed it between the resident and the roommate. The CNA then provided incontinence care. Interview with the Assistant Director of Nursing on 3/16/22 at 12:30 p.m., indicated they realized they only had a couple of screens and more have been ordered. The screens could be reused, however, they needed to be cleaned in between residents. This Federal tag relates to Complaint IN00372360. 3.1-18(b)			
F 0888 SS=B Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and			

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	(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions,			

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	intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff			

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	member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on record review and interview, the facility failed to ensure staff were fully vaccinated and/or had an exemption in place for 2 of 119 employees. This resulted in a 97.5% staff vaccination rate. (Employees 4 and 3) Finding includes: The COVID-19 Staff Vaccination Matrix was reviewed on 3/16/22 at 2:16 p.m. The Matrix indicated Employee 4 was partially vaccinated and had no exemptions in place. The employee was	F 0888	**F888** The facility requests paper compliance for this citationThis Plan of Correction is the center's credible allegation of compliance. 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	04/01/2022

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	hired on 12/19/21 and only worked as needed. Employee 3 had a medical exemption. The medical exemption, dated 3/15/22, provided by the Human Resource Director, was not complete. The exemption had not been filled out or signed by a licensed practitioner. There was no information containing what vaccine was contraindicated or reason/rationale as to why the employee needed a medical exemption. A religious exemption provided by the Human Resource Director for Employee 3 on 3/17/22 at 11:30 a.m., indicated the exemption had been dated as accepted on 3/14/22 by the Human Resource Director. The Human Resource Director nor Employee 3 indicated the employee had a religious exemption in place when both were interviewed on 3/16/22. 3.1-18(b)		and/or executed solely because it is required by the provisions of federal and state law.1) Immediate actions taken for those residents/staff identified:Employee 3 provided completed / approved religious exemption 3/17/2022. Employee 4 received COVID-19 first dose on 03/11/2022. 5) Date of compliance: 04/01/2022	