| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155530 | A. BUILDING 00<br>B. WING | 04/08/2022 |

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| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00376588.<br><br>Complaint IN00376588 - Substantiated. Federal/state deficiencies related to the allegations are cited at F686 and F921.<br><br>Unrelated deficiency is cited at F888.<br><br>Survey dates: April 7 & 8, 2022<br><br>Facility number: 000369<br>Provider number: 155530<br>AIM number: 100275190<br><br>Census Bed Type:<br>SNF/NF: 85<br>Total: 85<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 76<br>Other: 4<br>Total: 85<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 4/12/22. | F 0000 | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that- | | | |

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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| | (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<br>(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.<br>Based on observation, record review, and interview, the facility failed to ensure assessments of pressure ulcers were completed timely, treatments for pressure ulcers were initiated timely, and treatments were completed as ordered by the Physician for 2 of 3 residents reviewed for pressure ulcers. (Residents B and D)<br><br>Findings include:<br><br>1. Resident B's closed record was reviewed on 4/7/22 at 8:52 a.m. The diagnoses included, but were not limited to, anoxic brain damage and pressure ulcers of the sacral area. The resident was hospitalized from 1/15/22 to 1/27/22, 2/23/22 to 3/5/22, and 3/21/22 to present.<br><br>A Significant Change MDS assessment, dated 2/3/22, indicated the cognition status was unable to be assessed, was dependent for all activities of daily living, was always incontinent of bladder and bowel, had an unstageable (full tissue loss that may be covered with extensive necrotic tissue or by an eschar) pressure ulcer upon re-admission. The resident was on a pressure reduction bed, received pressure ulcer care, and nutrition/hydration interventions.<br><br>A Care Plan, dated 12/22/21 and revised on 2/8/22, | F 0686 | **The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after 5/4/2022**<br><br>686 Treatment/Services to Prevent/Heal Pressure Ulcers<br><br>1. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident B continues to be a closed file.<br>· All pressure injury orders were reviewed for accuracy.<br><br>2. **How other residents** | 05/04/2022 |

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| | indicated a risk for further pressure ulcers. The interventions included, observe skin with daily care, incontinent care, and medications as ordered.<br><br>A Care Plan, dated 1/27/22, indicated a pressure ulcer on the sacrum area. The interventions included, supplements, treatments as ordered, assess and measure the area weekly, and supplements as ordered.<br><br>On 2/23/22, the Care Plans indicated a pressure area to the left ear and the right and left elbows. The interventions indicated supplements as ordered, treatments as ordered, assess and measure the areas weekly.<br><br>A) A Wound Nurse Note, dated 1/27/22 at 2:48 p.m., indicated the sacrum pressure area measured 12.8 cm (centimeters) by 9.3 cm, was unstageable due to slough and necrotic tissue. The wound was 60% necrotic, 10% slough 20% granulation and 10% epithelial. There was a moderate amount of odorless serous drainage. The Physician was notified and orders obtained.<br><br>The Physician's Orders, dated 1/27/22, indicated the sacrum was to be cleansed, patted dry, and a hydrocolloid (protective dressing) was to be applied daily and as needed.<br><br>On 2/9/22, the sacrum pressure area measured 12.2 cm x 9.7 cm, was covered with 50% slough and 30% eschar.<br><br>A Physician's Order, dated 2/9/22, indicated the sacrum was to be cleansed, patted dry and Santyl (debriding agent) was to be applied. The area was to be covered with a dressing every day and as needed. | | **having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>All Residents with risk of skin impairment have the potential to be affected by the alleged deficient practice. All residents that have pressure ulcers have the potential to be affected by the alleged deficient practice.<br>· All residents with pressure injuries will have an audit completed to ensure that all orders and interventions are in place and care planned.<br>· All residents with treatment orders TAR were reviewed for lack of initials in TAR, any residents effected with missing initials in the TAR had wounds assessed and treatment changes ordered if indicated.<br>· Full house skin sweep completed to assess residents for potential skin breakdown.<br>· New or Readmissions to the facility have the potential to be affected, all new or readmission residents for the last 30 days were reviewed for skin impairment and treatment implementation.<br>3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?**<br>· DON/or Designee will conduct an in-service for all | |

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| | The Treatment Administration Record (TAR), dated 2/2022, indicated by the lack of initials the treatment to the sacrum had not been completed on February 13 and 17, 2022.<br><br>On 2/23/22, the sacrum pressure ulcer measured, 11.7 cm x 9.9 cm x 6 cm , there was 20% slough and 50% eschar present. (the resident was transferred to the hospital on 2/23/22)<br><br>The Re-admission Nurse's Assessment, dated 3/5/22, indicated the sacrum pressure area was 20 cm x 15 cm with a depth of 5.5 cm.<br><br>Physician's Orders for the sacrum treatment were not obtained until 3/7/22, and indicated the area was to be cleansed and patted dry. Calcium alginate (absorbent pressure ulcer treatment) was to be applied and the wound was to be covered with a dry dressing daily and as needed.<br><br>The TAR, dated 3/2022, indicated by a lack of initials the treatment for the sacrum wound had not been completed on March 9, 10, 12, and 16, 2022.<br><br>B) A Wound Sheet, dated 2/23/22, indicated an area was found on the left ear that measured 4.6 cm by 0.1 cm. There was 70% granulation and 10% exposed cartilage. (the resident was then transferred to the hospital on 2/23/22)<br><br>A Physician's Order, dated 2/23/22, indicated the left ear was to be cleansed, patted dry, then calcium alginate and a dry dressing was to be applied every other day and as needed.<br><br>A Re-admission Nurse's Assessment, dated 3/5/22, indicated the left ear area was 5.3 cm by 3.5 | | RN/LPN staff regarding wound care with emphasis the skin management program with emphasis on wound care, prevention, treatments, orders and care plans and proper procedure related to assessing and obtaining treatment orders for each type of wound.<br>· DON/ Designee will provide education to RN/LPN as it related to the new admission/ Readmission assessment with emphasis on assessing and obtaining treatment orders at time of admission.<br>· DON/ Designee will provide education to RN/ LPN as it related to identing new impaired skin issues with emphasis on assessing and obtaining treatment orders at time that impairment is found.<br>· Nurse Consultant/ Designee will educate Clinical IDT team on reviewing MARs/ TARs/ New wounds during AM clinical meeting to ensure adequate follow up completed.<br>· An in-service will be completed for RN/LPN staff by the Director of Nursing/Designee to provide education and expectations regarding Policy and Procedures as it relates to following physician's orders.<br>4. **How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance** | |

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| | cm and an area on the right ear was 4.5 cm x 4 cm.<br><br>A Physician's Order for treatment of the right and left ear was not obtained until 3/7/22 and indicated the right and left ears were to be cleansed, patted dry, and bacitracin was to be applied. The areas were to be left open to the air daily.<br><br>The TAR, dated 3/2022, indicated the right and left ear treatment was not completed on March 9, 12, and 16, 2022.<br><br>C) A Wound Note, dated 2/17/22 at 2:03 p.m., indicated a pressure area on the right elbow that measured 1.3 cm by 2 cm, no depth. Physician Orders were received.<br><br>A Physician's Order, dated 2/17/22, indicated skin prep (skin protectant) was to be applied to the right elbow and the area was to be covered with a protective dressing.<br><br>The Wound Notes, dated 2/23/22, indicated the right elbow was 2 cm by 2.5 cm with 70% slough present. The left elbow was a deep tissue injury (injury to tissues under the skin) and measured 1.6 cm by 2 cm . (was admitted to the hospital on 2/23/22)<br><br>A Re-admission Nurse's Assessment, dated 3/5/22, indicated the left elbow area was 3 cm by 2 cm.<br>There was no measurement or assessment of the right elbow.<br><br>A Physician's Order for the treatment of the right and left elbow was not obtained unit 3/7/22 and indicated the right and left elbow was to be cleansed, patted dry and covered with a protective dressing daily. | | **program will be put into place?**<br>· An audit tool “Wound and skin Prevention”, will be utilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed daily x4 weeks, weekly x2months, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters.<br>· ADON/Designee will audit treatment orders for accuracy and completion. The ADON will audit 5 residents 3 days per week for 4 weeks, then 3 resident 3 days per week for 4 weeks, then 1 resident 3 days a week for 4 weeks. Any concerns will be addressed if found.<br>· IDT will review all new skin impairments in clinical morning meeting with “New Skin Audit Sheet” to ensure that area was assessed, and treatment order obtained.<br><br>Results of the Audit tool will be presented to the QAPI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action.<br>If 95% threshold is not achieved, an action plan will be developed to achieve desired threshold. | |

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A Wound Assessment, dated 3/9/22, indicated the right elbow was 1.3 cm by 1.6 cm with granulation.

The TAR, dated 3/2022, the right and left elbow treatment was not completed on March 9, 12, and 16, 2022.

The Wound Assessments, dated 3/16/22, indicated the right elbow was 1.1 cm by 1.7 cm and no depth. The left elbow was 1.6 cm with 1.7 cm and slough was present.

A Physician's Order for a new wound treatment was not obtained until 3/21/22 and started on 3/22/22, and indicated to cleanse both elbows, pat dry, then apply calcium alginate and a protective dressing daily and as needed.

D) A Re-admission Nurse's Assessment, dated 3/5/22, indicated a DTI to the right heel and the left heel with a pressure area 5.7 cm by 3.3 cm.

A Physician's Order was not obtained until 3/7/22 and indicated both heels were to be cleansed, patted dry, and a protective dressing was to be applied daily.

The TAR, dated 3/2022, indicated the right and left heel treatment was not completed on March 9, 12, and 16, 2022.

The Wound Nurse was interviewed on 4/7/22 at 1:54 a.m., she indicated the resident was very compromised. All treatments should be initiated on admission and when he returned on 3/5/22, the treatments should have been started for all pressure areas. Treatments had not been completed as ordered. The Corporate RN

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| | indicated if the treatments were completed, there would have been initials on the TAR that indicated the treatment was completed.<br><br>2. On 4/7/22 at 7:50 a.m., Resident D indicated treatments were not always completed daily. She was lying on a low air loss mattress in bed. The Wound Nurse and CNA 1 then entered the room. The resident indicated she thought her pressure ulcer dressing may have come off when the staff had completed incontinent care at 6:30 a.m. The Wound Nurse indicated she would replace the dressing. CNA 1 then assisted the resident to turn onto her right side. There was a dressing on the left buttock area and was dated 4/6/22. The old dressing was removed and the Wound Nurse indicated there was now a small open area on the lower area of the skin around the pressure sore, which was due to a dressing injury. The Wound Nurse indicated the pressure areas were recurrent. The area on the left buttock was oblong, clean, with a red center. The Wound Nurse measured it at 3.7 cm (centimeters) by 1.9 cm and 0.2 cm in depth. The Wound Nurse indicated the area had not changed. The new area measured 1.8 cm by 1.2 cm. The Wound Nurse indicated when she was not in the facility, the nurses were responsible for ensuring the treatments were completed.<br><br>Resident D's record was reviewed on 4/7/22 at 3:34 p.m. The diagnoses included, but were not limited to, stroke and diabetes mellitus.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 1/10/22, indicated an intact cognitive status, no behaviors, required extensive assistance with bed mobility and was dependent for transfers. She was incontinent of bowel and | | | |

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| | bladder, had one stage two (partial thickness of skin loss), was on a pressure relief bed, had nutrition and hydration interventions, and received pressure ulcer treatments.<br><br>A Care Plan, dated 1/12/22, indicated a pressure ulcer on the left buttock. The interventions included, supplements as ordered and weekly measurements.<br><br>A Care Plan, dated 3/31/22, indicated a pressure ulcer was present. The interventions included, the treatment was to be provided as ordered.<br><br>A Physician's Order, dated 1/7/22 to 4/7/22, indicated the buttock was to be cleansed with wound cleaner and patted dry. Hydrofera Blue (wound treatment) was to be applied and the area was to be covered with a dry dressing daily and as needed.<br><br>The Treatment Administration Record (TAR), dated 3/2022, indicated by a lack of initials the treatment to the pressure area had not been completed on March 3, 9, 12, 16, 23, and 26, 2022.<br><br>The TAR, dated 4/2022, indicated by a lack of initials the treatment to the pressure area had not been completed on April 1 and 5, 2022.<br><br>A facility policy, dated 9/2013, titled, "Pressure Ulcer Risk Assessment", and received from the Corporate RN as current, indicated if pressure ulcers were not treated when discovered, they have the potential to become larger, painful, and infected.<br><br>This Federal tag relates to Complaint IN00376588.<br><br>3.1-40(a)(2) | | | |

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| | 3.1-40(a)(3) | | | |
| F 0888 SS=A Bldg. 00 | 483.80(i)(1)-(3)(i)-(x)<br>COVID-19 Vaccination of Facility Staff<br>§483.80(i)<br>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.<br><br>§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:<br>(i) Facility employees;<br>(ii) Licensed practitioners;<br>(iii) Students, trainees, and volunteers; and<br>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.<br><br>§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:<br>(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; | | | |

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| | and<br>(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.<br><br>§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:<br>(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;<br>(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;<br>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;<br>(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;<br>(vi) A process by which staff may request an exemption from the staff COVID-19 | | | |

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| | vaccination requirements based on an applicable Federal law;<br>(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;<br>(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:<br>(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<br>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;<br>(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 | | | |

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| | antibodies or convalescent plasma for COVID-19 treatment; and<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>§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;<br><br>Based on observation, record review, and interview, the facility failed to ensure unvaccinated staff were implementing the facility's extra precautions for preventing the spread of COVID-19, related to not wearing an N95 face mask during their shift when residents were present for 1 of 2 employees who were not fully vaccinated (Employee 2) and 1 of 1 employee who had a non-medical exemption reviewed (Employee 3).<br><br>Finding includes:<br><br>Employee 2 was observed on 4/7/22 during her shift with a surgical mask being worn and was observed entering and exiting resident rooms. Employee 2 was interviewed and indicated she had received one dose of the vaccination and needed to reschedule the second dose due to the pharmacy had canceled her last appointment. She indicated an N95 mask only needed to be worn on the COVID-19 Unit.<br><br>Employee 3 was observed on 4/7/22 during her | F 0888 | The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or **5/4/2022**<br>1. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?**· No residents were affected by the alleged deficient practice. All residents in care areas of employees 2 and 3 had the potential to be affected. Residents effected were monitored for signs and symptoms of COVID 19 with no residents affected.<br>· Employees 2 and 3 | 05/04/2022 |

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| | shift with a surgical mask being worn. She was observed on the 500 Unit, where there were residents identified as being on a Yellow Status (potential for COVID-19). She indicated an N95 mask had to be worn only if she entered the Yellow Status rooms.<br><br>During an interview on 4/8/22 at 11:01 a.m., the Infection Preventionist indicated she thought only the staff who had exemptions had to wear the N95 masks.<br><br>During an interview with Corporate RN 2, she indicated the N95 mask was to be used per the policy.<br><br>A facility policy, dated 2/2022, titled, "COVID-19 Vaccine Policy and Procedure", received from the Infection Preventionist as current, indicated the additional precautions and contingency plan for unvaccinated staff included an N95 or higher-level respirator was to be worn in direct care patient areas and while providing direct care to residents. The N95 or higher-level respirator must be worn by unvaccinated staff in areas where other staff or residents are within six feet.<br><br>3.1-18(b) | | were educated on proper PPE use while being partially vaccinated including use of N95 or higher-level respirator must be worn by unvaccinated staff in areas where other staff or residents are within six feet.<br><br>· Infection Preventionist was educated on COVID-19 Vaccine Policy and Procedure, including the additional precautions and contingency plan for unvaccinated staff included an N95 or higher-level respirator was to be worn in direct care patient areas and while providing direct care to residents. The N95 or higher-level respirator must be worn by unvaccinated staff in areas where other staff or residents are within six feet.2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. Residents continue to be monitored daily for signs and symptoms of COVID 19.<br>· IP/designee will complete audit of all staff that are unvaccinated to ensure all staff have signed Staff with Vaccination Exemptions or incomplete vaccination series Agreement which includes steps that must be | |

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| | | | taken as additional precautions including included an N95 or higher-level respirator was to be worn in direct care patient areas and while providing direct care to residents. The N95 or higher-level respirator must be worn by unvaccinated staff in areas where other staff or residents are within six feet.<br>3. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?**· All staff were in-serviced on standard and transmission-based precautions policy, COVID-19 Vaccine Policy and Procedure, including the additional precautions and contingency plan for unvaccinated staff included an N95 or higher-level respirator was to be worn in direct care patient areas and while providing direct care to residents. The N95 or higher-level respirator must be worn by unvaccinated staff in areas where other staff or residents are within six feet. · Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee to ensure that all unvaccinated staff are following additional precautions and contingency plan for unvaccinated staff. 4. **How the corrective action(s) will be monitored to ensure the** | |

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| | | | **deficient practice will not recur, i.e. what quality assurance program will be put into place?**· QAPI tool for COVID-19 Vaccine Policy and Procedure, including the additional precautions and contingency plan for unvaccinated staff will be completed daily x 5 , weekly x 4, and monthly x 3 months , the quarterly thereafter until compliance is maintained for at least two consecutive quarters. Results of the Audit tool will be presented to the QAPI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action.<br>If 95% threshold is not achieved, an action plan will be developed to achieve desired threshold. | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to stained privacy curtains, dirty substance on room entry door, an over the bed table with missing veneer, wall trim missing, wall scraped, and a loose call light plate with exposed wires, for 3 of 4 units observed. (Units 300, 400, and 500) | F 0921 | The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk | 05/04/2022 |

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| | Findings include:<br><br>During the initial observation of the facility on 4/7/22 at 6:13 a.m. through 6:35 a.m. the following was observed:<br><br>The privacy curtains for room 303 door and center beds were stained and had a brown colored substance on them.<br><br>There were stains on the privacy curtain for room 304 door bed.<br><br>The privacy curtain for room 307 door bed was tattered and stained.<br><br>There were stains on the privacy curtain for room 309 door bed.<br><br>The mat on the floor by room 407 door bed had tears on the plastic cover and the over the bed table had pealing and missing veneer.<br><br>The wall trim at the head of the beds in room 401 was missing.<br><br>The privacy curtain in room 502 by the door was stained. The bed by the window had scrapes on the wall and the call light face plate was loose and hanging with wires visible.<br><br>A tour of the above findings with the Director of Maintenance was completed on 4/8/22 at 12:35 p.m. through 12:45 p.m. He indicated the privacy curtains should be washed every two weeks. There were new over the bed tables and the one in 407 would be replaced. The entry door of 407 was observed with three areas of a dried brown substance on the door during the tour. He indicated vinyl wall protectors were being | | review in lieu of a post survey re-visit on or after 5/4/2022<br><br>F921<br>Safe/Functional/Sanitary/Comfortable Environment<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>· Privacy Curtains for room 303A and 303 B have been cleaned from the stain and brown colored substance on them.<br><br>· Privacy Curtain for room 304A has been cleaned from the stains.<br><br>· Privacy Curtain for room 307A has been changed and is no longer tattered or stained.<br><br>· Privacy Curtain for room 309A has been cleaned from the stains.<br><br>· The Mat on the floor by room 407A has been replaced and the over bed table has been replaced with a new one. | |

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| | implemented to protect the walls. He acknowledged all the above areas needed cleaning or repair.<br><br>This Federal tag relates to Complaint IN00376588.<br><br>3.1-19(e) | | · The wall trim at the head of the beds in room 401 has been replaced.<br><br>· The privacy curtain in room 502A has been cleaned from the stains. The wall by bed 2 in room 502 has been pained. And the call light face plate is now secured to the face plate so that the wire is no longer visible.<br><br>· The entry door to room 407 has been cleaned of the dried brown substance on the door.<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>· All residents have the potential to be affected by the alleged deficient practice.<br><br>· All resident rooms in the facility have been assessed and repairs have been performed as needed.<br><br>3. What measures will be put into place or what systemic | |

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| | | | changes you will make to ensure that the deficient practice does not recur?<br><br>· An all-staff in-service will be conducted by ED/designee for all maintenance issues to be reported to the Maintenance Director for repairs via the maintenance request form log.<br><br>·<br>Maintenance/Housekeeping will perform facility rounds monthly to identify problems or needed repairs via the form.<br><br>4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? | |