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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00387915. Complaint IN00387915 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F686, F690, and F692. Survey dates: August 28, 29, 30, 31 and September 1, 2022 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 5 Medicaid: 66 Other: 4 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/7/22.	F 0000	Please reference the enclosed 2567 as "plan of correction" For the Annual & Complaint survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on 9/22/22 serves as our allegation of compliance. The provider respectfully request a desk review on or after 9/22/22. Should you have any questions or concerns	

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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			regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.			

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	§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to staff not knocking on doors prior to entering resident rooms and hospital gowns being worn while in bed during the day for 2 of 4 residents reviewed for dignity. (Residents 127 and F) Findings include: 1. On 8/29/22 at 9:10 a.m., CNA 2 entered Resident 127's room to pick up her breakfast tray. The CNA did not knock before entering the room. After the CNA exited, RN 1 proceeded to enter the room for medication administration. The RN did not knock on the door prior to entering. Interview with the resident at the time indicated staff don't always knock before entering. The record for Resident 127 was reviewed on 8/29/22 at 1:54 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, cellulitis of the right lower limb, and acute osteomyelitis (bone	F 0550	**F550 Residents Rights/Exercise of Rights** **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.*	09/22/2022

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	infection) of the right ankle and foot. The Admission Minimum Data Set (MDS) assessment, dated 8/24/22, was in progress. The resident was cognitively intact for daily decision making. Interview with the Nurse Consultant on 8/31/22 at 12:13 p.m., indicated the staff members should have knocked on the door before entering the resident's room. 2. On 8/28/22 at 9:38 a.m. and 1:00 p.m., Resident F was observed lying in bed wearing a hospital gown. On 8/29/22 at 9:30 a.m. and 1:30 p.m., the resident was observed lying in bed wearing a hospital gown. On 8/30/22 at 8:09 a.m., 9:40 a.m., and 10:24 a.m., the resident was observed lying in bed wearing a hospital gown. The record for Resident F was reviewed on 8/29/22 at 2:30 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness), stroke, dementia, dysphagia (difficulty swallowing), anxiety disorder, heart disease, chronic kidney disease, and heart failure. The Modification of the Annual Minimum Data Set (MDS) assessment, dated 6/21/22, indicated the resident was severely impaired for decision making and it was very important for the resident to choose what clothes to wear. The resident had no oral problems and received a mechanically altered diet. There was no Care Plan indicating the resident wished to be dressed in a hospital gown.		**Immediate action taken for those residents identified?** CNA 2 and RN 1 was re-educated on knocking on resident’s door before entering Resident F was dressed according to their preference. **How the facility identified other residents?** All residents who reside in the facility have the potential to be affected by this deficient practice. **Measures put into place/System changes?** Staff have been re-educated on the importance of resident’s rights to include privacy. The Director of Nursing / Designee will be responsible for validating dignity/privacy rounds and subsequent follow up. **How will the corrected actions be monitored?** Director of Nursing or Designee will complete observations on 2 residents once a day at various times, 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure that residents are dressed according to their preferences and privacy is being maintained	

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	Interview with the Director of Nursing on 8/31/22 at 11:20 a.m., indicated there was no Care Plan for the resident to be dressed in a hospital gown. 3.1-3(t)		**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.** **Date of Completion: 09/22/2022**	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least			

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	30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or			

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	related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Parties were notified in writing related to a transfer to the hospital for 2 of 3	F 0623	**F623 Notice Requirements Before Transfer/Discharge** The facility requests paper	09/22/2022

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	residents reviewed for hospitalization. (Residents G and 44) Findings include: 1. The record for Resident G was reviewed on 8/31/22 at 9:06 a.m. Diagnoses included, but were not limited to, cerebral palsy, lack of coordination, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident was cognitively impaired for daily decision making. Nurses' Notes, dated 5/22/22 at 1:29 p.m., indicated the resident stated he would like to be discharged home. He was refusing to wear his oxygen and was refusing to eat. The resident was educated on the importance of using his oxygen and nutrition. The resident's Physician was called and staff were waiting for a response. At 1:54 p.m., the Physician was notified of the resident's status and orders were received to send the resident to the emergency room for evaluation. The resident was admitted to the hospital and returned to the facility on 5/28/22. Nurses' Notes, dated 6/18/22 at 8:10 p.m., indicated the resident's blood pressure was low at 64/37 (normal range 120/80). 911 was called and paperwork was given when they arrived. The resident was admitted to the hospital and returned to the facility on 6/23/22. Nurses' Notes, dated 7/26/22 at 11:33 a.m., indicated the resident was complaining of not feeling well. He had reduced and poor intake of		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 G POA was provided with a copy of the transfer notice and facility bed hold policy. Resident 44 POA was provided with a copy of the transfer notice and facility bed hold policy. **2) How the facility identified other residents:** All residents who transfer or are discharged are affected by this deficient practice. **3) Measures put into place/ System changes:**	

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	food and fluids. He also appeared pale and was flushed in the face. The Physician was notified and orders were obtained to send the resident to the emergency room for evaluation. The resident was admitted to the hospital and returned to the facility on 8/2/22. There was no documentation indicating the resident's Responsible Party had received written documentation of the State Transfer form when the resident was hospitalized on 5/22, 6/18, and 7/26/22. Interview with the Nurse Consultant on 8/31/22 at 12:13 p.m., indicated copies of the transfer notice should have been mailed to the resident's Responsible Party. 2. Resident 44's record was reviewed on 8/30/22 at 9:22 a.m. Diagnoses included, but were not limited to, depression, schizophrenia (mental disorder in which people interpret reality abnormally), and psychotic disorder (severe abnormal thinking and perceptions). The Quarterly Minimum Data Set (MDS) assessment, dated 7/22/22, indicated the resident was alert and orientated to person and place, but had mental illnesses that interfered with his ability to make appropriate reactions and decisions. A Nursing Progress Note, dated 8/24/22 at 8:00 p.m., indicated the resident was sent to a behavioral center hospital via transport. The Physician had completed the order earlier that day due to verbal and physical behaviors towards the nurse at 6:25 a.m. The facility had to wait for availability for the resident to be admitted and transported to the behavioral center.		Licensed nurses and Social Service Director will be re-educated on Bed hold policy/transfer notice. **4) How the corrective actions will be monitored:** The Social Services Director or designee will complete an audit weekly on all transfers and bed holds to ensure that all documentation was completed. The Social Services Director is responsible for compliance. **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: 09/22/2022**	

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	The record lacked documentation the resident's Representative was provided a written notice of the reason of the transfer when the resident was sent out to the hospital. Interview with the Social Service Director (SSD) on 8/30/22 at 12:43 p.m., indicated he did not mail the resident's Representative the written notice of the reason of the resident's transfer to the behavioral center hospital. Interview with the Director of Nursing on 8/30/22 at 1:12 p.m., indicated the SSD should have mailed the resident's Representative the State transfer form that included the reason for the transfer. A policy titled, "Transfer, Bed-Holds and Returns," was provided by the Nurse Consultant on 8/31/22 at 1:00 p.m. This current policy indicated, "...3. Prior to a transfer, written information will be given to the resident and the resident representatives that explains in detail... d. The details of the transfer (per the Notice of Transfer)...." 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			
	Based on record review and interview, the facility failed to ensure the Comprehensive Assessment was accurate related to the administration of insulin for 1 of 2 residents reviewed for resident assessment. (Resident 54) Finding includes:	F 0641	**F641 Accuracy of Assessments** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of*	09/22/2022

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	The record for Resident 54 was reviewed on 8/28/22 at 1:45 p.m. Diagnoses included, but were not limited to, stroke and coronary artery disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/30/22, indicated in the last 7 days the resident had received insulin 7 times. Physician's Orders, dated 12/23/21, indicated Ozempic (a non-insulin medication that may improve blood sugar) 2 milligrams (mg)/1.5 milliliters (ml), inject 0.5 mg 1 time a day every Wednesday. A Physician's Order, dated 8/24/22, indicated Ozempic 2 mg/1.5 ml, inject 1 mg one time a day every Wednesday. A telephone interview on 8/31/22 at 2:42 p.m. with the MDS Coordinator, indicated she was unaware Ozempic was not an insulin. 3.1-31(i)		*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:** The MDS for resident 54 was corrected **2) How the facility identified other residents:** All resident who resides in the facility have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** MDS coordinator will be in serviced on the importance of coding the MDS assessment accurately **4) How the corrective actions will be monitored:** The MDS Coordinator will complete a weekly audit of assessment completed for	

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			accuracy. **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: 09/22/2022**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to shaving for 1 of 7 residents reviewed for ADL's. (Resident G) Finding includes: On 8/29/22 at 10:30 a.m. and 1:40 p.m., Resident G was observed in bed. He had a growth of facial hair. On 8/30/22 at 9:08 a.m. and 1:05 p.m., the resident was observed in bed and the facial hair remained. On 8/31/22 at 8:49 a.m. and 12:39 p.m., the resident	F 0677	**F 677 ADL Care for Dependent Resident** **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*	09/22/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed in bed and the facial hair remained. The record for Resident G was reviewed on 8/31/22 at 9:06 a.m. Diagnoses included, but were not limited to, cerebral palsy, lack of coordination, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident was cognitively impaired for daily decision making and he needed extensive assistance with personal hygiene. The Care Plan, dated 1/12/22, indicated the resident required assistance with ADL's including bed mobility, eating, transfers, toileting, and bathing related to impaired mobility, cerebral palsy and stroke. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Encourage self participation as able. The shower sheets for the month of August 2022 indicated the resident had received a bed bath on 8/15, 8/17, 8/19, 8/22, 8/25, and 8/27/22. Interview with the resident on 9/1/22 at 1:30 p.m., indicated he wasn't growing his beard back and he would like to be shaved. Interview with the Wound Nurse on 9/1/22 at 1:35 p.m., indicated she would make sure the resident got a shave. This Federal tag relates to Complaint IN00387915. 3.1-38(a)(3)(D)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate action taken for those residents identified.** Resident G was shaved. How the facility identified other residents? All dependent residents residing in the facility have the potential to be affected by this alleged deficient practice. **What measures put into place/ Systemic changes?** Staff was re-educated on the importance of providing ADL care to include shaving as needed to residents. **How will the corrected action be monitored?** Director of Nursing or Designee will complete observation on 5 residents once a day, 5 times weekly for 4 weeks, and 5 residents 2x weekly thereafter to ensure ADL care compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for**	

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	155653	A. BUILDING 00 B. WING	09/01/2022

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			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. **Date of Completion: 09/22/2022**	
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 bruises were assessed and monitored and treatments were completed as ordered for 3 of 4 residents reviewed for skin conditions (non-pressure related). The facility also failed to ensure a follow up assessment was completed after a fall for 1 of 1 residents reviewed for death. (Residents G, 127, 46, and 78) Findings include: 1. On 8/29/22 at 10:30 a.m., Resident G was observed with a fading greenish/yellow bruise to	F 0684	**F684 Quality of Care** 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*	09/22/2022

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	the top of his left hand and wrist area. On 8/31/22 at 11:54 a.m., the area of bruising remained. The record for Resident G was reviewed on 8/31/22 at 9:06 a.m. Diagnoses included, but were not limited to, cerebral palsy, lack of coordination, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident was cognitively impaired for daily decision making and he needed extensive assistance with bed mobility and he was totally dependent for transfers. A Care Plan, dated 7/19/22, indicated the resident was at risk for complications related to antiplatelet therapy use. Interventions included, but were not limited to, daily skin inspection and report abnormalities to the nurse and observe/document/report as needed (prn) adverse reactions to antiplatelet therapy such as bruising. A Physician's Order, dated 8/3/22, indicated the resident was to receive Plavix (an antiplatelet medication which can cause bruising) 75 milligrams (mg) daily. There were no current orders to monitor the bruising to the resident's left hand and wrist area. The Weekly Skin Observation assessment, dated 8/27/22, indicated the resident had no skin concerns. Interview with the Director of Nursing on 8/31/22 at 2:45 p.m., indicated the resident's left hand/wrist would be assessed.		*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:** 1. Area of bruising was assessed, and an order put in place to monitor for Resident G 2. Treatment was completed for Resident 127's 3. Resident 78 no longer in facility 4. Bruising for Resident 46 was assessed, and an order put in place to monitor **2) How the facility identified other residents:** All residents who reside in the facility have the potential to be affected by this deficient practice **3) Measures put into place/ System changes:** Staff will be re-educated on assessing and monitoring non pressure areas, the importance of completing treatments per physicians' orders and completing post-fall follow up assessments.	

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A Physician's Order, dated 9/1/22, indicated to monitor the greenish/yellow bruise to the left wrist and notify the physician of any changes.

2. Interview with Resident 127 on 8/28/22 at 2:30 p.m., indicated the treatment to her right toe was to be completed daily. She indicated the treatment "hadn't been completed yet today" and it also wasn't completed on Friday or Saturday (8/26 and 8/27/22).

On 8/29/22 at 8:56 a.m., the resident indicated the treatment to her toe had not been completed yesterday (8/28/22). The resident proceeded to remove her sock and the ace wrap to her right foot. The gauze dressing was dated 8/26/22. The resident indicated it was a surgical wound, she had bunion surgery and the wound got infected.

The record for Resident 127 was reviewed on 8/29/22 at 1:54 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, cellulitis of the right lower limb, and acute osteomyelitis (bone infection) of the right ankle and foot.

The Admission Minimum Data Set (MDS) assessment, dated 8/24/22, was in progress. The resident was cognitively intact for daily decision making.

A Care Plan, dated 8/22/22, indicated the resident was at risk for further impaired skin integrity. Current areas of impairment included the right great toe. Interventions included, but were not limited to, monitor, document location, size, and treatment of skin injury. Report abnormalities, failure to heal, and signs and symptoms of infection to the physician.

4) How the corrective actions will be monitored:

Director of Nursing or designee will complete 5 wound care audits a week to ensure that the treatments are completed as ordered and ensure that 3 residents with bruising have been monitored weekly. DON/Designee will also review falls 5 days per week during clinical meeting to ensure post fall assessments are complete.

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: 09/22/2022

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A Physician's Order, dated 8/25/22, indicated the resident's right great toe was to be cleansed with normal saline, patted dry, packed loosely with iodoform, covered with 4 x 4 gauze, wrapped with kerlix and then wrapped with an ace bandage every day shift.

The August 2022 Treatment Administration Record (TAR), indicated the treatment to the right toe was signed out as being completed on 8/26, 8/27, and 8/28/22.

Interview with the Wound Nurse on 8/29/22 at 2:47 p.m., indicated she had completed the resident's treatment today and she did see that the old dressing was dated 8/26/22. She indicated she doesn't work the weekends and the nurse was supposed to complete the treatment. She also indicated she spoke with the nurse about signing out the treatment even though it had not been completed. 3. On 8/28/22 at 10:25 a.m., Resident 46 was observed to have a large, fading yellow/greenish bruise to the right side of her forehead.

On 8/29/22 at 1:55 p.m., the resident was observed sitting upright in her bed watching TV. There was an oblong yellow/green large discoloration to the right upper side of her forehead and along the right side of her face by her eye area.

Resident 46's record was reviewed on 8/29/22 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, lack of coordination, weakness and difficulty in walking.

The Admission Minimum Data Set (MDS) assessment, dated 7/6/22, indicated the resident was cognitively impaired. She was an extensive, one person assist with activities of daily living

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and a two person assist with walking.

The August 2022 Physician's Order Summary and the August 2022 Medication Administration Record (MAR), indicated she received Aspirin 81 milligrams daily as ordered.

A Post Fall Evaluation, dated 8/11/22 at 11:04 p.m., indicated she had fallen while walking to the bathroom and hit her head. A "hematoma" (bruise) was noted to the right side of her forehead and she was sent to the emergency room.

An Incident Note, dated 8/12/22 at 3:05 a.m., indicated she had returned from the emergency room. They observed a discolored raised area to the right side of the forehead.

A Supportive Documentation Nursing assessment, dated 8/12/22 at 3:48 a.m., indicated a contusion (bruise) to the forehead (scalp) and a contusion to the right shoulder.

A Physician's Order, dated 8/16/22, indicated to monitor the bruise on the right side of the forehead and notify MD of any changes each shift.

The MAR from 8/16-8/29/22, indicated the bruising was monitored each shift with no changes.

The Nursing Progress Notes from 8/12-8/16/22, lacked any description, size, or color of the hematoma/contusion.

The record from 8/12-8/16/22 lacked a full description of the discolored area from the time of the fall; the original size, the color, and the

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changes of the color and size.

Interview with the Director of Nursing on 8/30/22 at 10:28 a.m., indicated the midnight nurse put in a progress note of the discoloration. The day shift nurse should have fully described the discoloration, including size, colors, and changes.

4. Resident 78's closed record was reviewed on 8/29/22 at 2:56 p.m. Diagnoses included, but were not limited to, neurological conditions and lack of coordination.

The Quarterly Minimum Data Set (MDS) assessment, dated 5/1/22, indicated the resident had some cognitive impairment and could transfer and walk with supervision with the assistance of one person. He had no upper or lower extremity (arms and legs) impairments and used a walker.

A Post Fall Observation completed by LPN 1, dated 6/11/22 at 6:59 p.m., indicated the resident had fallen with his roommate as the witness. Resident 78 did not make a statement on what had happened. He indicated his pain level was a 2 on a scale of 10, (10 being the highest amount of unbearable pain), but did not indicate the location or a description of the pain. Under the "Musculoskeletal section, normal or consistent with prior alignment was unable to be determined and had a rotation/deformity of the right lower extremity." Under "Skin observation, he had a purplish bruise noted on his right front thigh."

The Risk Management Assessment completed by LPN 1 on 6/11/22 at 5:59 p.m., indicated his roommate witnessed that Resident 78 had fallen off of the bed, onto the floor, and he pulled himself back on the bed. The resident denied he had fallen. The resident was assessed with no

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injures at that time.

A SBAR (situation, background, assessment and recommendation tool) note, dated 6/12/22 at 8:22 p.m., indicated the nursing staff alerted the nurse. The resident had noted discolorations on his left inner and outer thigh, the area was warm and painful to touch. The physician was notified and ordered a stat (immediate) x-ray.

On 6/13/22 at 12:14 a.m., the X-Ray technician completed an x-ray to the right hip. There was observed increased ecchymosis and pain. The technician indicated there was a possible positive fracture of the femur neck.

On 6/13/22 at 4:10 a.m., a Nursing Progress Note indicated the primary physician approved sending the resident to the emergency room for a positive right hip fracture. 911 was called and responded in 3 minutes. The resident was transported to the emergency room.

Interview with LPN 1 on 8/31/22 at 10:17 a.m., with the Director of Nursing (DON) present, indicated the resident's roommate stated that Resident 78 had fallen out of his bed and put himself back into bed. The resident denied that he fell. The LPN indicated she had marked the fall form incorrectly, he had limited ROM (range of motion) in his right lower extremity. He had a purplish bruise on the front side of the right thigh, no pain, nothing unusual. He could put himself back to bed.

Interview with the DON on 8/31/22 at 10:17 a.m., indicated LPN 1 completed a risk assessment in the computer, and the computer system did not generate/pass along the fall into a Nurses' Note to be followed up on with the bruise and possible fall.

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	A policy titled, "Skin Condition Assessment and Monitoring Pressure and Non-Pressure," was provided by the Nurse Consultant on 8/31/22 at 1:00 p.m. This current policy indicated, "...Guidelines:...Non-pressure skin conditions (bruises/contusions, abrasions, laceration, rashes, skin, ears, surgical wounds, etc) will be assess for healing progress and signs of complications or infection weekly. Bruises: A bruise or contusion is an impact on the skins's surface over subcutaneous or deeper tissues. On the skin's surface, bruises undergo progressive color changes before they fade away...When bruises are healing without complications as indicated on the above table, the nurse will monitor the site weekly. At the point of signs of healing, approximately 7-14 days, or when the bruise has turned color to green, yellow, brown, the nurse will document a last entry indicating that the normal healing process has taken place without complications, and no further follow-up will be needed...." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a			

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	professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and interview, the facility failed to ensure residents with impaired vision received the necessary services related to following up with referrals to an Ophthalmologist for 1 of 1 residents reviewed for vision. (Resident H) Finding includes: Interview with Resident H on 8/28/22 at 11:06 a.m., indicated he needed new glasses. He also indicated the last time the eye doctor was at the facility, he was at dialysis. The resident stated he had two old pairs of glasses, one pair he "couldn't see that well out of" and the other pair was missing a lens. A pair of glasses was observed on his television stand and a lens was missing. The record for Resident H was reviewed on 8/30/22 and 2:05 p.m. Diagnoses included, but were not limited to, end stage renal disease and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/22, indicated the resident was cognitively intact for daily decision making. The resident's vision was adequate with corrective lenses. A Physician's Order, dated 8/9/21, indicated the resident may receive eye care services. A Physician's Order, dated 11/24/21, indicated the resident was to be referred to an Ophthalmologist for diabetic retinopathy and blindness to one eye. There was no documentation indicating the referral had been arranged.	F 0685	**F 685 Treatment/Devices to a Maintain Hearing/Vision** **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.* **Immediate action taken for those residents identified.** Resident H has a follow up follow up appointment with an Ophthalmologist. How the facility identified other residents? All residents residing in the facility who need necessary services have the potential to be affected by this alleged deficient practice.	09/22/2022

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	Interview with the Social Service Director on 8/30/22 at 9:27 a.m., indicated he had been working at the facility for only a few months. The last time the Optometrist was in the facility was on 8/10/22, however, the resident wasn't seen because he was at dialysis. He indicated the resident would be put on the list to be seen and he would schedule the visit for a Tuesday or Thursday when the resident wasn't at dialysis. Interview with the Director of Nursing (DON) on 8/31/22 at 2:45 p.m., indicated she would see if the resident was referred to the Ophthalmologist. Interview with the DON on 9/1/22 at 10:16 a.m., indicated she could not find a referral for the Ophthalmologist and the resident would be added to the list. 3.1-39(a)(1)		**What measures put into place/ Systemic changes?** Social Service Director was re-educated on the importance of following up with resident referrals for outside services. **How will the corrected action be monitored?** The Social Service Director will complete weekly audits on ancillary referrals weekly to ensure that all referrals have been followed. **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.** **Date of Completion: 09/22/2022**	
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-			

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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 (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 ensure pressure reducing interventions were in place for a resident with an acquired pressure ulcer related to a cushion in the wheelchair for 1 of 6 residents reviewed for pressure ulcers. (Resident B) Finding includes: On 8/29/22 at 1:30 p.m., Resident B was observed sitting up in a wheelchair. She was complaining that her "butt" hurt and she wanted to go back to bed. The resident was sitting directly on the seat of the wheelchair. There was no pressure reducing cushion observed in the chair. Interview with CNA 1 on 8/29/22 at 1:55 p.m., indicated the resident was assisted out of bed right before lunch and the trays were delivered to the unit around 12:15 p.m. On 8/30/22 at 12:25 p.m., the resident was observed sitting up in a wheelchair. She was sitting on the pillow from her bed and it was folded over in half. The resident was complaining that her "butt" hurt and she wanted to go back to bed. There was no pressure reducing cushion observed in the chair. At 1:36 p.m., the resident was placed in bed by CNA 1.	F 0686	**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** 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 B was provided a pressure off loading cushion to wheelchair. **2) How the facility identified**	09/22/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/31/22 at 8:25 a.m., the resident was sitting up in her wheelchair by the bed. She was sitting on her pillow that was folded over in half. There was no pressure reducing cushion observed in the chair. At 10:20 a.m., the Wound Nurse entered the room to put the resident back to bed and to render the treatment to her coccyx and right heel. At that time, she was made aware the resident was not sitting on a pressure reducing cushion in the wheelchair. The resident had a pressure ulcer on her coccyx area. The area was pink with granulation tissue present. The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), and type 2 diabetes. The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 1 person physical assist for transfers and she had a stage 3 pressure ulcer and a deep tissue injury. Both areas were unhealed. The Care Plan, revised on 8/8/22, indicated the resident was at risk for further impaired skin integrity. Current areas of impairment included the coccyx and right heel. The approaches included, but were not limited to, the resident needed a pressure reducing cushion to protect the skin while up in the chair. A Skin/Wound Note, dated 7/25/22 at 11:35 p.m., indicated the resident was assessed with a new open area noted to the coccyx.		**other residents:** All residents who have pressure areas have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Staff will be re-educated the importance ensuring that residents have pressure reducing interventions in place to prevent or assist with healing of pressure ulcers. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete observations on 7 residents a week to ensure that pressure reducing devices are in place. **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:**	

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	155653	A. BUILDING 00 B. WING	09/01/2022

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	A Skin/Wound Note, dated 7/29/22 at 2:46 p.m., indicated the Wound Physician assessed and debrided the wound on the coccyx. Physician's Orders, dated 8/22/22, indicated cleanse coccyx wound with normal saline, pat dry, apply calcium alginate and cover with a dry dressing every Monday, Wednesday and Friday. The coccyx pressure ulcer measured 2.58 centimeters (cm) by 1.98 cm on 7/25/22. After the debridement on 7/29/22, the ulcer measured 6.92 cm by 2.49 cm. The ulcer was classified as a Stage 3. A measurement on 8/26/22, indicated the ulcer measured 1.15 cm by 1.41 cm. Interview with the Wound Nurse on 8/31/22 at 10:35 a.m., indicated the wounds were much better. She was aware a pillow was not a pressure reducing cushion. The resident was not getting out of bed until recently and there was no pressure reducing cushion for the wheelchair. Interview with the Director of Nursing on 8/31/22 at 11:30 a.m., indicated the resident should have been sitting on a pressure reducing cushion. This Federal tag relates to Complaint IN00387915. 3.1-40(a)(2)		**09/22/2022**	
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent			

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	complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.			
	Based on interview, observation, and record review, the facility failed to ensure dependent residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 1 of 7 residents reviewed for ADL's (activities of daily living). (Resident 27) Finding includes: During an interview with Resident 27 on 8/28/22 at 10:17 a.m., he indicated his toe nails were long and he could not wear his socks. The doctor clipped them once, never came back, and he told the nursing staff. The resident took off his slippers and his toenails on both feet were observed to be approximately one half inch to one inch long. The toenails were thick and protruding over all of his toes. Interview and observation with Resident 27 on 8/30/22 at 9:56 a.m., indicated he had not had a visit from the podiatrist since he had been at the facility. Resident 27's record was reviewed on 8/30/22 at 8:57 a.m. Diagnoses included, but were not limited to neurological conditions and other lack of coordination. He was admitted to the facility on 3/9/22. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/22, indicated he was interviewable and a one person assist with bathing. He only needed supervision and set up	F 0687	**F 687 Foot Care** **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.* **Immediate action taken for those residents identified.** Resident H has a n appointment set up with Podiatry to trim toenails. How the facility identified other residents? All residents residing in the facility who need necessary services have	09/22/2022

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	for personal hygiene and dressing. The Shower Sheets, dated 8/16, 8/20, 8/22, 8/26, and 8/29/22, indicated the resident needed assistance with bathing. There was no indication of his toenails being long or trimmed. The August 2022 Physician's Order Summary, indicated the resident may receive services from the Podiatrist. A consent for podiatry services was signed by the resident on 3/11/22. The resident had not seen the podiatrist since admission. Interview with the Social Service Director (SSD) on 8/30/22 at 10:02 a.m., indicated the Podiatrist was here on 8/17/22 and the resident was not on the list as being seen. The SSD indicated the facility had changed Podiatrist services, and he had left a form at each Nurses' Station for the nurses to fill out for which residents needed to been seen by each entity for outside services. 3.1-47(a)(7)		the potential to be affected by this alleged deficient practice. **What measures put into place/ Systemic changes?** Staff was educated to notify Social Service Director of residents needing nail care that can not be completed in house **How will the corrected action be monitored?** The Interdisciplinary clinical Team will complete twice weekly Rounds to ensure that residents toe nails are trimmed. **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.** **Date of Completion: 09/22/2022**	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls, a resident was supervised after a behavioral outburst, and safe hot water temperatures were maintained for 2 of 2 residents reviewed for accidents and for 3 of 28 rooms on the second floor. (Residents B and 44 and Rooms 220, 218 and 216) Findings include: 1. On 8/28/22 at 1:00 p.m. and 1:42 p.m., Resident B was observed lying in bed. At that time, the resident's bed was not against the wall and was positioned in the middle on the right side of the room. There was only 1 floor mat on the left side of the bed. There was no floor mat on the right side of the bed. On 8/29/22 at 9:33 a.m., on 8/30/22 at 8:10 a.m. and 1:36 p.m., and on 8/31/22 at 8:25 a.m., and 10:20 a.m., the resident was observed lying in bed. At those times, the resident's bed was not against the wall and was positioned in the middle on the right side of the room. There was only 1 floor mat on the left side of the bed. There was no floor mat on the right side of the bed. The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle	F 0689	**F689 Free of Accident Hazards/Supervision Devices** 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:** 1. Resident B floor mat was placed on both sides of the bed 2. Resident 44 is not in the facility currently 3. Water Temperature for room 216,218 and 220 were corrected immediately	09/22/2022

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	weakness), and dementia without behaviors. The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 1 person physical assist for transfers and she had one fall since admission with no injury. The Care Plan, dated 7/8/22, indicated the resident was at risk for falls. The approaches included, but were not limited to, a floor mat next to the bed. A Fall Risk assessment, dated 7/7/22, indicated the resident was a moderate risk for falls. Nurses' Notes, dated 7/27/22 at 2:32 p.m., indicated the resident was found on the floor next to the bed. The Fall Investigation, dated 7/27/22 at 2:32 p.m., indicated the resident was sitting in a wheelchair prior to the fall. The resident was repositioned in the chair by staff and the housekeeper later informed the writer the resident was on the floor next to the bed. The resident had poor trunk strength and slid to the floor. The immediate action taken was a floor mat added for safety. Physician's Orders, dated 8/10/22, indicated floor mat next to the bed. Interview with the Director of Nursing on 8/31/22 at 11:30 a.m., indicated the resident had been moved several times due to construction and in her old rooms the bed was against the wall, so there was only need for one floor mat.2. Resident 44's record was reviewed on 8/30/22 at 9:22 a.m. Diagnoses included, but were not limited to, depression, schizophrenia (mental disorder in		**2) How the facility identified other residents:** All residents who utilize fall interventions and utilize water have the potential to be affected by the allege deficiency. **3) Measures put into place/ System changes:** Staff will be re-educated on falls, fall interventions and prevention. Staff was educated on reporting water temperatures that are too hot or cold to the Maintenance Director. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete rounds on 3 residents at least once a day 5 times per week to ensure that residents have their fall interventions in place. Maintenance Director is checking water temperatures in the affected rooms 5x's a week for 4 weeks and two other rooms randomly. **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**	

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	which people interpret reality abnormally) and psychotic disorder (severe abnormal thinking and perceptions). The Quarterly Minimum Data Set (MDS) assessment, dated 7/22/22, indicated the resident was alert and orientated to person and place, but had mental illnesses that interfered with his ability to make appropriate reactions and decisions. The resident had verbal behavioral symptoms for the last 1 to 3 days of yelling and cursing at staff, when alone in room, in the mornings, that had occurred in the last 7 days, the resident was not easily altered, and had repetitive questions/statements. No psychoactive medication was given, due to no orders for PRN (as needed) medications and the MD and guardian were notified at midnight on 8/24/22. The Nurse Progress Note, dated 8/24/22 at 8:00 p.m., indicated the resident was sent via transport to the behavioral center hospital. The Physician had completed the order earlier that day due to verbal and physical behaviors towards the nurse at 6:25 a.m. The facility had to wait for availability for the resident to be admitted and transported to the behavioral center. The record did not indicate, from the time of the verbal and physical behavior at 6:25 a.m. until he was transported at 8:00 p.m. on 8/24/22, that the resident or his dependent quadriplegic roommate was monitored for safety. A Social Service Note, dated 7/24/22 at 1:56 p.m., indicated the resident was admitted to the behavioral center hospital one month prior. A Care Plan, dated 6/8/21, indicated the resident		**plan of correction as indicated.** **5) Date of compliance: 09/22/2022**	

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expressed a strong sense of past roles. He may misinterpret communication or mistake others for whom he was upset and become verbally aggressive, loud and threatening. An intervention included, but was not limited to, when the resident became verbally abusive, move to a quiet, calm environment.

A Care Plan, dated 6/8/21, indicated the resident had a history of physical and verbal behavioral symptoms toward others (e.g., hitting staff on the buttocks and making sexual remarks), threatening others with objects in hand, and blocking pathways in room, and throwing items at staff. Interventions included, but were not limited to, when resident becomes physically and verbally abusive, stop and try task later, if the resident had delusions/hallucination, do not try to reason with or confront resident, and offer him reassurance.

Interview with the Director of Nursing on 8/30/22 at 2:55 p.m., indicated Resident 44's dependent roommate was in the room with Resident 44 the entire time from the behavior that morning until he was transported to the hospital that night. Resident 44 would have an outburst then calm down. The progress notes lacked monitoring of the resident and his roommate.

3. During initial room observations, the following was observed and then tested with the Maintenance Director on 8/28/22:

- Room 220's bathroom hot water temperature was 122 degrees Fahrenheit at 11:06 a.m. There were four residents who shared this bathroom.

- Room 218's bathroom hot water temperature was 122 degrees Fahrenheit at 11:08 a.m. There were four residents who shared this bathroom.

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- Room 216's bathroom hot water temperature was 125 degrees Fahrenheit at 11:15 a.m. There were four residents who shared this bathroom.

Interview with Housekeeping Staff Member 1 on 8/28/22 at 11:16 a.m., indicated she would have someone correct the hot water temperatures. She also indicated the water temperature should be between 100-120 degrees Fahrenheit.

Interview with the Maintenance Director on 8/28/22 at 2:06 p.m., indicated he tested the hot water temperatures in every room every day.

Interview with the contracted Service Repair Technician on 8/28/22 at 2:07 p.m., indicated the entire building was on the same hot water system. He had already turned down the hot water temperatures and they had been dialed in between 135-140 degrees Fahrenheit.

The August 2022 "Temperature Log," indicated only one resident's room on each floor was tested on 8/19, 8/22, 8/23, 8/24, 8/25 and 8/26/22. All of the water temperatures were checked before 10:15 a.m.

A policy titled, " Monitoring of Water Temperatures," was provided by the Nurse Consultant on 8/29/22 at 2:50 p.m. This current policy indicated, "...Policy...1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more that 120 degrees Fahrenheit, or the the maximum allowable temperature per state regulations. 2. Maintenance staff is responsible for checking thermostats and temperature controls and recording these checks in a maintenance log. 3. Maintenance staff shall conduct random

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	weekly tap water temperature checks to ensure that all the water temperatures are maintained comfort for the residents and record the water temperatures in a safety log...." 3.1-19(r)(1) 3.1-19(r)(2) 3.1-45(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 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			

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	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 Physician's Orders were obtained for foley catheters and urostomy (an opening in the abdomen that redirects urine away from the bladder) care was documented for 2 of 5 residents reviewed for catheters. (Residents C and D) Findings include: 1. The closed record for Resident C was reviewed on 8/29/22 at 2:58 p.m. Diagnoses included, but were not limited to, stage 4 pressure ulcer of the sacral region, urinary retention, and urinary tract infection. The resident was admitted to the facility on 7/15/22 and discharged on 7/21/22. The 5 day Medicare Minimum Data Set (MDS) assessment, dated 7/21/22, indicated the resident had short and long term memory problems and she was severely impaired for daily decision making. The resident had an indwelling foley catheter and was occasionally incontinent of urine. The Clinical Admission Assessment, dated 7/15/22, indicated the resident had a 16 french indwelling foley catheter due to having a neurogenic bladder and a Stage 3/4 pressure injury. The Supportive Nursing Documentation Assessments, dated 7/18 at 3:04 p.m., 7/19 at 12:07 p.m., and 7/21/22 at 12:00 a.m., indicated the	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** 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:** 1. Resident C no longer resides in the facility 2. Resident D physician orders were obtained for daily care of the urostomy and monitoring for signs and symptoms of infection. **2) How the facility identified other residents:**	09/22/2022

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	resident had a foley catheter. The July 2022 Physician's Order Summary (POS), indicated the resident did not have an order for the foley catheter. There was no order for the foley catheter or catheter care listed on the July 2022 Medication and Treatment Administration records. Interview with the Director of Nursing on 9/1/22 at 4:20 p.m., indicated there was no order for the resident's foley catheter. 2. During an interview on 8/28/22 at 10:20 a.m., with Resident D, indicated she had chronic Urinary Tract Infections (UTI) and had been recently hospitalized. She cleaned her own urostomy (an opening in the belly that re-directs urine away from the bladder) and around the stoma. The record for Resident D was reviewed on 8/30/22 at 3:01 p.m. Diagnoses included, but were not limited to, paraplegic, UTI, septic shock, and artificial opening of the urinary tract. The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/22, indicated the resident was alert and oriented, and an ostomy was present. The resident was frequently incontinent of bladder. The Care Plan, revised on 5/25/22, indicated the resident had been noted to refuse medications, treatments, and care. She preferred to do her own colostomy and urostomy care. The Care Plan, dated 8/11/21, indicated the resident had a urostomy in place due to paraplegia secondary to spinal cord injury and diagnosed with a UTI. The approaches included, but were		All residents who a foley catheter or urostomy have the potential to be affected by this deficient practice. An audit was conducted for all residents who have a foley or urostomy to ensure that all appropriate physician orders are in place. **3) Measures put into place/ System changes:** Licensed staff will be re-educated on assuring that upon admission residents have the appropriate orders for foley catheter or urostomy. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete admission audit 5 times a week to ensure that appropriate orders are in place. DON /Designee will observe 1 staff member providing catheter care weekly for 4 weeks on alternate shifts & thereafter until compliance is met. **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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	not limited to, monitor and document for signs and symptoms of discomfort on urination and frequency, pain and discomfort, and signs and symptoms of UTI. A Physician's Order, dated 11/30/21, indicated urostomy care, monitor stoma for signs and symptoms of infection and notify physician if changes occur every shift. The order was discontinued on 8/15/22. A Physician's Order, dated 1/22/22, indicated to cleanse the insertion site daily and as needed with warm water or saline solution every shift. The order was discontinued on 8/15/22. Physician's Orders, dated 8/23/22, indicated to change the urostomy bag every three days and as needed. Physician's Orders, dated 8/16/22, indicated to notify the Physician for dislodgement and adverse symptoms of urostomy. Cleanse around urostomy site as needed with warm water or saline solution. There were no current Physician's Orders to clean around the urostomy daily and monitor for signs and symptoms of infection around the urostomy site. The Treatment Administration Record for 8/2022, indicated cleansing around the urostomy site and monitoring the stoma for signs of infection was not completed 8/16-8/30/22. Interview with the Director of Nursing on 8/31/22 at 11:30 a.m., indicated the resident did not perform good hand hygiene all the time, so she was not to be the only one doing the care to the		**will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/22/2022**	

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	urostomy. Nursing staff were to be looking at the site every shift and cleaning the stoma daily. This Federal tag relates to Complaint IN00387915. 3.1-41(a)(1)			
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed, swallowing guidelines not followed, and Registered Dietitian recommendations not acted upon in a timely manner for 6 of 8 residents reviewed for nutrition. (Residents H, G, E, F, J, and B)	F 0692	**F692 Nutrition/Hydration Status Maintenance** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	09/22/2022

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Findings include:

1. The record for Resident H was reviewed on 8/30/22 at 2:05 p.m. Diagnoses included, but were not limited to, end stage renal disease and type 2 diabetes mellitus.

The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/22, indicated the resident was cognitively intact for daily decision making. He needed supervision with eating and set up help. The resident also received a therapeutic diet.

A Care Plan, dated 7/10/22, indicated the resident was at risk for impaired nutritional status related to end stage renal disease with dependence on dialysis, diabetes, therapeutic diet, and history of weight loss. The resident was also at risk for malnutrition. Interventions included, but were not limited to, provide and serve diet and supplements as ordered. Monitor intake and record every meal.

The Food Consumption Logs, dated 8/3 through 8/31/22, indicated the following:
-No breakfast or lunch was documented on 8/27/22.
-No lunch was documented on 8/31/22.
-No dinner was documented on 8/5, 8/8, 8/11, 8/16, and 8/18/22.
-No meals were documented on 8/6, 8/7, and 8/25/22.

Interview with the Director of Nursing on 8/31/22 at 2:45 p.m., indicated the food consumption logs should have been completed.

2. The record for Resident G was reviewed on 8/31/22 at 9:06 a.m. Diagnoses included, but were

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1) Immediate actions taken for those residents identified:
1. Resident H was assessed by the Registered Dietician no negative outcome noted
2. Resident G was assessed by the Registered Dietician with no negative outcome noted
3. Resident E had a Cookie swallow and diet was upgraded.
4. Resident F was assessed by Dr. Patel no negative outcome noted.
5. Resident J was assessed by the Registered Dietician with no negative outcome noted.
6. Resident B was assessed by the Registered Dietician with no negative outcome noted.

2) How the facility identified other residents:

All resident who resides in the facility have the potential to be affected by this deficient practice.

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	not limited to, cerebral palsy, lack of coordination, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident was cognitively impaired for daily decision making. He needed supervision with eating and set up assistance. The resident had a recent weight loss and received a mechanically altered/therapeutic diet. A Care Plan, dated 6/8/22, indicated the resident was at risk for impaired nutritional status due to readmission to the facility, weight loss, and risk for malnutrition. Interventions included, but were not limited to, offer substitute if less than 50% of meal was consumed and provide meal assistance as needed. The Food Consumption log, dated 8/2 through 8/30/22, indicated the following: -No breakfast or dinner was documented on 8/20 and 8/21/22. -No breakfast was documented on 8/7/22. -No lunch was documented on 8/23/22. -No dinner was documented on 8/9, 8/14, 8/16, 8/17, 8/19, and 8/25/22. -No meal consumption was documented on 8/29/22. Interview with the Director of Nursing on 8/31/22 at 2:45 p.m., indicated the food consumption logs should have been completed. 3. On 8/30/22 at 12:41 p.m., Resident E was observed in his room in bed. He was eating his dessert and his lunch tray was on the over bed table. The resident was served ground ham, there was no gravy on the ham, scalloped potatoes, greens, and corn bread.		**3) Measures put into place/ System changes:** 1. Staff will be in serviced on the importance of documenting resident meal consumptions and following swallowing guidelines. 2. DON was educated on the importance of following up with the Dietician's recommendations timely. **4) How the corrective actions will be monitored:** The DON or designee will audit meal consumption daily 5x /week for 4 weeks. And thereafter until compliance is met. Also Registered Dietician and Speech Therapy recommendations will be reviewed daily during the clinical meeting. **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: 09/22/2022**	

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On 8/31/22 at 8:25 a.m., the resident was observed in his room in bed eating breakfast. He was served pancakes, ground sausage with no gravy, scrambled eggs, and cereal. At 12:25 p.m., the resident was served lunch. He received a chopped up chicken breast with no gravy, noodles, green beans, and dessert.

The record for Resident E was reviewed on 8/30/22 at 10:12 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and stroke.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/18/22, indicated the resident was cognitively intact for daily decision making. The resident required supervision with eating and set up assistance. He received a mechanically altered diet.

A Care Plan, dated 5/11/22, indicated the resident was at risk for impaired nutritional status related to bipolar, depression, impaired mobility, mechanically altered diet, and history of weight loss. The resident was at risk for malnutrition. Interventions included, but were not limited to, monitor, document, and report as needed (prn) signs and symptoms of dysphagia. Provide diet and supplements as ordered and monitor intake and record every meal.

A Physician's Order, dated 10/13/21, indicated the resident was to receive a mechanical soft texture diet with gravy and double portions at breakfast.

A Physician's Order, dated 8/24/22, indicated effective 8/16/22 the resident was to receive Speech Therapy 2-4 times a week for 29 days to address dysphagia and/or swallow dysfunction.

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Nurses' Notes, dated 8/23/22 at 3:48 p.m., indicated recommendations were received from Speech Therapy for a cookie swallow for a diet upgrade. The Physician was notified and orders were received.

The Food Consumption log, dated 8/1 through 8/30/22, indicated the following:
-No breakfast was documented on 8/3/22.
-No breakfast or lunch was documented on 8/2, 8/19, 8/25, and 8/27/22.
-No dinner was documented on 8/1, 8/5, 8/11, and 8/29/22.

Interview with the Director of Nursing on 9/1/22 at 10:16 a.m., indicated the food consumption logs should have been completed and the resident should have received gravy with his meat. 4. On 8/28/22 at 1:00 p.m., Resident F was observed feeding herself in bed. There were no staff assisting or cueing the resident.

On 8/30/22 at 8:09 a.m., the resident was observed lying in bed. The head of the bed was at a 45 degree angle. At that time, the CNA served the resident her breakfast. The resident's eyes were closed and the CNA tried several times to awaken her without success. The breakfast tray was left there in front of her. At 8:17 a.m., the Wound Nurse answered the call light, which the resident's roommate put on by accident. She did not stop and help the resident. At 8:20 a.m., the Corporate Housekeeping Director entered the room and offered some assistance for the resident to eat, however, she still would not wake up. The resident remained lying in bed at the 45 degree angle with her breakfast tray in front of her. At 8:29 a.m., QMA 1 entered the room to pass the resident her medications, however, the resident

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still did not wake up. The QMA covered the breakfast tray and took the medications back to the medication cart.

On 8/30/22 at 10:24 a.m., the resident was observed lying in bed and awake. The head of her bed was at a 45 degree angle and she was observed drinking water from the styrofoam cup on the over bed table. At 12:23 p.m., the resident was observed sitting in a geri recliner chair. She was not seated at a 90 degree angle and her lunch tray was in front of her. She was served lemonade to drink, greens, ham, potatoes, and cornbread. The resident began feeding herself, she took one bite after another with no sips of liquid to drink in between. There were no staff cueing, assisting, or watching the resident eat. The resident continued to feed herself with no staff assistance and not at a 90 degree angle. At 12:40 p.m., staff came in and took the resident's meal tray as she was done eating.

At 12:50 p.m., the resident's family member came in and brought the resident a Kentucky Fried Chicken meal of a chicken pot pie. He placed the chicken pot pie in front of the resident, however, she was having trouble eating it, as she was not sitting upright in the chair. At 1:03 p.m., 2 CNA's entered the room and repositioned the resident so she was sitting upright. She began to feed herself bite after bite with no sips of liquid in between. There were no staff cueing, assisting, or monitoring the resident as she ate the food. The resident finished the meal at 2:00 p.m. and was only observed to take 2 sips of Gatorade while she ate the food.

On 8/31/22 at 8:30 a.m., the resident was observed lying in bed at a 60 degree angle. She was not sitting upright at a 90 degree angle. She was

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eating her breakfast meal which consisted of ground sausage, pancakes, hot cereal, apple juice, and milk. She was observed to take multiple bites of food and was not alternating with liquids. At 9:36 a.m., she was finished with the breakfast and did not drink any of her milk and drank 90% of the apple juice which was in a 6 ounce cup. She ate all of her hot cereal and pancakes.

The record for Resident F was reviewed on 8/29/22 at 2:30 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness), stroke, dementia, and dysphagia (difficulty swallowing).

The Modification of the Annual Minimum Data Set (MDS) assessment, dated 6/21/22, indicated the resident was severely impaired for decision making. The resident had no oral problems and received a mechanically altered diet.

The Care Plan, revised on 6/26/22, indicated the resident had a nutritional problem related to a mechanically altered diet due to the diagnosis of dysphagia. The approaches included, but were not limited to, encourage the resident to follow speech recommendations and remain upright at 90 degrees while eating and for 30-45 minutes after meals. Swallow before taking another bite or sip. Alternate liquids and solids.

Physician's Orders, dated 5/24/22, indicated the resident was to remain upright at 90 degrees while eating and for 30 to 45 minutes after meals. Swallow before taking another bite or sip. Alternate liquids and solids and resident may self feed.

Physician's Orders, dated 5/26/22, indicated a regular diet with a mechanical soft texture.

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Interview with the Director of Nursing on 8/31/22 at 11:20 a.m., indicated the Speech Therapist made those recommendations and those were to be followed.

5. On 8/30/22 at 8:20 a.m., Resident J was observed in bed. The head of the bed was at a 60 degree angle and the resident was feeding herself breakfast. She was served a biscuit and gravy, scrambled eggs, milk, and juice.

The record for Resident J was reviewed on 8/29/22 at 2:10 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and aphasia (loss of ability to express speech).

The Quarterly Minimum Data Set (MDS) assessment, dated 7/22/22, indicated the resident was not cognitively intact. The resident had no oral problems, weighed 122 pounds and had a significant weight loss.

The Care Plan, revised on 8/3/22, indicated the resident had a nutritional problem related to decreased mobility following a stroke. The approaches were to monitor intake and record every meal.

The resident weighed 134 pounds on 6/21/22 and 122 pounds on 7/21/22, which resulted in a 8.96% weight loss in 1 month. The resident's current weight as of 8/10/22 was 121 pounds.

A Registered Dietitian's (RD) Note, dated 7/6/22 at 11:28 p.m., indicated the resident had a 7.1% weight loss over the past week. House shake in place for nutritional support with good acceptance. Recommend increase house shake to

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twice a day and weekly weight next week.

Physician's Orders, dated 7/12/22 indicated house shake two times a day.

The Food Consumption Log for 8/2022 indicated the meals were not documented for the breakfast meal on 8/3, 8/4, 8/6, 8/18, 8/22, 8/23, and 8/26/22. The meals were not documented for the lunch meal on 8/3, 8/4, 8/6, 8/18, 8/22, 8/23, and 8/26/22 and not documented for the dinner meal on 8/1, 8/4, 8/15, 8/17, 8/22, and 8/23/22.

Interview with the Director of Nursing on 9/1/22 at 9:15 a.m., indicated the RD recommendations were not completed in a timely manner and the food consumption documentation was to be completed after every meal.

6. On 8/28/22 at 1:00 p.m., Resident B was observed lying in bed. She was sitting in an upright position and her lunch tray was in front of her. She was served chicken, french fries, and broccoli. The health shake was observed spilled all over the floor.

The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), type 2 diabetes, dementia without behaviors, and protein calorie malnutrition.

The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making. The resident needed supervision with 1 person physical help for eating. She weighed 134 pounds and had a significant weight loss.

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The Care Plan, revised on 8/3/22, indicated the resident was at risk for impaired nutritional status due to therapeutic diet and weight loss.

The resident weighed 144 pounds on 7/14/22 and 128 pounds on 8/16/22, which resulted in a 11.11% loss.

A Registered Dietitian's (RD) Note, dated 8/3/22 at 10:28 a.m., indicated the resident had 9.8 pound weight loss in the last week. Recommend a 4 ounce house shake twice a day and continue with weekly weights.

Physician's Orders, dated 8/9/22, indicated house shake twice a day in the a.m. and p.m.

The 8/2022 Medication Administration Record, indicated the health shake was initiated on 8/9/22 in the a.m.

The Food Consumption Logs for 8/2022, indicated the breakfast meal was not documented on 8/3, 8/4, 8/6, 8/7, 8/19, 8/23, and 8/26/22. The lunch meal was not documented on 8/3, 8/4, 8/6, 8/7, 8/19, 8/23, and 8/26/22 and the dinner meal was not documented on 8/1, 8/4, 8/5, 8/18, and 8/23/22.

Interview with the Director of Nursing on 9/1/22 at 9:15 a.m., indicated the RD recommendations were not completed in a timely manner and the food consumption documentation was to be completed after every meal.

The current 9/1/20 "Food and Nutrition Services" policy, provided by the Director of Nursing on 8/31/22 at 3:50 p.m., indicated RD recommendations will be given to the facility, who will follow through and implement them. The clinical designee will follow through on these

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recommendations in a timely manner. Recommendations that were more urgent would be handled and returned within 72 hours or less. This Federal tag relates to Complaint IN00387915. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review, and interview, the facility failed to ensure medications were safely administered through a percurtaneous endoscopic gastrostomy (peg) tube (a tube directly inserted into the stomach for nutrition) and placement of the tube was checked prior to medication administration for 1 of 1 peg tube	F 0693	**F693 Tube Feeding Mgmt/Restore Eating Skills** The facility requests paper compliance for this citation. *This Plan of Correction is the*	09/22/2022

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	155653	A. BUILDING 00 B. WING	09/01/2022

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medication administrations observed. (Resident 23)

Finding includes:

On 8/30/22 at 4:44 p.m., RN 1 was observed pouring and preparing medication for Resident 23. At that time, the RN poured Metoprolol (a blood pressure medication) 100 milligram (mg) 1 tablet, Atoravastatin (a cholesterol medication) 10 mg 1 tablet, and Tylenol 325 mg 2 tablets into a plastic medication cup. She removed a plastic sleeve from the side of the cart and placed all 4 pills into the sleeve. She then crushed all 4 of the pills together and placed them into a 4 ounce plastic cup and walked into the resident's room. She performed hand hygiene and donned clean gloves to both hands. She obtained tap water from the sink and placed 30 cubic centimeters (cc) of water into the plastic cup and stirred the medication with a plastic spoon. The RN removed the plunger from the syringe, unclamped the peg tube and flushed 30 cc's of water down the tube per gravity. She did not check for placement of the tube prior to administering the water and medication. She poured the entire mixture of all 4 of the medications down the peg tube per gravity and finished the administration with a final flush of 30 cc's of water.

The record for Resident 23 was reviewed on 8/31/22 at 1:00 p.m. Diagnoses included, but were not limited to, stroke and dysphagia (difficulty swallowing).

The Admission Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident was cognitively intact and received a therapeutic mechanically altered diet.

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 23 was assessed, and no negative outcome noted related to receiving medications all at once and not having placement checked prior to medications given.

2) How the facility identified other residents:

All residents who have a peg tube and receive medications have the potential to be affected by this deficient practice.

3) Measures put into place/ System changes:

Licensed staff will be re-educated on proper medication administration via peg tube. licensed staff cited were given 1:1

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	The Care Plan, dated 7/1/22, indicated the resident was at risk for complications secondary to requiring a tube feeding related to the stroke. The approaches included, but were not limited to, check for tube placement and gastric contents/residual volume per facility protocol. There were no Physician's Orders prior to the medication administration on 8/30/22 to combine all the medications together and administer at one time. A Physician's Order, dated 8/31/22, indicated may crush and combine medications to administer via peg unless contraindicated by pharmacy and/or doctor. Interview with RN 1 on 8/30/22 at 4:56 p.m., indicated she was able to crush and mix all the medications together to administer through the peg tube. RN 1 indicated she checked for placement prior to hanging the new enteral feeding, however, she confirmed she did not check for placement prior to administering the medications. Interview with the Director of Nursing on 9/1/22 at 10:10 a.m., indicated the medications were to be given one at a time through the peg tube and the nurse should have checked for placement prior to administering the medications. The current 2/15/21, "Enteral Feeding Tube Medication Administration" policy, provided by the Nurse Consultant, indicated prior to the flushing of a feeding tube, the administration of medication via a feeding tube, or the providing of tube feedings, the nurse performing the procedure ensures the proper placement of the feeding tube. Prior to medication administration flush the tube		education. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 2 medication pass audits a week until substantial compliance. **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: 09/22/2022**	

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	with 30 milliliters (ml) of water, mix each crushed medication with 5 to 10 ml of water and flush with 10 ml of water in between each medication. 3.1-44(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct rate and there were Physician's Orders for oxygen for 2 of 2 residents reviewed for oxygen. (Residents B and 27) Findings include: 1. On 8/28/22 at 1:00 p.m. and 1:42 p.m., Resident B was observed lying in bed. At that time, the oxygen tubing was around her neck and not in her nares. The concentrator in the room was set at 3 liters per minute (lpm). On 8/29/22 at 9:33 a.m., the resident was observed in bed. At that time, the oxygen tubing was around her neck and not in her nares. The concentrator in the room was set at 3 liters per minute. On 8/29/22 at 1:30 p.m., the resident was observed	F 0695	p paraid="1409698114" paraeid="{ca049e54-4f2d-43f8-95cb-65e0473ac2a5}{170}" >F695 Respiratory/Tracheostomy Care and Suctioning The facility requests paper compliance for this citation The 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	09/22/2022

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sitting up in a wheelchair. She was wearing oxygen per a nasal cannula and the concentrator was set at 3 liters per minute.

The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke, chronic obstructive pulmonary disease (COPD) and dementia without behaviors.

The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making and had received oxygen at the facility.

The Care Plan, dated 7/8/22, indicated the resident was at risk for complications including shortness of breath which was experienced while lying flat and upon exertion.

Physician's Orders, dated 7/7/22, indicated oxygen via nasal cannula administer at 2 liters per minute continuously.

Interview with the Director of Nursing on 8/31/22 at 11:30 a.m., indicated the oxygen rate should have been set at 2 liters.2. During an interview with Resident 27 on 8/28/22 at 10:17 a.m., he was observed to have on oxygen via nasal cannula with a flow rate of 2 liters per minute (lpm) continuously. The oxygen tubing was dated 8/20 and he indicated they usually changed the tubing every Monday, but they had not changed it "in awhile."

Interview with the resident on 8/30/22 at 9:54 a.m., indicated he usually wore oxygen at night or when it was humid outside. He had been using the oxygen since he contracted COVID-19 about three

is prepared and/or executed solely because it is required by the provision of federal and state law.

Immediately actions taken for those residents:

p paraid="2084573114" paraeid="{ca049e54-4f2d-43f8-95cb-65e0473ac2a5}{223}" >Resident B oxygen set to the correct liter.

Resident 27 an order for oxygen obtained from physician.

How the facility identified other residents

·All resident who resident in the facility have the potential to be affected by this deficient practice.

Measures put into place/ System changes

p paraid="288230760" paraeid="{12686eb2-3f73-427c-b9ac-d32ef8100701}{2}" >Nursing staff educated on following physicians orders related to oxygen therapy's educated oxygen therapy requires a physician order and must be set to the correct rate.

How the corrective actions will be

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months ago.

Resident 27's record was reviewed on 8/30/22 at 8:57 a.m. Diagnoses included, but were not limited to neurological conditions and respiratory failure. He was admitted to the facility on 3/9/22.

The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/22, indicated he was interviewable and on oxygen therapy.

The August 2022 Physician's Order Summary, indicated to monitor temperature and oxygen saturation every night shift.

The pulse oximeter (a noninvasive device that estimated the amount of oxygen in your blood) readings were completed on the following dates and times, with his oxygen in use:

8/30/2022 2:09 a.m., 97.0 % Oxygen via Nasal Cannula
8/26/2022 3:19 a.m., 99.0 % Oxygen via Nasal Cannula
8/24/2022 2:12 a.m., 98.0 % Oxygen via Nasal Cannula
8/23/2022 2:50 a.m., 98.0 % Oxygen via Nasal Cannula
8/19/2022 2:37 a.m., 92.0 % Oxygen via Nasal Cannula
8/17/2022 12:13 a.m., 98.0 % Oxygen via Nasal Cannula
8/16/2022 1:27 a.m., 97.0 % Oxygen via Nasal Cannula
8/12/2022 2:21 a.m., 98.0 % Oxygen via Nasal Cannula
8/11/2022 1:16 a.m., 98.0 % Oxygen via Nasal Cannula
8/10/2022 1:46 a.m., 98.0 % Oxygen via Nasal Cannula

monitored:

An audit tool will be developed to ensure that resident's oxygen therapy is administered correctly per doctor's order and ensure that the 02 tubing's and humidifiers are checked and dated appropriately per policy. At least 2 random residents will be selected per audit. This will be completed 3 times a week for 4 weeks. Then 2 times weekly for three months. Any deficiencies will be corrected immediately.

Date of completion: 09/22/2022

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8/9/2022 1:06 a.m., 99.0 % Oxygen via Nasal Cannula
8/7/2022 12:54 a.m., 96.0 % Oxygen via Nasal Cannula
8/6/2022 1:28 a.m., 95.0 % Oxygen via Nasal Cannula
8/4/2022 1:24 a.m., 97.0 % Oxygen via Nasal Cannula
8/3/2022 12:13 a.m., 97.0 % Oxygen via Nasal Cannula
8/2/2022 12:33 a.m., 96.0 % Oxygen via Nasal Cannula

The record lacked a current order for oxygen. The previous oxygen order for 4 lpm was discontinued on 7/12/22.

A Care Plan, dated 3/10/22, indicated the resident was at risk for complications including shortness of breath experienced while lying flat and upon exertion secondary to Emphysema/COPD (chronic obstructive disease). Interventions included, but were not limited to, encourage and/or assist with elevating head of bed to alleviate shortness of breath while lying flat, monitor for difficulty breathing (dyspnea) on exertion.

Interview with RN 2 on 8/30/22 at 10:11 a.m., indicated she had not worked the second floor and would have to view his orders for his oxygen. Follow up with RN 2 indicated Resident 27 did not have a Physician's Order for oxygen.

Interview and observation with the Director of Nursing (DON) on 8/30/22 at 10:40 a.m., indicated the resident had his "own personal oxygen concentrator." The oxygen concentrator was on and flowing at the rate of 2 lpm and the tubing was dated 8/20/22. The resident was observed to not have the oxygen on at that time. The resident

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	indicated to the DON that he used oxygen at night and especially when the weather was humid. The DON indicated the oxygen order was discontinued and she was unaware the nurses had charted on his oxygen use without a Physician's Order. 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or			

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	written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, record review, and interview, the facility failed to post and provide daily staffing for all licensed staff working in the facility. This had the potential to affect 75 of 75 residents who resided in the facility. Finding includes: On 8/28/22 at 8:31 a.m., the nurse staffing sign was not posted by the temporary entrance where visitor and employees entered the building during construction of the main entrance. The receptionist had unlocked the door. On 8/29/22 at 8:00 a.m., the nurse staffing sign was not posted by the temporary entrance where visitor and employees entered the building during construction of the main entrance. On 8/29/22 at 8:15 a.m., the nurse staffing sign was not posted on the first or second floors, nor by the temporary entrance that had been used by visitors and employees during the construction of the main entrance. Interview with Receptionist 1 on 8/29/22 at 8:19 a.m., indicated the staffing sheet was usually given to her and she would put the posting on the stand by the door. The nurse staffing posting signs were reviewed	F 0732	p="" paraid="1622513836" paraeid="{a1a5ba6c-eb38-4161-bd07-3dfb8b06ae57}{171}">F732 Posted Nurse Staffing Information 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. Immediate actions taken for those residents identified: p="" paraid="496213496" paraeid="{a1a5ba6c-eb38-4161-bd07-3dfb8b06ae57}{235}">Daily staffing sheet posted with all licensed staff working immediately How the facility identified other residents: No residents were affected by this alleged deficient practice Measures put into place/	09/22/2022

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	for the month of August 2022, they lacked the daily resident census. Interview with the Director of Nursing on 8/29/22 at 9:21 a.m., indicated she provided the nurse staffing posting sign to the receptionist on Fridays for Friday, Saturday and Sundays. They were displaying the nurse staff postings at the front entrance that was under construction. The nurse staff postings should have been at the temporary entrance where visitors entered. It was a miscommunication. The construction had been ongoing for the last 6 weeks at the front entrance. All staff and visitors had been entering through another temporary entrance. There was a sign posted on the doors at the front entrance that indicated "No residents or visitors beyond this point." A policy titled, "Nurse Staffing Information," was provided by the Nurse Consultant on 8/31/22 at 1:00 p.m. This current policy indicated, "Intent : It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy: 1. The facility will post the following information on a daily basis:...c. The total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift...d.. Resident census...."		System changes: DON and receptionist were re-educated on the importance of posting the daily staffing. ol="" role="list" start="4" How the corrective actions will be monitored: The administrator will audit the placement of the daily staffing to ensure that it is posted. 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. Date of compliance: 09/22/2022	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure blood pressures were monitored, blood pressure medication was held per parameters, and insulin was administered as ordered by the Physician for 2 of 5 residents reviewed for unnecessary medications. (Residents B and 25) Findings include: 1. The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke, atrial fibrillation (irregular heartbeat), and dementia without behaviors. The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making. Physician's Orders, dated 7/7/22, indicated	F 0757	p="" paraid="363296489" paraeid="{3c50dbc2-69aa-4d1e-92e2-bf5768bc0855}{184}">F 757 Drug Regimen is free from unnecessary Drugs 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. Immediate actions taken for those residents identified: ol="" role="list" start="1"	09/22/2022

Hydralazine HCl (a medication used to treat high blood pressure) tablet 25 milligrams (mg). Give 1 tablet by mouth three times a day for hypertension and hold for systolic (top number) less than 130. The medication was scheduled for a.m., mid day, and night time.

The Medication Administration Record (MAR) for 8/2022, indicated the Hydralazine was administered to the resident on the following days with the following blood pressures for the a.m. dose:

8/3 124/76
8/6 129/82
8/10 126/70
8/13 128/78
8/14 128/75
8/15 129/72
8/16 116/78
8/18 122/68
8/19 118/67
8/23 126/64
8/25 125/74
8/26 124/76
8/27 128/78
8/28 122/74

The MAR for 8/2022, indicated the Hydralazine was administered to the resident on the following days with the following blood pressures for the night dose:

8/7 129/82
8/9 126/70
8/13 123/74
8/14 128/75
8/16 116/68
8/17 122/68
8/18 122/75

The physician was notified of resident B, blood pressure medications weren't held per parameters. Resident B has not had a negative outcome.
The physician was notified that resident 25 insulin wasn't held per parameters. Resident 25 has not had a negative outcome. How the facility identified other residents: All residents who receive medications have the potential to be affected by this deficient practice. Measures put into place/ System changes: p="" paraid="1218885307" paraeid="{8259db7c-ae7c-4cab-8662-c4b8f9b4cf1a}{43}">Licensed nurses will be educated on the importance of following physicians orders. How the corrective actions will be monitored: The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed. 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. Date of compliance: 09/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

8/19 129/82
8/30 128/76

There was no documentation on the 8/2022 MAR for a mid day blood pressure prior to the administration of the Hydralazine.

Interview with the Director of Nursing on 9/1/22 at 9:15 a.m., indicated there was no mid day blood pressure obtained before the administration of the Hydralazine and the medication had been administered when the systolic blood pressure was below 130. 2. Resident 25's record was reviewed on 8/30/22 at 9:37 a.m. Diagnoses included, but were not limited to, diabetes mellitus.

The Significant Minimum Data Set (MDS) assessment, dated 7/8/22, indicated the resident received insulin injections.

The August 2022 Physician's Order Summary, indicated the resident was to receive Humalog Insulin 6 units under the skin with meals for diabetes. Hold the insulin injection if the resident's blood sugar was under 150.

The August 2022 Medication Administration Record (MAR), indicated on the following dates and times, the resident received his insulin even though his blood sugar (bs) was less than 150:

- 8/1 at 12:00 p.m., bs was 127
- 8/1 at 8:00 p.m., bs was 80
- 8/2 at 8:00 a.m., bs was 110
- 8/2 at 12:00 p.m., bs was 116
- 8/5 at 12:00 p.m., bs was 148
- 8/6 at 8:00 a.m., bs was 132
- 8/8 at 8:00 a.m., bs was 117
- 8/8 at 12:00 p.m., bs was 117

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	- 8/8 at 6:00 p.m., bs was 126 - 8/9 at 6:00 p.m., bs was 145 - 8/11 at 12:00 p.m., bs was 142 - 8/13 at 6:00 p.m., bs was 126 - 8/14 at 6:00 p.m., bs was 143 - 8/15 at 8:00 a.m., bs was 143 - 8/16 at 12:00 p.m., bs was 117 - 8/17 at 12:00 p.m., bs was 135 - 8/17 at 6:00 p.m., bs was 113 - 8/18 at 6:00 p.m., bs was 147 - 8/18 at 12:00 p.m., bs was 147 - 8/18 at 6:00 p.m., bs was 141 - 8/19 at 12:00 p.m., bs was 149 - 8/19 at 6:00 p.m., bs was 148 - 8/20 at 6:00 p.m., bs was 116 - 8/21 at 6:00 p.m., bs was 136 - 8/27 at 6:00 p.m., bs was 126 The record lacked documentation indicating the Humalog Insulin was held with blood sugars below 150. A Care Plan, dated 4/12/22, indicated the resident was at risk for complications related to the diagnosis of diabetes mellitus. Interventions included, but were not limited to, diabetes medication as ordered by the doctor. Interview with the Nurse Consultant on 9/1/22 at 11:19 a.m., indicated the check marks with the initials on the MAR indicated the insulin was administered and not held per the Physician's order. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs.			

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	§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			

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	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure AIMS (Abnormal Involuntary Movement, a rating scale that was designed to measure involuntary movements known as tardive dyskinesia) scales were completed, diagnoses were provided for antipsychotic use, and there were indications for the use of an as needed (prn) anti-anxiety medication for 3 of 5 residents reviewed for unnecessary medications. (Residents E, B, and 128) Findings include: 1. The record for Resident E was reviewed on 8/30/22 at 10:12 a.m. Diagnoses included, but were not limited to, psychosis, bipolar disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 8/18/22, indicated the resident was cognitively intact for daily decision making. The resident had received an antipsychotic medication during the assessment reference period. A Physician's Order, dated 7/26/22, indicated the resident was to receive Seroquel (an antipsychotic medication) 300 milligrams (mg) every evening for psychosis. An AIMS scale was completed on 11/23/21. There were no other AIMS scales available for review.	F 0758	F758 Free from Psychotropic Meds 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: ol="" role="list" start="1" Aims was completed for Resident E. Medication was discontinued for resident B Resident 128 assessed no negative outcome noted. How the facility identified other residents: All residents who receive antipsychotic medications have the potential to be affected by this deficient practice. ol="" role="list" start="3" Measures put into place/ System changes: Licensed nurses will be educated	09/22/2022

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	Interview with the Director of Nursing on 8/31/22 at 2:45 p.m., indicated AIMS scales were to be completed quarterly or at least every 6 months. 2. The record for Resident B was reviewed on 8/29/22 at 2:55 p.m. The resident was admitted to the facility on 7/7/22. Diagnoses included, but were not limited to, stroke and dementia without behaviors. The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated the resident was moderately impaired for decision making. The Care Plan, dated 7/8/22, indicated the resident was at risk for complications secondary to receiving psychotropic medications. Physician's Orders, dated 7/8/22, indicated Quetiapine Fumarate (Seroquel an antipsychotic medication) Tablet 50 milligrams (mg). Give 1 tablet by mouth two times a day for antipsychotic. There was no diagnosis for the Seroquel. There was no Abnormal Involuntary Movement Scale (AIMS- a rating scale that was designed to measure involuntary movements known as tardive dyskinesia) assessment completed prior to the start of the antipsychotic medication. Interview with the Director of Nursing on 9/1/22 at 9:15 a.m., indicated the resident transferred from another Long Term Care Facility and she was receiving the Seroquel over there. There was no AIMS assessment completed, nor was there a diagnosis for the Seroquel. She was on the list to be seen by behavior health for this month. 3. Resident 128's record was reviewed on 8/31/22 at 8:35 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia with Lewy Bodies (a type of progressive dementia that leads		on the importance of following physicians orders and that PRN antipsychotics intervention need to be documented prior to giving. How the corrective actions will be monitored: ol="" role="list" start="3" The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed and that all PRN medications have the appropriate interventions. DON/Designee will audit 2 charts weekly to ensure that AIMS assessments are complete for 4 weeks and thereafter until compliance is met. 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. ol="" role="list" start="5" Date of compliance: 09/22/2022	

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to a decline in thinking, reasoning and independent function), and a psychotic disorder with hallucinations. He was admitted on 8/26/22.

On 8/31/22 at 8:35 a.m., Resident 128 was observed sitting on the couch peacefully by the Nurses' Station with his mask on. A few minutes later, he was assisted with ambulation to the dining room for breakfast.

The August 2022 Physician's Order Summary, indicated to administer Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 12 hours as needed (prn) for anxiety or behaviors.

The Medication Administration Record indicated the resident was administered the Lorazepam 0.5 mg on 8/29/22 at 5:47 p.m.

A Care Plan, dated 8/29/22, indicated the resident was at risk for complications secondary to the use of anti-anxiety medications. An intervention included, but was not limited to, observe/record occurrence for target behavior symptoms and document per the facility's protocol.

The record lacked documentation for why the resident had received the prn Lorazepam on 8/29/22 at 5:47 p.m.

Interview with the Director of Nursing on 9/1/22 at 2:24 p.m., indicated the nurse should have documented what behaviors had occurred and the reason why the resident needed the prn Lorazepam.

A policy was requested, but not received by the end of the Exit Conference on 9/1/22.

3.1-48(a)(3)

3.1-48(a)(4)

F 0759
SS=D
Bldg. 00

483.45(f)(1)
Free of Medication Error Rts 5 Prcnt or More
§483.45(f) Medication Errors.
The facility must ensure that its-

§483.45(f)(1) Medication error rates are not 5 percent or greater;

Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication administration. Two errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 7.41%. (Residents 127 and 16)

Findings include:

1. During Medication Administration Pass on 8/30/22 at 9:36 a.m., RN 2 was preparing to administer an Intravenous (IV) antibiotic to Resident 127. The RN removed the IV antibiotic of Cefazolin Sodium 2 grams (gm) from the package. She primed the tubing, flushed the PICC (peripherally inserted central catheter) line ports with normal saline and administered the medication. At 10:55 a.m., the IV had infused and was finished. RN 2 removed the tubing, flushed the PICC line and left the room.

The record for Resident 127 was reviewed on 8/31/22 at 9:30 a.m.

Physician's Orders, dated 8/26/22, indicated Cefazolin Sodium Solution Reconstituted 2 gm IV every 8 hours for wound infection. The scheduled times for administration were 12:00 a.m., 8:00 a.m., and 4:00 p.m.

F 0759 — Completion date: 09/22/2022

F 759 Free of Medication Errors
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 state law.

ol class="NumberListStyle1 SCXW138511146 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;"
Immediate actions taken for those residents identified:
1. Resident 127 assessed, and no

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	Interview with the Director of Nursing on 9/1/22 at 10:00 a.m., indicated the IV antibiotic was administered late. 2. During Medication Administration on 8/31/22 at 8:49 a.m., LPN 1 was observed preparing and pouring medication for Resident 16. She poured 12 pills into a plastic cup and indicated at that time, the resident was also to receive insulin. She removed a vial of Lispro insulin and drew up 28 units. The medication label on the box the vial was in, indicated to administer 28 units before meals. The LPN entered the resident's room at 9:00 a.m., and administered the 28 units of insulin into his right arm. Interview with the resident at that time, indicated he had already eaten his eggs, and most of his hot cereal. The record for Resident 16 was reviewed on 8/31/22 at 9:40 a.m. Physician's Orders, dated 3/5/22, indicated Humalog Solution (Insulin Lispro), inject 28 units subcutaneously before meals for diabetes. The scheduled time was for 7:30 a.m. Interview with the Director of Nursing on 9/1/22 at 10:00 a.m., indicated the insulin was administered late. 3.1-48(c)(1)		negative outcome noted. 2. Resident 16 assessed, and no negative outcome noted. All residents who receive medications have the potential to be affected by this deficient practice. ol class="NumberListStyle1 SCXW138511146 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Measures put into place/ System changes: Licensed nurses will be educated on the importance administering medication timely per physicians' orders. How the corrective actions will be-monitor: The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or	

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			until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will $' any trends or patterns and make recommendations to revise the plan of correction as indicated ol class="NumberListStyle1 SCXW138511146 BCX8" role="list" start="5" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Date of compliance: 09/22/2022	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from			

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	the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, record review, and interview, the facility failed to ensure a resident was seen by the dentist for routine dental services for 1 of 1 residents reviewed for dental services. (Resident D) Finding includes: During an interview with Resident D on 8/28/22 at 10:18 a.m., she indicated she had asked to see the dentist about 3 weeks ago and had not heard anything else about it. Some of the resident's teeth were observed to be missing and decayed. The record for Resident D was reviewed on	F 0791	p="" paraid="2066433288" paraeid="{fed7c33a-0f70-40c8-aa4e-2da746950da4}{171}">F 791 Routine Emergency Dental Services The facility requests paper compliance for this citation The 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	09/22/2022

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8/30/22 at 3:01 p.m. Diagnoses included, but were not limited to, paraplegic, type 2 diabetes, and Parkinson's disease.

The Significant Change Minimum Data Set (MDS) assessment, dated 6/19/22, indicated the resident had no dental issues.

The Quarterly MDS assessment, dated 7/23/22, indicated the resident was alert and oriented.

The Care Plan, dated 1/4/22, indicated the resident had upper and lower dentures. The approaches included, but were not limited to, coordinate arrangements for dental care and transportation as needed. Refer to the dentist as needed.

An Admission Assessment, dated 3/21/22, indicated the resident had obvious or likely cavity or broken natural teeth. An Assessment, dated 5/3/22 and 6/13/22, indicated there were no issues with the resident's teeth. An Assessment, dated 8/16/22, indicated the resident had obvious or likely cavity or broken natural teeth.

A Social Service Progress Note, dated 8/12/22, indicated the dentist was here, however, the resident was not seen due to being in the hospital.

Interview with the Social Service Director (SSD) on 8/30/22 at 3:50 p.m., indicated the dentist was in the facility in August 2022, however, the resident was in the hospital. He had only been working in the facility for 3 months, so he was unaware if there had been prior dental visits.

Interview with the Medical Records Supervisor on 8/31/22 at 8:25 a.m., indicated there were no dental visits in the past year to the facility.

plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law'. Immediately actions taken for those residents: p="" paraid="1336231023" paraeid="{fed7c33a-0f70-40c8-aa4e-2da746950da4}{226}">Resident D has a follow up dental appointment scheduled. How the facility identified other residents All resident residing in the facility who needs necessary services have the potential to be affected by this alleged practice. Measures put into place/ System changes Social service Director was re-educated on the importance of following up with resident referrals for outside services.
ol="" role="list" start="4"
How the corrective actions will be monitored:
Social Services Director will complete weekly audits on ancillary referrals weekly to ensure that all referrals have been followed. 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 3x consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of completion: 09/22/2022

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	3.1-24(a)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure bowls and pans were properly stored on the shelves in the kitchen and food was properly served under sanitary conditions on the tray line. This had the potential to affect the 69 residents who received food from the kitchen. (The Main Kitchen) Findings include: During an initial tour with a continuous observation of the kitchen on 8/28/22 at 8:36 a.m. until 9:00 a.m., the following occurred:	F 0812	**F 812 Food procurement Store/prepare/Serve-Sanitary** It is the policy of the facility to procure food from sources approved or considered satisfactory by federal, state or local authorities. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** · No resident was affected by	09/22/2022

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	155653	A. BUILDING 00 B. WING	09/01/2022

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HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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	1. On a bottom wired shelf in the corner of the kitchen, near the cooler and freezer, there were several pans stored facing up. 2. On another bottom shelf in the kitchen, mixing bowls and colanders were stored facing up. 3. During an observation of the breakfast tray line, Cook 1 had placed scrambled eggs on a plate, with the same gloved had that he had touched the serving spoon, the handle of the pan that he had cooked more eggs in, and he placed a packaged donut on the same plate. The packaging was observed to be touching the eggs each time a packaged donut was placed on a plate. Cook 1 did not remove his gloves during the entire observation of the plating of food and cooking of eggs in a pan on the stove. Interview with Cook 1 on 8/28/22 at 8:49 a.m., indicated the only items that were placed in a bowl were oatmeal and cereal. The packaged donut went on the plate next to the scrambled eggs. Interview with the Dietary Manager on 8/28/22 at 1:18 p.m., indicated the packaged donut or other foods, should have been taken out of the package or placed on the tray with its package still on. The pans, bowls and colanders should have been stored facing in a downward position to not collect contaminates. A policy titled, "Dishwashing: Machine Operation," was provided by the Nurse Consultant on 8/31/22 at 3:10 p.m. This current policy indicated, "... Procedure...9. f. Use clean, washed hands to pull out clean racks, and allow to air dry before putting dishes away for storage. Place glasses, cups, pots, and pans upside down		this deficient practice. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. · This had the potential to affect all 73 residents who receive food from the kitchen. 2. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. · The pans, colander & mixing bowls were re-sanitized & then stored properly. · Pre-packaged food throughout the rest of the survey was served properly. · Cook was given 1:1 in-service regarding proper food & storage of kitchen equipment immediately. · All kitchen staff were re-educated during survey. · Dietary consultant and or Administrator will conduct observation of the kitchen to cover sanitation and proper storage of food at least three times weekly for 4 weeks. Then 2 times weekly for 3 months. Any deficiencies will be corrected immediately. 3. Quality Assurance Plans to monitor facility performance to make sure that corrections are	

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	on the drying rack...." 3.1-21(i)(3)		achieved and are permanent. · All plan of correction observation tool will be reported by the Administrator and or Dietary Consultant to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 4. Dates when corrective action will be completed: September 22.2022	
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,			

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identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or 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.

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to monitoring for COVID-19 signs and symptoms while COVID positive for 1 of 1 residents. The facility also failed to ensure hand hygiene was completed prior to donning gloves and a lancet was disposed of properly for 1 of 1 glucometers observed and 1 of 6 residents observed during medication administration. (Residents 36, 127, D, and 12) Findings include: 1. The record for Resident 36 was reviewed on 9/1/22 at 11:55 a.m. Diagnoses included, but were not limited to, COVID positive. The resident was admitted to the facility on 6/3/22. The Admission Minimum Data Set (MDS) assessment, dated 6/10/22, indicated the resident was moderately impaired for daily decision making. Nurses' Notes, dated 7/11/22 at 9:36 a.m., indicated	F 0880	**F880 Infection Prevention Control** **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:** 1. Resident 36 is now out of	09/15/2022

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	the lab had informed the facility the resident was positive for COVID. The resident's Physician and family were notified and he was placed in isolation. A Physician's Order, dated 7/11/22, indicated the COVID Screener assessment was to be completed every shift due to his positive status. The COVID Screener assessments were completed on the following dates: -7/12/22 at 2:31 a.m. -7/14/22 at 12:00 a.m. -7/15/22 at 4:12 a.m. -7/19/22 at 12:00 a.m. -7/20/22 at 12:00 a.m. Interview with the Director of Nursing on 9/1/22 at 3:15 p.m., indicated the COVID Screener assessments should have been completed as ordered. She indicated vital signs with oxygen saturation were being completed as well as monitoring of signs and symptoms which were documented on the Medication Administration Record (MAR), however, the COVID Screener was where the respiratory assessment was to be documented. 2. During Medication Administration Pass observation on 8/30/22 at 9:36 a.m., RN 2 was preparing to administer an Intravenous (IV) antibiotic to Resident 127. The RN removed the IV antibiotic of Cefazolin Sodium 2 grams (gm) from the package. She primed the tubing, flushed the PICC (peripherally inserted central catheter) line ports with normal saline and administered the medication. At 10:55 a.m., the IV had infused and was finished. RN 2 donned a pair of clean gloves to both hands and did not perform hand hygiene. She realized she had no alcohol wipes, so she removed her gloves and left the room and did not perform hand hygiene. RN 2		quarantine for Covid-19 2. Resident 127 was assessed and was not negatively affected 3. RN 1 was re-educated on proper performance of hand hygiene prior to donning and doffing gloves 4. The lancet used for Resident D's Blood Glucose was dispose of properly 5. QMA 1 was re-educated on proper disposal of lancets after use. **2) How the facility identified other residents:** All residents who are Diabetic and are positive for Covid-19 have the potential to be affected by the alleged deficiency. **3) Measures put into place/ System changes** Staff will be re-educated regarding infection control guidelines related to Covid-19. Proper hand hygiene and proper disposal of lancets after use.	

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	came back to the room performed hand hygiene and donned a pair of clean gloves, removed the tubing, flushed the PICC line and left the room. 3. On 8/30/22 at 12:32 p.m., QMA 1 was preparing to check Resident D's blood sugar by the way of a glucometer. The QMA gathered supplies and entered the room, donned clean gloves, but did not perform hand hygiene. She wiped the resident's finger with an alcohol pad, pricked it with a lancet, and obtained blood with the strip in the glucometer. QMA 1 removed the gloves and rolled them into a ball with the used lancet inside the gloves. She walked out of the room and threw everything into the garbage can on the side of the medication cart. She removed a germicide wipe and cleaned the glucometer with her bare hands. She did not perform hand hygiene after the removal of the gloves. Interview with QMA 1 on 8/30/22 at 12:45 p.m., indicated she had thrown her gloves including the used lancet into the garbage can. QMA 1 was observed preparing an insulin injection for Resident 12 on 8/30/22 at 12:45 p.m. She drew up 25 units of Lispro insulin and entered the resident's room. She donned a pair of clean gloves to both hands and administered the insulin into the resident's abdomen. She did not perform hand hygiene prior to donning the gloves. Interview with the Director of Nursing on 9/1/22 at 9:00 a.m., indicated hand hygiene was to be performed before donning and after doffing clean gloves. The current and revised 1/2/21 "Glucose Testing-Glucometer" policy, provided by the Nurse Consultant on 9/1/22 at 11:57 a.m., indicated		**4) How the corrective actions will be monitored:** The Director of Nursing or designee will audit covid monitoring screeners daily to ensure that they were complete and accurate, 5 random hand hygiene observations a week and 3 blood glucose observations a week. **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: 09-22-2022**	

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	remove the test strip from the machine and dispose of test strip and lancet in the sharps box. The current and updated 2/8/22, "COVID-19 Infection Control Guidance in Long-term Care Facilities", indicated hand hygiene [use of alcohol-based hand rub (ABHR) is preferred]: Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. 3.1-18(b)			