STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	09/01/2021

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ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00361074 and IN00361245. This visit included a State Residential Licensure Survey. Complaint IN00361074 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00361245 - Unsubstantiated due to lack of evidence. Survey dates: August 25, 26, 27, 30, 31, and September 1, 2021 Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 86 SNF: 12 Residential: 23 Total: 121 Census Payor Type: Medicare: 19 Medicaid: 65 Other: 14 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 9, 2021	F 0000	Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted September 1, 2021 This letter is to inform you that the plan of correction attached is to serve as Arbor Trace's credible allegation of compliance. We allege compliance on October 1, 2021 . Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request desk review.	

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

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review the facility failed to obtain an order for change in treatment to a gastrostomy tube (g-tube) site, change a g-tube to a Foley catheter, and to remove a Foley catheter to place a new g-tube on 1 of 1 resident reviewed for g-tube management. (Resident F) Findings include: The clinical record for Resident F was reviewed on 8/27/2021 at 11:45 AM. The diagnoses included, but were not limited to, cerebral palsy, abnormal posture, constipation, fever, contracture, candida stomatitis, pain, epilepsy, muscular weakness, mixed receptive and expressive language disorder. A Quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) for 6/24/2021 indicated resident was unable to participate in BIMS with cognition coded as severely impaired with no behaviors noted. Further noted resident is always incontinent of bowel and bladder, total dependence with all activities of daily living with the exception of eating being exempt due to resident being NPO (nothing by mouth) per	F 0684	F684 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The physician was notified of the gastrostomy tube (GT) change using a Foley catheter. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Residents who have a GT have the potential to be affected by the alleged deficient practice and their orders have been reviewed to ensure orders are in place for changing the GT. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur	10/01/2021

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	physician order. No skin area identified on the MDS, but nonsurgical dressings and ointments noted on treatments. Under nutrition, it was selected that the resident receives 51% or more from tube feedings. A physician order dated 5/15/2020 read, "cleanse j/gtube [sic] site with soap and water. Pay dry and apply drain sponge. Special instructions: Cleanse every day and PRN [as needed]." A physician order dated 8/27/2021 read, "Stop feeding for 4 hours when resident has s/s of distress such as abdominal pain, abdominal distention, or leaking around G-tube site." Care plan for "enteral feeding via G-tube related to CP [Cerebral Palsy]", dated 8/9/18, listed under approach to "Observe for any drainage/leakage at the G-tube site and report it to the physician if it occurs." Care plan for history of skin breakdown surrounding stoma sites, dated 6/4/20, indicated approach of, "Cleanse stoma daily and prn. Apply wounder cream per order". A nursing note from 08/11/2021 stated, "Mickey tube removed due to it causing pressure injury to G-tube site. 16 Fr [16 Fr (French) refers to the size of the Foley catheter used] foley cath inserted and inflated to 15cc [cc- cubic centimeters, standard conversion is 1 cc is equivalent to 1 ml]. Air bolus injected, auscultated, in correct placement. G-tube site cleansed max absorb dressing and split sponges placed." There were no physician orders to change the g-tube noted in the clinical record until		Licensed nurses educated regarding obtaining for changing GT. The systemic change includes licensed nurses will be educated upon hire and annually regarding the GT policy. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON/designee will audit residents with GT to ensure orders are obtained for changing the GT weekly x 30 days. Then monthly x 11 months for a total of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5) By what date the systemic changes for each deficiency will be completed: 10/1/2021	

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	8/31/2021. No additional dressing orders or treatment application to g-tube site was present in the clinical record on 8/11/2021. A nursing note from 08/12/2021 stated, "Pressure injury remains to G-tube site. 16f Foley in place. Sponges changed to G-tube site. TF [tube feeding] administering per orders." Nursing note from 08/18/2021 stated, "Pressure injury remains to G-tube site. 16f Foley in place. Sponges changed to G-tube site." Nursing note entered for 08/19/2021, but recorded on 8/23/2021 read, "Area around g-tube site is not pressure related. Is due to leakage from G-tube and gastric acid causing area to skin. Treatment in place. Resident scheduled to See MD [Medical Doctor] 9 regarding abd. [abdominal] distention and area around g-tube site." The nursing note was signed by the Director of Nursing (DON). An observation conducted on 8/25/2021 at 2:15 PM, noted resident to be sitting in his Geri chair at the nurses' station. Tube feeding was running, and privacy bag was over the feeding. Resident's site was not able to be visualized at this time. Interview with RN (Registered Nurse) 3 indicated that the resident had a Foley catheter in place of his g-tube due to leaking and sponge dressings around the site. An observation conducted on 8/27/2021 10:45 AM, noted resident to be in bed at that time with head of bed elevated over 40 degrees. Resident was resting at this time. LPN (Licensed Practical Nurse) 2 verified that Foley was in place and split sponge dressing applied to side dated 8/27/2021. Tube feeding running per order at			

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	this time. Nursing note dated 08/28/2021 stated, "Foley catheter placed for feeding is leaking at connection site. New G-tube placed with 10cc of fluid placed in retention balloon. Air bolus auscultated and G-tube is in correct position. Area to G-tube site cleansed and txmt [treatment] applied." There were no physician orders to change Resident F's g-tube dated for 8/28/21. An interview conducted with DON on 8/30/2021 at 2:15 PM, it was disclosed resident has an area of breakdown around his tube site. This is a stable area of chronic dermatitis that he has been seen by Gastroenterologist for and has trialed multiple courses of treatment including ointments, some of which were helpful for a short time. DON continue to monitor this weekly on wound rounds to assess overall status of tube site but does not keep, record, or have measurements of this area. About 2 weeks ago, the evening nurse saw the site and thought it was pressure. DON believes that staff nurse then contacted MD 9. At the time of the interview, the area of concern is stable and slightly improved since last rounding. No documentation for contact with MD 9 on 8/11/2021 was present in Resident F's clinical record. A physician order dated 8/31/2021 read, "May use foley catheter in place of Mickey button until resident seen by MD 9." Policy presented by ED (Executive Director) on 8/27/2021 at 2:32 PM titled "Changing of a			

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	Gastrostomy Tube" under subtitle Preparation read, "1. Verify that there is a physicians' order for this procedure." Policy presented by Corporate Nurse 5 on 9/1/2021 at 1:43 PM titled "Protocol for Following Physician Orders", read "All licensed staff will verify and follow the physician orders as written. If for any reason, the physician order cannot be followed, the professional will contact the physician for further instructions." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §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, interview and record review, the facility failed to ensure fall interventions were in place and ensure a resident, documented as needing 2 staff assistance with transfers, was transferred with 2 staff to where the resident was lowered to the floor for 1 of 3 residents reviewed for accidents. (Resident 50) Findings include: A. The clinical record for Resident 50 was reviewed on 8/30/21 at 11:23 a.m. The diagnoses included, but were not limited to, Parkinson's	F 0689	F689 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Fall interventions for resident 50 have been reviewed to ensure they are in place. Therapy has assessed resident to determine transfer status. C NA assignment sheet and care plans have been reviewed and updated.	10/01/2021

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	disease, dementia, anxiety disorder and history of falling. An admission assessment, dated 4/14/21, indicated Resident 50 was at risk for falls. A fall care plan, dated 4/15/21, indicated the following, "...Resident at risk for falling and fall related injuries related to weakness...." The interventions listed the following: - 2-person transfer at all times, dated 6/8/21, - non-skid footwear at all times, dated 6/2/21, - wear hipsters at all times, dated 5/17/21, - Dycem to seat of recliner chair, dated 4/29/21, - Assist with ADL's (activities of daily living) as needed to meet needs, dated 4/15/21 & - Assist with transfers as needed, dated 4/15/21. An Admission Minimum Data Set (MDS) assessment, dated 4/20/21, documented Resident 50 needing extensive assistance with 2 staff person for bed mobility and transfers. A Quarterly MDS assessment, dated 6/23/21, documented Resident 50 needing extensive assistance with 2 staff person for bed mobility and transfers. An observation conducted on 8/30/21 at 2:08 p.m., with Personal Care Assistant (PCA) 6, noted Resident 50 sitting in his recliner with no Dycem noted underneath the cushion he was sitting on. PCA 6 indicated Resident 50 was not wearing hipsters during the observation and stated she was unsure if the resident was supposed to wear them or not. An observation conducted on 8/30/21 at 3:58 p.m., noted Resident 50 remaining in his		2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Residents residing in the facility have the potential to be affected. Fall interventions have been reviewed to ensure they are in place and therapy has assessed the residents to determine transfer status. C NA assignment sheets and care plans have been updated. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Nursing staff have been educated regarding the importance of having fall interventions in place and transferring residents with the appropriate amount of assistance as determined by therapy. The systemic change includes nursing staff will receive education upon hire and annually regarding the fall policy. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON/designee will audit 5	

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	recliner. PCA 14 was present, and she indicated Resident 50 doesn't have hipsters on and she hasn't seen him with those on. She was unsure if Resident 50 should be wearing hipsters. An observation conducted on 8/31/21 at 1:03 p.m., with Licensed Practical Nurse (LPN) 2, noted Resident 50 up in his wheelchair while being assisted with eating by LPN 2. LPN 2 indicated Resident 50 was not wearing hipsters during the observation and was unsure where they were located. B. The following fall events were noted in Resident 50's clinical record: 4/17/21- Resident observed on floor in room. Intervention was to ensure frequently used items were in reach. 4/29/21- Resident found sitting on floor in front of his recliner. Intervention was to apply Dycem in wheelchair and recliner. 5/4/21- Resident found sitting on floor in front of his recliner. Intervention was to place remote to recliner on the back of the recliner. 5/15/21- Resident found on floor and was complaining of left shoulder pain. He dislocated his left shoulder, and the intervention was to have hipsters on at all times. A progress note, dated 6/7/21, indicated the following, "...IDT [interdisciplinary team] Post fall assessment for fall on 6/5/21. Resident lost balance while transferring with CNA [certified nursing assistant] with gait belt present. CNA unable to hold resident up, lowered resident to the floor. Resident was not incontinent...Root cause: loss of balance...Intervention initiated by IDT: resident 2 person transfer...."		residents' fall interventions to ensure they are in place and will observe transfers to ensure appropriate amount of assistance is utilized weekly x 30 days. Then monthly x 11 months for a total of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5) By what date the systemic changes for each deficiency will be completed: 10/1/2021	

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	Physical Therapy (PT) notes were reviewed for May and June of 2021. The following date(s) noted documentation of therapy staff utilizing 2 staff assistance with transfers and ambulation for Resident 50: 5/4/21, 5/7/21, 5/9/21, 5/10/21, 5/11/21, 5/13/21, 5/20/21, 5/21/21, 6/1/21, 6/2/21, 6/3/21 and 6/4/21. An interview conducted with PCA 6, on 8/30/21 at 2:08 p.m., indicated she utilizes 2 staff members to transfer Resident 50 due to him leaning forward during transferring. An interview conducted with LPN 2, on 8/31/21 at 1:03 p.m., indicated Resident 50 needs 2 staff assistance with transfers due to his gait being unsteady related to his diagnosis of Parkinson's disease and having his shoulder dislocated. An interview conducted with Corporate Nurse 5, on 9/1/21 at 3:30 p.m., indicated the fall interventions should be in place per the care plan. A policy titled "Fall Prevention", dated May of 2016, was provided by Corporate Nurse 5, on 8/31/21 at 10:50 a.m. The policy indicated the following, "...STEP ONE: FALL RISK ASSESSMENT...The fall risk assessment will be completed on each new admission...STEP FIVE:			

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	INDERDISCIPLINARY GUIDELINES...If a fall occurs, the interdisciplinary team [IDT] will meet collectively and examine the fall using the following criteria...iii. A root cause analysis will be performed...iv. A member/designee of the IDT will assist the team and update the care plan and the nurse aide assignment sheets to ensure accuracy of fall preventions...STEP SIX: CARE PLANNING...Fall risk care plans will be kept current by the IDT and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0692 SS=D 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;			

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	§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 interview and record review, the facility failed to ensure weights were obtained for new admissions to the facility for 3 of 6 residents reviewed for nutrition. (Resident 50, Resident G and Resident 199) Findings include: 1. The clinical record for Resident 50 was reviewed on 8/27/21 at 2:59 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia and diabetes mellitus. Resident 50 was admitted to the facility on 4/14/21. The weights were reviewed under the "Vitals" tab located in Resident 50's clinical record. The admission weight was recorded at 181.6 pounds on 4/22/21. This was 8 days after Resident 50's admission to the facility. A physician order, dated 4/15/21, indicated weekly weights to be obtained for 4 weeks. The "Weight Administration History" report, dated April of 2021, noted no weekly weights obtained for 4/19/21 and 4/26/21 for the reasoning as "other". The next weight documented for Resident 50 was on 5/20/21 as 175.6 pounds. 2. The clinical record for Resident G was reviewed on 8/27/21 at 1:01 p.m. The diagnoses included, but were not limited to, cellulitis, dysphagia and weakness.	F 0692	F692 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 50, G and 199 have been weighed monthly and have not experienced significant weight loss. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Newly admitted residents have the potential to be affected. New admissions for the last 30 days have been audited to determine if weights have been obtained upon admission. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Nursing staff have been educated to obtain weights upon admission. The systemic change includes nursing staff will be educated on the weight policy upon hire and	10/01/2021

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	The following weights were noted in Resident G's clinical record: 8/9/21- admission weight of 150.2 pounds and 8/23/21 of 149.1 pounds. A physician order, dated 8/9/21, indicated weekly weights to be obtained for 4 weeks. The "Weight Administration History" report, dated August of 2021, noted no weekly weight obtained for 8/16/21. 3. The clinical record for Resident 199 was reviewed on 8/31/21 at 9:50 a.m. The diagnoses included, but were not limited to, dysphagia, weakness and Parkinson's disease. Resident 199 was admitted to the facility on 8/5/21. An admission weight of 155 pounds was noted for Resident 199. There were no weekly weights obtained after the admission weight. There were no physician orders for weekly weights x4 weeks to be obtained for Resident 199 after his admission to the facility. A policy titled "Weight Management Policy", dated March of 2015, was provided by Corporate Nurse 5 on 8/31/21 at 10:50 a.m. The policy indicated the following, "...Initial weight: Upon admission/re-admission the resident's weight and height will be obtained by the nurse aide or designee...4 Weeks post admit weights: New admission/re-admission resident's will be weighed at admission and weekly x4 weeks and monthly thereafter if the weight is determined to be stable...."		annually. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON/designee will audit new admissions daily x 30 days to ensure weights have been obtained. Then weekly x 8 weeks and monthly x 8 months for a total of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5) By what date the systemic changes for each deficiency will be completed: 10/1/2021	

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

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	3.1-46(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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, interview and record review, the facility failed to ensure infection control practices were maintained during medication administration and ensure a catheter drainage bag did not make contact with the floor	F 0880	F880 Directed POC The directed plan of correction (DPOC) is to serve as Arbor Trace's credible allegation of compliance.	10/01/2021

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	for 1 of 4 residents observed for medication administration and 1 of 3 residents reviewed for urinary catheters. (Resident J and Resident 50) Findings include: 1. An observation of medication administration was conducted on 8/31/21 at 8:20 a.m., with Licensed Practical Nurse (LPN) 2. She proceeded to remove an individual package for each medication listed below: Aspirin 81 milligrams, Vitamin D3 1,000 units, Gabapentin 600 milligrams, Namenda 10 milligrams, Calcium tablet, Senna 8.6 milligrams, Torsemide 10 milligrams, Tylenol with codeine 300-60 milligrams (2 tablets from the medication card) located inside the narcotic drawer, & Zoloft 25 milligrams (3 tablets in total). While LPN 2 proceeded to open the individual packaging of the vitamin D3 1,000 units tablet the tablet fell onto the top of the medication cart. She proceeded to take her bare hand and pick up the tablet and place it back into the medication cup. The rest of the medications were placed into that same medication cup and Resident J took the medications by mouth. A policy titled "Licensed Nurse Med Pass Clinical Skills Validation", undated, was provided by Corporate Nurse 5, on 8/31/21 at 10:50 a.m. The policy indicated the following, "...16. Tablets and capsules were handled so that fingers do not touch medication...."		Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citation.** **F880 Infection Prevention and Control** **S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident J and Resident 50 have remained free of signs or symptoms of infection. LPN 2 was immediately educated regarding hand hygiene during med pass. Resident 50's foley catheter drainage bag was changed. (Attachment A) **II. The facility will identify other residents that may potentially be affected by**	

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	2. An observation was conducted of Resident 50, on 8/30/21 at 2:08 p.m., to where he was sitting in his recliner where his catheter bag was hanging from the right side of the recliner and making contact with the floor. An observation was conducted of Resident 50, on 8/30/21 at 3:58 p.m., still sitting in his recliner with the catheter bag remained hanging from the right side of the recliner and making contact with the floor. A policy titled "Urinary Catheter Care", revised December 2017, was provided by Corporate Nurse 5 on 8/31/21 at 3:44 p.m. The policy indicated the following, "...General Guidelines...11. Be sure the catheter tubing and drainage bag are kept off the floor...." This Federal tag relates to Complaint IN00361074. 3.1-18(b) 3.1-18(l)		**practice.** Other residents residing in the facility receiving medications and residents with Foley catheters have the potential to be affected. Residents are observed for signs of infection including Covid-19 and have been found to be free of symptoms. (See Attachment B) **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · CMS-CDC Fundamentals of Covid-19 Prevention Training Self-Assessment Questionnaire completed indicating need for "Hand Hygiene and PPE Training" which was implemented for facility staff. (Attachment C) · Root Cause Analysis (RCA) with facility consultant Infection Preventionist, including input from the facility Medical Director/DON/IP was completed (See Attachment D) · Consultant Infection Preventionist educated IDT/Leadership team on "Hand Hygiene and PPE Training" utilizing CDC and WHO guidelines (Attachment E) · Involved staff were educated regarding performing	

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			hand hygiene during medication administration and foley catheter management (Attachment F) · Staff were educated when to perform hand hygiene during medication administration and foley catheter management. (See Attachment G) **IV.** The facility LTC Infection Control Self-assessment was reviewed with the consulting Infection Preventionist resulting in an updated LTC Infection Control assessment being completed with input from the Consultant IP/Medical Director and DON (See Attachment H) **V. The facility will monitor the corrective action by implementing the following measures.** · The IP/DON or designee will observe the licensed nurse and QMAs during medication administration to ensure hand hygiene is performed appropriately daily for 4 weeks, then weekly for 12 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit tool. (See Attachment H) · The IP/DON or designee, will observe Foley catheter bags to	

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			ensure drainage bags do not make contact with the floor daily for 4 weeks, then weekly for 12 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 (2) audit tool (See attachment I) The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **VI. Plan of correction completion date.** Date of compliance: 10/1/2021 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Arbor Trace's credible allegation of compliance.	
R 0000 Bldg. 00		R 0000	Please find enclosed the Plan of	

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	This visit was for a State Residential Licensure Survey. Survey dates: August 25, 26, 27, 30, 31, and September 1, 2021 Facility number: 000455 Residential Census: 23 Arbor Trace Health and Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on September 9, 2021		Correction to the annual Recertification and State Licensure Survey conducted September 1, 2021 This letter is to inform you that the plan of correction attached is to serve as Arbor Trace's credible allegation of compliance. We allege compliance on October 1, 2021 . Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request desk review.	