STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00228872 and IN00229364. Complaint IN00228872 - Substantiated. Federal/State deficiencies related to the allegations are cited at F328. Complaint IN00229364 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F202, F241, and F309. Unrelated deficiency cited. Survey dates: May 10 & 11, 2017 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 87 SNF: 22 Total: 109 Census Payor Type: Medicare: 24 Medicaid: 66 Other: 19 Total: 109	F 0000		

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/15/17.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that			

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	is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			
	Based on record review and interview, the facility failed to notify a resident's responsible party/ family of a transfer to the Emergency Room due to a change in condition, for 1 of 3 residents reviewed	F 0157	**F157** **The facility requests paper compliance for this citation.**	06/10/2017

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	for family notification in a total sample of 8. (Resident B) Finding includes: During an interview with a family member of Resident B on 05/10/17 at 8:15 a.m., she indicated the resident's Responsible Party had been on vacation when the resident's condition had changed and they had notified the facility to call another family member if needed. (The other family member was listed on the face page (resident information) as the second person to be notified). She indicated there was only a message left on their home answering machine to call the facility, which they received when they returned from vacation. She indicated the resident had been transferred to the Emergency Room and admitted into the Hospital on 04/30/17 and the family was not aware of the transfer/admission to the Hospital until 05/02/17. Resident B's record was reviewed on 05/10/17 at 8 a.m. Diagnoses included, but were not limited to diabetes and stroke. A Nurse's Note, dated 04/30/17 at 1:15 p.m. (clarified with LPN 5 as incorrect time and should have been 3:15 p.m.),		*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 has been discharged from the building.** **2) How the facility identified other residents:** **Any resident with a change in condition has the potential to be affected.**	

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	indicated "resident 911...presented with diaphorisis (sic), cold and clammy skin, film over both eyes. resident as (sic) tremors, and unable to respond appropriately. @ 1800 (6 p.m.) called hospital and pt (patient) will be admitted...left message with family..." A Resident Concern Form, dated 05/02/17, indicated the second contact family member had a concern due to coming to visit the resident and did not know the resident was in the hospital, and said the primary contact was on vacation and he was supposed to be contacted and was not. During an interview on 05/10/17 at 9:25 a.m., LPN 5 confirmed she had been the Nurse to transfer the resident to the Hospital and had called both home and cell phone numbers for the Responsible Party and left a message. She indicated she had called the Secondary Contact and left a message and passed the information on to the next nurse. She indicated she was unaware the Responsible Party was on vacation. There was no follow up by the facility to ensure the family was aware the resident had been transferred to the Hospital. A facility policy, dated 01/01/14,		**3) Measures put into place/ System changes:** **In-service will be completed, for nurses, educating them on the family and physician notification requirements. An audit tool was created to monitor for proper family and physician notification.** **4) How the corrective actions will be monitored:** **An audit will be completed under the supervision of the DON or designee 5x/ week to monitor for proper notification of physician and family for any resident with a change in condition.**	

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	received as current from the Director of Nursing, and titled, "Change in Condition Physician Notification Overview Guidelines", indicated the Responsible Party was to be notified of changes in condition. This Federal tag relates to Complaint IN00229364. 3.1-5(a)(2)		**The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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: 06/10/17**	
F 0202 SS=D Bldg. 00	483.15(c)(2)(ii) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES (c)(2) Documentation. (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- [483.15(c)(2)(i) will be implemented beginning November 28, 2017 (Phase 2)] (A) The resident's physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(A) or (B) of this and (B) A physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(i) (C) or (D). Based on record review and interview, the facility failed to ensure a resident who was transferred to the Emergency Room and admitted into the Hospital was	F 0202	**F202** **The facility requests paper**	06/10/2017

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	transferred with the appropriate information, related to phone numbers and names of Responsible Party/Power of Attorney/Healthcare Representative, for 1 of 3 residents reviewed for Emergency Room/Hospital transfers. (Resident B) Finding includes: During an interview with a family member of Resident B on 05/10/17 at 8:15 a.m., she indicated the resident's Responsible Party had been on vacation when the resident's condition had changed and they had notified the facility to call another family member if needed. (The other family member was listed on the face page (resident information) as the second person to be notified). She indicated there was only a message left on their home answering machine to call the facility, which they received when they returned from vacation. She indicated the resident had been transferred to the Emergency Room and admitted into the Hospital on 04/30/17 and the family was not aware of the transfer/admission and the hospital had no paper work with phone numbers or names of family members to notify. Resident B's record was reviewed on 05/10/17 at 8 a.m. Diagnoses included, but were not limited to diabetes and		**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 has been discharged from the facility.** **2) How the facility identified**	

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	stroke. A Nurse's Note, dated 04/30/17 at 1:15 p.m. (clarified with LPN 5 as incorrect time and should have been 3:15 p.m.), indicated "resident 911...presented with diaphorisis (sic), cold and clammy skin, film over both eyes. resident as (sic) tremors, and unable to respond appropriately. @ 1800 (6 p.m.) called hospital and pt (patient) will be admitted...left message with family..." The "Transfer/Discharge Report" sent with the resident was left blank in the area for "Primary Contact". The Nursing Home to Hospital Transfer Form, and lacked the information for the Responsible Party/Power of Attorney/Healthcare Representative. During an interview on 05/10/17 at 11:55 a.m., the Medical Records Nurse confirmed no contact phone numbers or family names were sent with the resident with the transfer to the Emergency Room/Hospital. This Federal tag relates to Complaint IN00229364. 3.1-12(a)(3)		**other residents:** **Residents who are transferred to the ER or hospital have the potential to be affected.** **3) Measures put into place/ System changes:** **Nurses in-serviced on procedures for completing paperwork related to ER or hospital transfers. Audit tool created to monitor for correct completion of transfer paperwork.** **4) How the corrective actions will be monitored:** **Audit will be completed by the DON or designee 5x/week for all ER and hospital transfers to ensure proper paperwork completion.** **The results of these audits will**	

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			be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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: 06/10/17**	
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to incontinence care for 1 of 1 residents observed during incontinence care. (Resident D) Findings include: During an incontinence care observation with CNA 1 on 5/10/17 at 5:35 a.m., Resident D was observed in bed. The resident was laying on her right side	F 0241	**F241** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	06/10/2017

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	toward the wall and crying out loud. At that time, the CNA obtained a wet washcloth with soap and a towel. She removed the resident's soiled incontinent brief, which was saturated with urine and fresh bowel movement. The CNA did not speak to the resident or tell her what she was going to do. The CNA washed the resident and still had not spoken to her regarding what she was doing. The resident continued to cry out loud as the CNA placed a clean brief on her. The incontinent pad was also wet with urine, so the CNA removed that pad and placed the resident on her back. At that time, the CNA indicated to the resident "Ok Ok, I am sorry I know." The resident continued to cry as the CNA placed her back onto her right side. The CNA indicated "Raise your head." She adjusted the resident's pillow and covered her up and left the room. The record for Resident D was reviewed on 5/10/17 at 8:47 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, stroke, anxiety, and mood disorder. The Admission Minimum Data Set (MDS) assessment, dated 4/10/17, indicated the resident was not cognitively intact and was severely impaired for decision making. The resident was		*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:** **CNA 1 was given individual re-education on the procedure for providing incontinence** **care with Dignity and Respect.** **Resident D has had no changes in mood or dignity concerns.** **2) How the facility identified other residents:** **Any resident who requires staff**	

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	totally dependent with a 2 person physical assist for toileting. The current 4/2017 plan of care indicated the resident had a history of social inappropriateness, being tearful with no explanation. The Nursing interventions were to explain care in advance, use terms resident understands. Explain all procedures before starting and allow time to adjust, at least 30 seconds for dementia residents. Interview with the Director of Nursing on 5/11/17 at 10:30 a.m., indicated the CNA should have at least informed the resident what she was going to do before she provided incontinence care. This Federal tag relates to Complaint IN00229364. 3.1-3(t)		**assist with care has the potential to be affected.** **3) Measures put into place/ System changes:** **All nursing staff were reeducated on the procedure for providing hands on care with Dignity and Respect, including providing privacy and explaining procedures prior to and during care.** **An audit tool was created to monitor hands on care to ensure that it is provided with Dignity and Respect.** **4) How the corrective actions will be monitored:** **An audit will be completed by DON or designee on providing hands on care with Dignity and Respect for 3 residents 3x/week on a variety of shift and units.**	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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: 06/10/17**	
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management.			

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	The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure necessary care and services were provided, related to not thoroughly assessing residents with changes of condition for 2 of 3 residents reviewed for changes of condition in a total sample of 8. (Residents B and G) Findings include: 1. Resident B's record was reviewed on 05/10/17 at 8 a.m. Diagnoses included, but were not limited to, diabetes and stroke. A Nurses' Note, dated 04/28/17 at 7:58 p.m., indicated the resident was transferring with assistance from the wheelchair to the toilet, and he stated his knee was going out. He was lowered to the floor, assessed with no injuries, assisted off the floor with the mechanical lift and two assistants. The Physician and	F 0309	**F309** **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.*	06/10/2017

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	family were notified. A 72 hour Follow Up for Change in Condition, dated 04/29/17 at 11 a.m., indicated "pt (patient) is not responding to questions as usual. Is not able to put weight on left leg but denies any pain. (Physician's Name) notified but did not want to send to ER (Emergency Room) at this time. Monitor VS (vital signs) and mental status over weekend...Ordered labs for Monday..." A 72 hour Follow Up for Change in Condition, dated 04/29/17 at 6 p.m., read, "Resident responds to questions...able to put weight on left leg. MD aware stated, monitor VS and observe for changes in mental status over week end..." A Nurse's Note, dated 04/29/17 at 6:05 p.m., indicated the resident was alert and oriented, blood pressure was 128/100, temperature was 100.9. A Nurse's Note, dated 04/30/17 at 1:15 p.m. (clarified with LPN 5 as incorrect time and should have been 3:15 p.m.), indicated "resident 911...presented with diaphorisis (sic), cold and clammy skin, film over both eyes. resident as (sic) tremors, and unable to respond appropriately. @ 1800 (6 p.m.) called hospital and pt (patient) will be		**1) Immediate actions taken for those residents identified:** **Resident B has been discharged from the facility. A thorough assessment has been completed for Resident G.** **2) How the facility identified other residents:** **Any resident with a change in condition has the potential to be affected.** **3) Measures put into place/ System changes:**	

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	admitted...left message with family..." There were no assessments completed after 4/29/17 at 6:05 p.m. through 04/30/17 at 3:15 p.m. A Hospital Physician's History & Physical, dated 05/01/17, indicated, "...noted to be somewhat lethargic by the nursing staff and I was called on the day prior to admission to the emergency room...vital signs were stable...had no fever, just lethargy and therefore our plan was to monitor...check labs on him first thing Monday morning...However, instructions were to send him out if he starts developing fevers or vital signs become unstable..." During an interview on 05/10/17 at 9:25 a.m., LPN 5 indicated she had just received report from the Day Shift Nurse and was informed the resident was not doing well and had not been well for the past few days. He had been lethargic. He was sitting in the wheelchair, pale in color, his neck was extended, the oxygen saturations were below 90 and pulse was 130, and she called 911. The CNAs had informed her they had been telling the Nurses' something was wrong with the resident. During an interview on 05/10/17 at 2:10		**In-service completed for all nurses on procedure for completing thorough assessments with any change in condition. Audit tool created to monitor the completion of thorough assessment for changes in condition.** **4) How the corrective actions will be monitored:** **An audit tool will be completed by DON or designee 5x/week to monitor for completion of a thorough assessment with any change in condition.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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.**	

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	155156	A. BUILDING 00 B. WING	05/11/2017

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	p.m., CNA 6 indicated she was the CNA who had lowered the resident to the floor and had notice a change in him then. He required more assistance than usual and she had informed the Nurse of the change, and the Nurse notified the Physician . On 04/30/17, she reported again to the Nurse the change in condition and the Nurse assessed the resident and sent him to the hospital. During an interview on 05/10/17 at 2:35 p.m., the Director of Nursing (DON) confirmed there were no documented assessments completed from 4/29/17 at 6:05 p.m. through 04/30/17 at 3:15 p.m. 2. Resident G's record was reviewed on 05/11/17 at 9:50 a.m. Diagnoses include, but were not limited to, deep vein thrombosis (DVT) of the right lower extremity. A care plan, dated 04/03/17, read, "Deep Vein Thrombosis Rt (right) Femoral vein". Interventions included, inspect legs and feet for skin color/temperature, pale , cool, edematous, pinkish red, warm along the course of the vein. A Physician's Order, dated 03/31/17, was to schedule a venous doppler test of the right leg related to deep vein thrombosis.		**5) Date of compliance:** **06/10/17**	

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	The results of the venous doppler, dated 04/01/17, indicated there was a subacute thrombus (blood clot) in the common femoral and femoral vein of the right lower extremity. A Nurse's Note, dated 04/02/17 at 2 p.m., indicated the Physician had been notified of the venous doppler results and orders were received to discontinue the aspirin 81 mg (milligrams) daily and to start Eliquis (anticoagulant) 2.5 mg, twice a day. There were two "72 Hour Follow Up for Change in Condition" reports, dated 04/03/17 at 6:28 a.m. and 04/03/17 at 1:16 p.m., which indicated the resident was resting in bed, the aspirin was discontinued, waiting on the Eliquis to be delivered, and no therapy was being performed. A Nurse's Note, dated 04/03/17 at 2 p.m., indicated the resident complained of pain all over, was cool to touch, blood pressure 92/45, oxygen saturation 78-86%, the Physician was notified, and the resident was transferred to the Emergency Room and admitted into the Hospital. There were no assessments of the resident's right lower extremity status			

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	from 03/31/17 through 04/03/17 at 2 p.m. The Hospital History & Physical, dated 04/04/17, gave the admission diagnoses to include, healthcare associated pneumonia and deep vein thrombosis of the right lower extremity. During an interview on 05/11/17 at 10:45 a.m., the DON confirmed there were no specific assessments documented for the deep vein thrombosis/ right lower extremity. This Federal tag relates to Complaint IN00229364. 3.1-37(a)			
F 0328 SS=D Bldg. 00	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents			

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	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 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 (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy			

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	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. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. Based on observation, record review, and interview, the facility failed to stay with a resident during a nebulizer treatment and provided oxygen as ordered by the Physician for 3 of 3 residents observed for respiratory care. (Residents D, H, &, J) Findings include: 1. On 5/10/17 at 4:43 a.m. and 5:35 a.m., Resident D was observed in bed. At those times, the resident was not wearing any oxygen. There was an oxygen tank against the wall by the room door. The record for Resident D was reviewed on 5/10/17 at 8:47 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, stroke, anxiety, and mood disorder.	F 0328	**F328** **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.*	06/10/2017

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	The Admission Minimum Data Set (MDS) assessment, dated 4/10/17, indicated the resident was not cognitively intact and was severely impaired for decision making. A 3/29/17 Physician Order indicated Oxygen 1.5 liters via mask at bedtime for dry mouth. Interview with LPN 3 on 5/10/17 at 4:43 a.m., indicated the resident was not wearing oxygen. Interview with CNA 1 on 5/10/17 at 5:35 a.m., indicated she had thought the resident used to wear oxygen. Interview with the Director of Nursing on 5/11/17 at 10:30 a.m., indicated if there was a Physician's Order for oxygen, then the resident should have been wearing it. 2. During a nebulizer treatment observation with LPN 2 on 5/10/17 at 5:20 a.m., Resident H was observed in bed. LPN 2 assessed the resident prior to administering the treatment. She poured the medication into the compartment and placed the mask over the resident's face. The nurse left the room and proceeded to continue to pass her medications to other residents. The resident was left alone for the duration of the nebulizer treatment.		**1) Immediate actions taken for those residents identified:** **Nurse remained present while residents H, and J received nebulizer treatments. Times of treatments for residents H, and J were adjusted to ensure adequate time for nurse to supervise as needed. Oxygen was discontinued for resident D.** **2) How the facility identified other residents:** **Other residents who receive nebulizer treatments or oxygen have the potential to be affected.** **3) Measures put into place/ System changes:** **In-serviced nursing staff on the procedures for nebulizer and oxygen administration. An audit tool was created to**	

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	The record for Resident H was reviewed on 5/10/17 at 12:15 p.m. Diagnoses included, but were not limited to, heart failure and COPD. The Admission Minimum Data Set (MDS) assessment, dated 4/25/17, indicated the resident was alert and oriented. Physician Orders, dated 4/18/17, indicated Ipratropium (breathing medication) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) 1 vial every 6 hours. There was no documentation of a self administration of medication assessment in the chart. Interview with Assistant Director of Nursing 4 on 5/10/17 at 11:17 a.m., indicated the Nurses were to stay with the resident until the nebulizer treatment was competed. 3. During a nebulizer treatment observation with LPN 2 on 5/10/17 at 11:26 a.m., Resident J was observed in a wheelchair in her room. LPN 1 assessed the resident prior to administering the treatment. She poured the medication into the compartment and placed the		**monitor for correct application and procedure for nebulizer and oxygen use.** **4) How the corrective actions will be monitored:** **An audit will be completed by DON or designee on 3 residents 3x/week on varied shifts to ensure proper procedure is followed for the application and administration of nebulizer treatments and oxygen.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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: 06/10/17**	

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	mask over the resident's face. The nurse left the room and walked back to her medication cart down the hall by the nurse's station. The record for Resident J was reviewed on 5/10/17 at 10:30 a.m. Diagnoses included, but were not limited to COPD, anxiety, and dyspnea. The Quarterly Minimum Data Set (MDS) assessment, dated 3/26/17, indicated the resident was alert and oriented. Physician Orders, dated 6/10/14 and on the current 5/2017 Order Summary, indicated Ipratropium .5-2.5 (3) milligrams (mg)/3 milliliters (ml) 1 vial four times a day. There was no documentation of a self administration of medication assessment in the chart. Interview with LPN 1 on 5/10/17 at 11:45 a.m., indicated she was aware she was supposed to stay with the resident during the nebulizer treatment, however, she had administered another resident their nebulizer treatment prior to this resident and that was about to finish up. She indicated she had to administer 4 nebulizer treatments at the same time and they last for 15 minutes.			

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	The current and undated "Nebulized Mist Inhalation Treatment" policy, provided by the Director of Nursing on 5/10/17 at 1:50 p.m., indicated Nursing was to remain with the resident sufficiently long enough to ensure technique and use of all medication. This Federal tag relates to Complaint IN00228872. 3.1-47(a)(6)			
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2);			

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	(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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 prevent the spread of infection related to hand washing after glove removal and the disposal of soiled linens and briefs for 1 of 1 residents observed for incontinence care. (Resident D) Finding includes: During an incontinent care observation with CNA 1 on 5/10/17 at 5:35 a.m., Resident D was observed in bed. At that time, the CNA obtained a wet washcloth with soap and a towel. She removed the resident's soiled incontinent brief, which was saturated with urine and fresh bowel movement, and threw it on the carpeted floor in her room. After cleaning the resident, she threw both the towel and washcloth on the floor as well as the soiled incontinence pad. The CNA removed her gloves, threw them on the floor and walked out of the room. She entered the room with a clean incontinent pad. The CNA donned a clean pair of gloves to both hands and placed the pad under the resident. She removed the	F 0441	**F441** **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:** **Incontinence care was provided for resident D using**	06/10/2017

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	blanket and the top sheet and her gloves and threw all of that on the floor and left the room. She walked back into the room with clean linens and donned another pair of gloves to both hands. The CNA picked up the soiled linens and placed them into plastic bags and walked out of the room. The CNA did not wash her hands after each glove removal or before leaving the room for the last time. The current and undated "Hand Washing" policy provided by the Director of Nursing DON) on 5/10/17 at 1:50 p.m., indicated hands were to be washed at a minimum, before putting on and after taking off gloves. The current and updated 1/1/2015 "Linen Handling" policy, provided by the DON on 5/10/17 at 1:50 p.m., indicated "Every effort will be made to ensure that soiled linens or clothing does not come into contact with uniforms, furniture, or other areas deemed clean. Soiled linens shall not be placed on the floor." Interview with the DON on 5/11/17 at 10:30 a.m., indicated the CNA should not have thrown the soiled linens on the floor and she should have washed her hands after the gloves were removed. 3.1-18(l)		**proper infection control techniques. Carpet in room for resident D was shampooed.** **2) How the facility identified other residents:** **Any resident receiving incontinence care has the potential to be affected.** **3) Measures put into place/ System changes:** **In-service completed for staff in all departments on proper infection control procedures including handwashing, glove use, and disposal of soiled linens and briefs.** **Audit tool created to monitor for compliance with infection control procedures.**	

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	3.1-19(g)(1)		**4) How the corrective actions will be monitored:** **An audit will be completed by DON or designee on 3 residents 3x/week on a variety of shifts and units to monitor for proper infection control techniques including handwashing, glove use, and disposal of soiled linens and briefs.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achievedx3 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: 06/10/17**	