STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300009475	A. BUILDING B. WING	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED AT HOME	5250 E US HIGHWAY 36 SUITE 850, AVON, IN, 46123

(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
N0000	Initial Comments This visit was for a State Re-licensure survey of a Deemed Home Health Provider. Survey Dates: 08-22, 08-23, 08-24 and 08-25-2022. Census: 129 QR by Area 3 on 8-29-2022	N0000	Uploaded signed 2567 POC accepted on 9-12-2022 Deborah Franco, RN	2022-09-23

N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review, interview, and observation, the agency failed to implement its policy and failed to ensure all employees had physical exams no more than 180 days before the date that the employee had direct patient contact in 3 of 5 Registered Nurses (RN) employee records reviewed. (Alternate Administrator/Clinical Manager, RN #2 and 3) Findings Include: 1. A review of an agency policy with a revised date of 10-07, titled “Health Clearance,” policy number IN7-14, stated, “1. All Associates engaging in direct	N0462	Action: 1) Theadministrator or designee will review 100% of current employee HR records toensure compliance by 9/23/2022 2) The3 HR files cited in the survey of the Alternate Administrator/Clinical Manager,RN #2 and 3 will be brought into compliance by 9/23/2022 Education: 1) The administrator or designee provided education to alladministrative staff and field clinicians regarding the need to ensure allemployees had physical exams no more than 180 days before the date that theemployee had direct patient contact and on agency policy titled “HealthClearance,” policy number IN7-14. Monitor: Human Resource (HR) Record Review: 1) The administrator or	2022-09-23

	patient care must provide proof of a physical examination by a physician or other provider authorized by state law to conduct such an examination no more than 180 days before the date that the Associate has direct patient contact…." 2. Alternate Administrator/Clinical Manager's personnel record was reviewed on 08-25-22, and evidenced a start date of 03-25-19, and the first patient contact date was marked NA by the Administrator. The Alternate Administrator/Clinical Manager's file failed to evidence any record of a physical examination prior to employment with the home health agency. During an interview on 08-24-22 at 9:35 AM, RN #2 confirmed the Alternate Administrator/Clinical Manager had completed direct patient care visits for them when RN 2 was unable to see assigned patients. The Alternate Administrator/Clinical Manager		designee will review 100% of allnewly hired employee HR records to ensure all new employees had physical examsno more than 180 days before the date that the employee had direct patientcontact weekly x 8 weeks or until 100% compliance has been achieved 2) Ongoing monitoring will be performed through quarterly HRRecord Review, reviewed in QAPI x 2 quarters and reported to the governingbody. Responsible Party: Administrator	

	confirmed having provided the direct patient care skilled service of wound care to Patient #7. 4. RN #2's personnel record was reviewed on 08-25-22, and evidenced a start date of 06-17-15, and a first patient contact date of 06-29-15. RN #2's filed failed to evidence any record of a physical examination prior to employment with the home health agency. 5. During a home on 08-24-22 at 9:35 AM, at Patient #7's residence, observed the skilled care provided by RN #2 to Patient #7.			

	6. RN #3's personnel record was reviewed on 08-25-22, and evidenced a start date of 10-22-18, and a first patient contact date of 10-29-18. RN #3's filed failed to evidence any record of a physical examination prior to employment with the home health agency. 7. During a home on 08-24-22 at 11:35 AM, at Patient #6's residence, observed the provision of direct care of a skilled care visit provided by RN #3 to Patient #6.			

	8. During an interview on 08-25-22 at 12:45 PM, the Administrator confirmed physicals were required for staff who may be involved in the provision of direct care visit to the agency's patients. The Administrator further confirmed that the Alternate Administrator/Clinical Manager, RN #2, and RN #3's personnel files failed to evidence documentation/proof of a physical examination as required by agency policy and state rule.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the agency failed to ensure direct care employees (RN #1, RN #2, and LPN # 1) implemented agency policy to follow infection control guidelines in 3 of 4 skilled nursing home visits (Patients #1, 4, and 7.)	N0470	N0470 Education: 1) The administrator or designee provided 1:1 education to the clinicians involved in the care of patients #1, #4, and #7, regarding infection control, hand hygiene, hand hygiene teaching for patient/caregivers and tablet hygiene referencing policies 10-03 “Standard	2022-09-23

	Findings Include: 1. A review of an agency policy with the revised date of 08-21, titled "Standard Precautions," policy number 10-03, indicted "Policy: All clinicians performing job-related responsibilities will observe Standard Precautions and instruct patients and their families and /caregivers in infection control precautions as appropriate ... " 2. A review of an agency policy with the revised date of 04-22, titled "Surveillance, Prevention, and Infection Control," policy number 10-01, indicated "...Hand Hygiene, Infections, and Symptoms: Hand Hygiene is the most effective means of preventing disease transmission in the home ... " 3. A review of an agency policy with the revised date of 04-22, titled "Disinfecting Tablet Computers," policy number 10-17, indicated "Policy: All professional staff will ensure their assigned Company-owned tablet computer equipment is cleansed with approved		"Surveillance, Prevention, and Infection Control," and 10-17 "Disinfecting Tablet Computers," and the CDC guidelines titled "When to Perform Hand Hygiene," was competed on 9/7/2022. 2) The administrator or designee provided education to all administrative and field clinicians regarding infection control, hand hygiene, hand hygiene teaching for patient/caregivers and tablet hygiene referencing policies 10-03 "Standard Precautions,", 10-01"Surveillance, Prevention, and Infection Control," and 10-17 "Disinfecting Tablet Computers," and the CDC guidelines titled "When to Perform Hand Hygiene," was competed on 9/7/2022. Monitor: Home visit observation 1. The Administrator or designee to perform 4 wound care home visits weekly focusing	

	disinfection products after each patient visit ... The most efficient personal action one can take to avoid transmission of bacteria, viruses, and other pathogens remains proper hand hygiene before, during, and after every patient interaction regardless of device type, operating system, or stated purpose ... " 4. A review of an article from the Center for Disease Control last updated January 2021, "When to Perform Hand Hygiene," retrieved from cdc.gov/hand hygiene/providers/index.html indicated, "Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient. Before performing an aseptic task [e.g., placing an indwelling device] or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove		on infection control, hand hygiene, hand hygiene teaching for patient/caregivers and tablet hygiene x 6 weeks or until 100% compliance has been achieved 2. Ongoing review will be performed through annual supervisory visits, annual skills and new hire orientation. The survey response information will be reviewed in QAPI x 2 quarters and reported to the governing body Responsible Party: Administrator	

	removal. Wash with Soap and Water: When hands are visibly soiled ... After known or suspected exposure to spores ... When using alcohol-based hand sanitizer: Put the product on your hands and rub your hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds ... The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product ... and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right time ... When and How to Wear Gloves: Wear gloves ... when ... contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment			

	could occur ... Change gloves and perform hand hygiene during patient care; if gloves become damaged, gloves become visibly soiled...moving from work on a soiled body site to a clean body site on the same patient or in another ... " 5. During a home visit on 08-23-22 at 10:30 AM, for Patient #1, LPN#1 was observed re-instructing the family member to change the gastrointestinal feeding tube dressing. After hand hygiene and donning gloves, the family member was instructed to remove the old dressing. The LPN instructed the caregiver to discard the dressing in the trash reciprocal, remove their gloves, and apply new gloves without performing hand hygiene. Upon completion of the visit, the LPN cleaned their equipment but failed to clean the tablet before placing it in their bag. This practice failed to follow the agency policies and infection control guidelines. 6. During a home visit on			

	#4, RN #1 was observed to remove a dressing from Patient #4's midline incisional abdominal area, discard the old dressing in the trash reciprocal, remove their gloves and perform hand hygiene. The RN was then observed to obtain a syringe, remove the top of the saline bottle, place the syringe in the bottle, get saline, and then irrigate the wound. The RN failed to don new gloves and perform hand hygiene after removing the lid from the saline bottle. The RN was then observed to open a package containing a gauze dressing, went to the kitchen to obtain soap left at the kitchen sink, was observed to cleanse the outer peri-wound, then pat dry the area, with another gauze removed from a package without having removed their gloves and performing hand hygiene. The RN removed their gloves, completed hand hygiene, donned new gloves, and obtained the package of packing strips. The RN then used the patient's scissors without cleaning them prior to use and cut the packing strip removed from the package. The RN removed a border foam dressing from the package and			

applied the bandage to the wound. This practice failed to follow the agency policies and infection control guidelines.

During an interview on 08-23-22 at 3:55 PM, the Alternate Administrator/Clinical Manager confirmed RN #1 failed to follow infection control guidelines during their wound care visit.

6. During a home visit on 08-24-22 at 9:35 AM, for Patient #7, RN #2 was observed to perform hand hygiene, don gloves, reach into a box to obtain a hydrofera blue wound dressing, opened the package, applied the dressing to Patient #7's right posterior calf wound, without first having removed the gloves and having performed hand hygiene after reaching into the box and opening the packages. The RN reached into the box, obtained a packaged abdominal dressing, opened the package, and applied it to Patient #7's posterior right leg to cover the hydrofera blue dressing. The RN obtained a box of 2-layer

	compression wrapping, opened the packages, and wrapped Patient #7's right leg with a cotton layer wrap. The RN dropped the roll on the floor and then tore a piece off the roll and used the rest of the cotton layer wrap to continue to wrap Patient #7's right leg without disposing of the cotton wrapping and obtaining a new roll. Upon completing the compression layer dressing, the RN picked up the soiled dressing and barriers and placed them in a trash bag. The RN then picked up their tcomputer ablet and had Patient #7 sign the tablet without cleaning the tablet or disposing of their gloves and performing hand hygiene after having handled trash. The RN failed to offer hand hygiene to the patient after touching the computer tablet and failed to clean the computer tablet after the visit completion. This practice failed to follow the agency policies and infection control guidelines. During an interview on 08-24-22 at 10:30, RN #2 confirmed they broke infection			

	control during wound care and with their computer tablet. 7. During the daily conference on 08-24-22 at 4:45 PM, the Administrator and Alternate Clinical Manager/Clinical Manager were made aware of the home visit findings. The Alternate Administrator/Clinical Manager confirmed there were infection control issues during the home visits that need to be addressed.			
N0539	Scope of Services 410 IAC 17-14-1(a)(1) Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23). Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse (RN) performed a complete nursing assessment in accordance with accepted standards of clinical practice, of their patient during their visits in 3 of 3 RN home visits. (RN #1, 2, and 3)	N0539	N0539 Education: 1) The administrator or designee provided 1:1 education to the RN #1, 2 and 3 of regarding the need to ensure a complete nursing assessment is performed in accordance with accepted standards of clinical practice to include but not limited to assessing lung sounds, bowel sounds, pedal pulses and skin referencing policies 03-05 "Initial and Comprehensive	2022-09-23

	Findings Include: 1. A review of an agency policy with a revised date of 01-22, titled "Initial and Comprehensive Assessments," policy number 03-05, stated "... Assessments will be performed by a clinician who has demonstrated verbal/written knowledge of the specific skills needed to perform assessments ... Each patient's physical (including vital signs), nutritional, and psychosocial status will be assessed ..." 2. A review of an agency policy with a revised date of 01-22, titled "Care Planning," policy number 03-1, stated, "... Pertinent instruction related to the patient's care and treatments the HHA (Home Health Agency) will provide specific to the patient's care need ..." 3. A review of Constantine, L., MSN, RN, C-FNP. (2004, June 15), "Overview of Nursing Health Assessment," Retrieved January 16, 2019, from rn.com "... PULMONARY ASSESSMENT:		Assessments," and 03-01 "Care Planning," on 9/7/2022. 2) The administrator or designee provided education to all administrative and field nurses clinicians regarding the need to ensure a complete nursing assessment is performed in accordance with accepted standards of clinical practice to include but not limited to assessing lung sounds, bowel sounds, pedal pulses and skin referencing policies 03-05 "Initial and Comprehensive Assessments" and 03-01 "Care Planning," on 9/7/2022. Monitor: Home visit observation 1. The Administrator or designee to perform 4 RN home visits weekly focusing on a complete nursing assessment to include but not limited to assessing lung sounds, bowel sounds, pedal pulses and skin x 6 weeks or until 100% compliance has been achieved	

	When examining pulmonary system … Inspect the thoracic cage, Auscultate the anterior and posterior chest. Have the patient breathe slightly deeper than normal through their mouth; Auscultate from C-7 to approximately T-8, in a left to the right comparative sequence. You should auscultate between every rib … Identify any adventitious breath sounds …" 4. A review of Nurse.org, dated April 7, 2020, indicated, "How to Conduct a Head-to-Toe-Assessment: … LENGTH OF ASSESSMENT … the duration of the exam is directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes. The Order of a Head-To-Toe-Assessment 1. GENERAL STATUS: Vital signs, … Temperature, … Pain. 2. HEAD, EARS, EYES, NOSE, THROAT … 3. NECK … 4. RESPIRATORY: Listen to lung sounds front and back, Assess respiratory expansion level, Ask about coughing, and Palpate thorax. 5. CARDIAC: Palpate the carotid and temporal pulses		2. Ongoing review will be performed through annual supervisory visits. The survey response information will be reviewed in QAPI x 2 quarters and reported to the governing body Responsible Party: Administrator	

	bilaterally; Listen to the heartbeat. 6. ABDOMEN: ... Listen to bowel sounds ... Ask about problems with bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet, including, Radial, Femora, Posterior tibial, Dorsalis pedis. 8. EXTREMITIES: ... Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor. Check for lesions, abrasions, and rashes; Check for tenderness, lumps, lesions; Check if the patient is pale, clammy, dry, cold, hot, or flushed. 10. NEUROLOGICAL: Oriented x3; assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale." 5. During a home visit on 08-23-22 at 3:50 PM, with Patient #4, RN #1 was observed completing their patient assessment. RN #1 auscultated the posterior left upper and middle lung sounds, then right upper and middle lung sounds. RN #1 failed to assess lower right and left lung fields and anterior lung fields and the RN failed to listen to Patient #4's bowel sounds.			

	A review of the clinical record of Patient #4, with a start of care date of 12-29-21, and a recertification period of 06-27-22 to 08-25-22, evidenced an agency document titled "Home Health Certification and Plan of Care," physician signed and dated 07-18-22. The plan of care indicated, but was not limited to, the following diagnoses: encounter for surgical after following surgery on the digestive system, malignant neoplasm of colon, essential hypertension, and encounter for attention to ileostomy. The plan of care contained a subsection titled "Orders of Discipline and Treatments:" indicated, "... Skilled nurse to assess/evaluate co-morbid conditions including HTN (hypertension) and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications, Nursing assessment to be performed by RN ... Skilled nurse to observe and monitor nutritional status to minimize complications ..."			

A review of an agency document titled "Visit Note Report," dated 06-25-22 evidenced a subsection titled "Gastrointestinal." The subsection indicated "Bowel sounds ostomy for elimination" was documented. The subsection titled "Respiratory" evidenced RN#1 assessed the respiratory system, and the patient had slight shortness of breath when walking more than 20 feet or climbing stairs.

During an interview on 08-24-22 at 8:35 AM, the Alternate Administrator/Clinical Manager confirmed RN #1 did not listen to bowel sounds and only listened to posterior lung sounds during their assessment.

6. During a home visit on 08-24-22 at 11:55 AM, with Patient #7, RN #2 was observed completing their respiratory assessment. RN #2 auscultated Patient #7's posterior right upper lobe, left upper lobe, right middle lobe, l middle lobe but failed to assess the right

	lower lobe and left lower lobe. The RN then auscultated the patient's anterior right upper lobe, left upper lobe, right middle lobe, and left middle lobe but failed to auscultate the left and right posterior lung sounds. The RN failed to obtain pedal pulses and examine both bilateral lower extremities. A review of the clinical record of Patient #7, with a start of care date of 08-23-21, and a recertification period of 08-18-22 to 10-16-22, evidenced an agency document titled "Home Health Certification and Plan of Care" electronically signed by RN #2 and dated 08-16-22. The plan of care indicated but was not limited to the following diagnoses: Parkinson's disease, blister right lower leg, edema, type 2 diabetes mellitus with diabetic neuropathy, and essential hypertension. The plan of care contained a subsection titled "Orders of Discipline and Treatments:" that indicated, "...Skilled nurse to observe/assess co-morbid conditions including wound management and other			

conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications. Nursing Assessment to be performed by RN ... "

During an interview on 08-24-22 at 1:10 PM, the Alternate Administrator/Clinical Manager confirmed the nursing staff should listen to all six lung fields. The Alternate Administrator/Clinical Manager further confirmed that RN #2 had not completed a thorough nursing assessment in accordance with acceptable standards of clinical practice.

7. During a home visit on 08-24-22 at 11:15 AM, with Patient #6, RN #3 was observed to complete their initial start of care nursing assessment. RN #3 auscultated the posterior right upper lobe, left upper lobe, right middle lobe, left middle lobe, then anterior right upper lobe, left upper lobe, right middle lobe, and left middle lobe. The RN failed to auscultate the posterior right

	and left lobes and anterior right and left lower lobes. During an interview on 08-24-22 at 1:10 PM, the Alternate Administrator/Clinical Manager, when queried about assessment and lung sounds, stated, "Yes, I know. There are 6 lung fields."			
N0552	Scope of Services 410 IAC 17-14-1(a)(2) Rule 14 Sec. 1(a) (2) The licensed practical nurse shall perform duties in accordance with the Indiana Nurse Practice Act (IC 25-23). Based on observation, record review, and interview, the agency failed to ensure the Licensed Practical Nurse (LPN) performed a complete nursing assessment of their patient (Patient #1) during their visit in 1 of 1 LPN home visits. (LPN #1) Findings Include: 1. A review of an agency policy with a revised date of 01-22, titled "Initial and Comprehensive Assessments," policy number 03-05, stated "...Assessments will be performed by a clinician who	N0552	Education: 1) The administrator or designee provided 1:1 education toLPN #1 on the need to ensure a complete nursing assessment is performed inaccordance with accepted standards of clinical practice to include but notlimited to assessing lung sounds and bowel sounds referencing policies 03-05"Initial and Comprehensive Assessments," and 03-01 "Care Planning," on 9/7/2022. 2) The administrator or designee provided education to alladministrative and field nurses clinicians regarding the need to ensure acomplete nursing assessment is performed in accordance with	2022-09-23

	has demonstrated verbal/written knowledge of the specific skills needed to perform assessments... Each patient's physical (including vital signs), nutritional, and psychosocial status will be assessed..." 2. A review of an agency policy with a revised date of 01-22, titled "Care Planning," policy number 03-1, stated, "...Pertinent instruction related to the patient's care and treatments the HHA (Home Health Agency) will provide specific to the patient's care need..." 3. A review of Constantine, L., MSN, RN, C-FNP. (2004, June 15), "Overview of Nursing Health Assessment," Retrieved January 16, 2019, from rn.com indicated " ... PULMONARY ASSESSMENT: When examining pulmonary system ... Inspect the thoracic cage, Auscultate the anterior and posterior chest. Have the patient breathe slightly deeper than normal through their mouth; Auscultate from C-7 to approximately T-8, in a left to the right comparative		accepted standardsof clinical practice to include but not limited to assessing lung sounds andbowel sounds referencing policies 03-05 "Initial and Comprehensive Assessments"and 03-01 "Care Planning," on 9/7/2022. Monitor: Home visit observation 3) TheAdministrator or designee to perform 2 LPN home visits weekly focusing ona complete nursing assessment to include but not limited to assessing lungsounds, bowel sounds, pedal pulses and skin x 6 weeks or until 100% compliancehas been achieved 4) Ongoingreview will be performed through annual supervisory visits. The surveyresponse information will be reviewed in QAPI x 2 quarters and reported to thegoverning body ResponsibleParty: Administrator	

sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ..."

4. A review of Nurse.org, dated April 7, 2020, indicated, "How to Conduct a Head-to-Toe-Assessment: ... LENGTH OF ASSESSMENT ... the duration of the exam is directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes. The Order of a Head-To-Toe-Assessment 1. GENERAL STATUS: Vital signs, ... Temperature, ... Pain. 2. HEAD, EARS, EYES, NOSE, THROAT ... 3. NECK ... 4. RESPIRATORY: Listen to lung sounds front and back, Assess respiratory expansion level, Ask about coughing, and Palpate thorax. 5. CARDIAC: Palpate the carotid and temporal pulses bilaterally; Listen to the heartbeat. 6. ABDOMEN: ... Listen to bowel sounds ... Ask about problems with bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet, including, Radial, Femora, Posterior tibial, Dorsalis pedis. 8.

EXTREMITIES: ... Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor. Check for lesions, abrasions, and rashes; Check for tenderness, lumps, lesions; Check if the patient is pale, clammy, dry, cold, hot, or flushed. 10. NEUROLOGICAL: Oriented x3; assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale."

5. During a home visit on 08-23-22 at 10:30 AM, with Patient #1, LPN #1 was observed to complete their patient assessment. LPN #1 finished temperature, oxygen saturation, and blood pressure; the LPN failed to assess bowel sounds and failed to assess lung sounds.

A review of the clinical record of Patient #1, with a start of care date of 08-09-22, and an initial certification period of 08-09-22 to 10-07-22, evidenced an agency document titled "Home Health Updated Plan of Care Report." The updated plan of care indicated the following

	of the floor of the mouth, dysphagia, oropharyngeal phase, dysarthria, and anarthria. The plan of care contained a subsection titled "Orders of Discipline and Treatments:" that indicated, "...Skilled nurse to teach gastrostomy management such as definition, symptom monitoring, site/skincare, and feeding/flushing ... Skilled nurse to observe/assess co-morbid conditions including wound management and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications..." During an interview on 08-24-22 at 8:35 AM, the Alternate Administrator/Clinical Manager confirmed the LPN did not listen to lung or bowel sounds during their assessment and should have done so.			