STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING 00 B. WING	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00404475, IN00404749, and IN00406481. Complaint IN00404475 - No deficiencies related to the allegations are cited. Complaint IN00404749 - No deficiencies related to the allegations are cited. Complaint IN00406481 - No deficiencies related to the allegations are cited. Survey dates: April 23, 24, 25, 26 & 27, 2023 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 108 SNF: 11 Total: 119 Census Payor Type: Medicare: 12 Medicaid: 91 Other: 16 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 8, 2023.	F 0000	5-21-2023 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey 1345 N. Madison Ave Anderson, IN 46011 Dear Ms. Buroker: On April 27, 2023, a Recertification and State Licensure with Complaint (IN00404475, IN0040479, IN00406451) survey was completed. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is respectively submitted as our formal request for a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of March 25,2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian McKamie		05/16/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Please feel free to call me with any further questions at 1-765-644-2888 Respectfully submitted, Brian McKamie	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do			

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	not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to provide showers according to the resident's preferences for 1 of 3 residents reviewed for choices. (Resident 26) Finding includes: During an interview on 4/23/22 at 11:27 a.m., Resident 26 was resting in her bed with her eyes closed. Her hair was disheveled. She indicated she required staff assistance with her activities of daily living due to numbness in her bilateral hands and the need for a mechanical lift to get out of bed. Staff had provided bed baths, but she felt trapped in her bed and she wanted to get a shower rather than a bed bath. She was unaware of which days of the week she was scheduled to get a shower because she had not been offered a shower. She spoke with a CNA about getting a shower on the shower bed, about two to three weeks ago. When she asked other CNAs about using the shower bed, they were unaware of what she referred to. The resident's family had also contacted the facility about the condition of her hair. Resident 26's clinical record was reviewed on 4/25/23 at 4:17 p.m. Diagnoses included heart failure, abnormal posture, muscle wasting and atrophy of multiple sites, chronic pain, depression, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 4/6/23, indicated the resident was cognitively intact. She did not exhibit rejection of care behaviors during the assessment period. She required total dependence on staff members for bed mobility, transfers, dressing,	F 0561	F561 D Self-Determination The facility respectively requests Desk review 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 action taken for those residents identified: • Residents #26 was offered a shower. Personal shower preferences were reviewed, and the care plan was updated. 2.) How the facility identified other residents: • Any resident residing in the facility had the potential to be affected. • Personal preferences were reviewed for the facility residents and care plans were updated for accuracy. • Concerns regarding bathing preferences will be reviewed in clinical meetings with timely follow up. 3.) Measures put into place/ Systemic changes: • Facility staff will be educated on	05/25/2023

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	toileting, personal hygiene, and bathing. Bathing did not occur during the assessment period. She was always incontinent of bowel and bladder. A current care plan for self-care deficit, last revised 8/19/22, indicated the resident needed assistance related to weakness, malaise, and chronic pain. Interventions included one person assistance for bathing and a mechanical lift required for transfers. The resident's care plan lacked information regarding the resident's bathing preference. Review of the bathing task for March 2023 and April 2023 indicated the resident preferred a shower rather than a bed bath. Bed baths were provided on the following dates: 3/1/23, 3/4/23, 3/8/23, 3/11/23, 3/18/23, 3/25/23, 4/1/23, 4/5/23, 4/8/23, 4/12/23, 4/15/23, 4/19/23 and 4/22/23. Showers were not provided to the resident during March 2023 and April 2023. A facility shower reference sheet indicated the resident's showers were scheduled for Wednesdays and Saturdays. During an interview on 4/27/23 at 11:06 a.m., LPN 8 indicated she was uncertain if the facility had a shower bed. During an interview on 4/27/23 at 11:10 a.m., LPN 8 indicated the facility had a shower bed on the Intermediate Unit. The shower bed would not fit well in the Family Tree Unit shower room and allow privacy. Any resident who needed the shower bed to get a shower according to their preferences could be taken to the Intermediate Unit shower room, as long as they were covered well for privacy during transport.		Personal Preferences • Bathing preference audits will be conducted with 5 residents weekly per social services/designee to determine if concerns are addressed to satisfaction. 4.) How the corrective actions will be monitored: • The responsible party for this plan of correction is Director of Nursing/Social Services with Executive Director oversight. • Review of the bathing preference audits and interviews with 5 residents weekly to ensure preferences for bathing/showers have been provided to their satisfaction. • The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 95% 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: 5-25-2023	

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	During an interview on 4/27/23 at 11:53 a.m., LPN 10 indicated a resident who preferred to have a shower with the inability to get in a regular shower chair, could be offered a shower bed to get a shower. Residents had the right to choose their preferred type of bathing. During an interview on 4/27/23 at 11:56 a.m., CNA 9 indicated she never used the shower bed for any residents. The facility had a reclining shower chair, as well as a shower bed. Resident 26 might be a good candidate for the reclining shower chair. She had given the resident bed baths and not offered the resident a shower in the reclining shower chair because she had previously refused to get up. The resident had refused to get up in her high backed reclining wheelchair. During an observation on 4/27/23 at 12:15 p.m., the resident was in bed with wet hair. She indicated she had not been offered a shower. The Beautician had just came to her room and washed her hair on this date. She really wanted to get in the shower rather than getting a bed bath in her bed. She had refused to get in her high backed reclining wheelchair because it made her feel trapped, but she had not refused to get out of bed for a shower. During an interview on 4/27/23 at 12:18 p.m., LPN 8 indicated the resident had improved since March when her pain was managed better. She also started eating. She had previously refused to get up in her Broda chair and believed the aides had not offered her showers because they did not realize she felt like getting up for showers. During an interview on 4/27/23 at 2:46 p.m., the DON indicated the residents had the right to			

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	choose their type of bathing. She indicated the resident had a preference for showers indicated in the medical record and should have been offered showers. A current, undated, facility document titled " STATEMENT OF RESIDENTS' RIGHTS INTRODUCTION," provided by the Administrator on 4/23/23 at 9:45 a.m., indicated the following: "...The facility shall insure that all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident, and shall encourage and assist each resident in the fullest possible exercise of these rights...." 3.1-3(u)			
F 0584 SS=C Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes			

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	resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to maintain floors in a clean, well-maintained condition, replace transition threshold strips, maintain paint integrity on door frames and handrails, and ensure wallpaper was affixed to the wall for 6 of 6 halls/units observed (100 Intermediate, 100 medicare, 200, 300, 400 and 500 halls). This deficient practice had the potential to impact 119 of 119 residents. Findings include:	F 0584	F 584D Safe/Clean/Comfortable/Homelike Environment 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	05/25/2023

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	During an environmental tour, accompanied by the Environmental Services Director (ESD), on 4/27/23 from 10:57 a.m. to 11:20 a.m., environmental concerns regarding, floor cleanliness, missing transition threshold strips, paint chipped on door frames and handrails, and wallpaper not being affixed to the wall were identified as follows: a. The following locations were missing threshold transition strips were two different styles of flooring joined together. This resulted in gaps were dust and debris had collected: Resident rooms 314, 311, 314, 315, 307, 520, 521, 519, 517, and 516. The area where the 300 hall joined the center atrium of the Family Tree Unit, The two 200 hallway doorways to the dining area and the door to the TV lounge, The area where the 400 hall joined the center atrium of the Family Tree Unit, and The area where the hall leading to the Family Tree Dining Room joined the atrium. b. The following locations had a heavy gray build-up in the door jams and/or thresholds as follows: The 300 hall door which exited to the courtyard, Resident rooms 317, 313, 137, 207, 206, 407, 419, 420, 519 and 520, The area where 200 hall joined the center atrium of the Family Tree Unit, The 200 hallway courtyard exit door, The area where the 500 hall joined the center atrium of the Family Tree Unit, and All doorways in the long hallway which connected the Family Tree Unit with the Main Area of the facility.		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: • No resident was identified to have been affected. • Threshold transition strips noted in rms 314, 311, 314, 315, 304, 520, 521, 519, 517, and 516 hall, 300 hall atrium, 200 hallway doorways and door to TV lounge, 400 halls leading to family tree dining room were repaired. • Heavy Build-up noted on door jams on 300 hall door, Rms 317, 313, 137, 207, 206, 407, 420, 519, and 520, 200 halls adjoining the center atrium, 200 hallway courtyards exit door, 500 hall adjoining the center atrium, doorways in the long hall connecting Family Tree with Main Area were cleaned • Areas of chipped paint, missing tiles include room 310, 520, and 519, hallway leading from atrium to the Family Tree Dining Room where different types of flooring meet, Family tree Dining room off far north pillar, Intersection of 100 Medicare and 100 Intermediate and Kitchen Hallway, 200 and 300	

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	c. The following locations had chipped and/or missing floor tile, allowing dust and debris to collect: The doorways to resident rooms 310, 520, and 519, The hallway leading from the atrium into the Family Tree Dining Room where the two types of flooring met, The Family Tree Dining Room running off the far north pillar, and The intersection of the 100 Medicare, 100 Hall Intermediate, and Kitchen Hallway. d. The following locations had floor drain caps which sat lower than the floor, allowing for a dip to be corrected. The dip collected dust and debris and was deep enough to catch a small wheel or walker tip: The 300 hallway outside the dining area, and The 200 hallway outside the dining area. e. The following locations had door frames with multiple chips in the paint: Resident rooms 122, 137, 124, 142, 144, 148, 151, 152, 156, 157, and 170, The beauty shop, and The 100 hall intermediate dining room. f. The following location had hand rails with multiple missing paint chips: The handrails throughout the long hallway, which connected the Family Tree Unit with the Main Area of the facility. h. The following areas had wallpaper hanging loose from the wall with exposed drywall:		hallway outside dining areas were painted • Door Frames with chipped paint, rooms 122, 137, 124, 144, 148, 151, 152, 156, 157, and 170 were painted. • Hand Rails missing paint: Long hallway connecting Family Tree and Main Area of facility were painted. • Exposed drywall rooms 409 and 419 was painted. 2)How the facility identified other resident: • No resident was identified to have been affected related to identification of needed facility repairs. • Facility wide walk-through audit was completed by Administrator, Maintenance Director, and Housekeeping Supervisor to identify needed facility repairs. 3)Measures put into place/ System changes: • The Maintenance Director added identified needed facility repairs to Preventative Maintenance Log and TELS, together with the Administrator needed repairs were prioritized and placed on a repair schedule. • Environmental Service Director reviewed and updated the Daily Task and Deep Cleaning Schedule, reviewed with the Administrator/designee to determine prioritization of task which will be reviewed during scheduled morning meetings.	

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	Resident rooms 409 and 419, on the wall beside the bathroom door. During an interview on 4/27/23 at 11:20 a.m., the ESD indicated the floors and/or door jams throughout the facility needed attention. The handrails in the long connecting hall had multiple chips. There were many chips on the door frames in the 100 units. It appeared the threshold transition strips had come loose and were not replaced. During an interview on 4/27/23 at 12:13 p.m., the ESD indicated any facility staff member could fill out a paper work order for any area of the facility that needed repair. He also indicated those with computer access could use a computerized form to file the same concern. During an interview on 4/27/23 at 11:55 a.m., the Maintenance Assistant indicated there were transition threshold floor strips in the equipment room, which had been there since November 2022 or earlier. The facility did paint touch ups one day a week, on Wednesdays. They could not do the whole building in one day due to size. Approximately one hall could be touched up each week. An undated, facility document titled, "Daily Cleaning Assignments," provided by the ESD on 4/27/23 at 11:56 a.m., indicated the following: "...Daily Task-Baseboards/Floors..." An undated, untitled, facility document, provided by the ESD on 4/27/23 at 11:56 a.m., labeled as a check list for deep cleaning, indicated the following: "...Floor, Cove Base, Corners & Edges, Hard floors...."		Noting that schedules may change secondary to situation. • Administrator /designee will review daily during stand-up meeting scheduled facility maintenance repairs. • Preventative Maintenance log will be reviewed and initialed weekly by the Administrator /designee for completed repairs. Cleaning schedules will be signed weekly by the administrator/designee to validate completion. • Staff educated in completing needed repair work orders. • Angel Rounds will be completed 5 times weekly to identify any areas in need of repair and reviewed in scheduled stand-up meetings. 4)How the corrective actions will be monitored: • The responsible party for this plan of correction is the joint effort of the Administrator/Maintenance Director/and Housekeeping Supervisor who will round together 2 times weekly to identify additional areas for repair or cleaning. • Identified areas are placed on a Preventative Maintenance log /TELS for follow up. • Review of weekly updates to cleaning schedule. • The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months.	

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	3.1-19(f)		• The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 5-25-2023 **1)Immediate actions taken for those residents identified:** ·No resident was identified to have been affected. ·Threshold transition strips noted in rms 314, 311, 314, 315, 304, 520, 521, 519, 517, and 516 hall, 300 hall atrium, 200 hallway doorways and door to TV lounge, 400 halls leading to family tree dining room were repaired. ·Heavy Build-up noted on door jams on 300 hall door, Rms 317, 313, 137, 207, 206, 407, 420, 519, and 520, 200 halls adjoining the center atrium, 200 hallway courtyards exit door, 500 hall adjoining the center atrium, doorways in the long hall connecting Family Tree with Main Area were cleaned ·Areas of chipped paint, missing tiles include room 310, 520, and 519, hallway leading from atrium to the Family Tree Dining Room where different types of flooring meet, Family tree Dining room off	

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			far north pillar, Intersection of 100 Medicare and 100 Intermediate and Kitchen Hallway, 200 and 300 hallway outside dining areas were painted ·Door Frames with chipped paint, rooms 122, 137, 124, 144, 148, 151, 152, 156, 157, and 170 were painted. ·Hand Rails missing paint: Long hallway connecting Family Tree and Main Area of facility were painted. ·Exposed drywall rooms 409 and 419 was painted. **2)How the facility identified other resident:** ·No resident was identified to have been affected related to identification of needed facility repairs. ·Facility wide walk-through audit was completed by Administrator, Maintenance Director, and Housekeeping Supervisor to identify needed facility repairs. **3)Measures put into place/ System changes:** ·The Maintenance Director added identified needed facility repairs to Preventative Maintenance Log and TELS, together with the Administrator needed repairs were prioritized and placed on a repair schedule. ·Environmental Service Director reviewed and updated the Daily	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Task and Deep Cleaning Schedule, reviewed with the Administrator/designee to determine prioritization of task which will be reviewed during scheduled morning meetings. Noting that schedules may change secondary to situation. ·Administrator /designee will review daily during stand-up meeting scheduled facility maintenance repairs. · Preventative Maintenance log will be reviewed and initialed weekly by the Administrator /designee for completed repairs. Cleaning schedules will be signed weekly by the administrator/designee to validate completion. ·Staff educated in completing needed repair work orders. ·Angel Rounds will be completed 5 times weekly to identify any areas in need of repair and reviewed in scheduled stand-up meetings. **4)How the corrective actions will be monitored:** ·The responsible party for this plan of correction is the joint effort of the Administrator/Maintenance Director/and Housekeeping Supervisor who will round together 2 times weekly to identify additional areas for repair or cleaning. · Identified areas are placed on a Preventative Maintenance log	

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			/TELS for follow up. ·Review of weekly updates to cleaning schedule. ·The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months. ·The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 5-25-2023**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure pressure relieving boots were in place as ordered for 1 or 1	F 0686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer	05/25/2023

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	residents reviewed for pressure ulcers. (Resident 85) Findings include: During an observation, on 4/24/23 at 9:10 a.m., Resident 85 was awake, lying in bed without socks or pressure relieving boots. His heels were not floated in the bed. On 4/25/23 at 10:22 a.m., the resident was lying on his back in bed, without pressure relieving boots applied or his heels floated. On 4/26/23 at 9:32 a.m., the resident was observed lying in bed on his right side, facing the window. He was without pressure relieving boots and his heels were not floated. Resident 85's clinical record was reviewed on 4/24/23 at 3:03 p.m. Diagnoses included, Alzheimer's disease, lumbar fracture, muscle wasting, and diabetes mellitus type 2. A significant change (MDS) minimum data set assessment, dated 2/25/23, indicated the resident was cognitively intact, required extensive assistance with bed mobility, dressing, eating, and toileting, and was at risk for impaired skin integrity. A current order, dated 4/7/23, indicated to apply pressure relieving boots to resident's bilateral lower extremities. A wound note, dated 4/21/23 at 4:31 p.m., indicated the resident had a new Stage 1 (observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence; may include		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Immediate actions taken for those residents identified: • Resident #85 was assessed, orders reviewed, and care plan updated. 2.) How the facility identified other residents: • Any resident residing in the facility with orders for pressure relieving boots had the potential to be affected. • A facility audit was conducted by Director of Nursing/designee and Unit managers to review those residents with current orders for Pressure relieving boots. • Orders were reviewed, and care plans were updated as needed. • Any new identified issues were reported to the primary physician for review. 3) Measures put into place/	

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	changes in skin temperature, tissue consistency and/or sensation) pressure wound to his left ankle, measuring 2.0 cm (centimeter) length x 3.5 cm width. The note included preventative measures to float heels while in bed with use of pressure relieving boots. A current care plan, initiated on 4/7/23, for pressure ulcers indicated the resident required assistance with turning, repositioning, and was on hospice for end of life care. The interventions included to float heels, encourage resident to wear pressure relieving boots, encourage resident to reposition as able, and to provide offloading to ulcer site. A current "Kardex report," provided by the DON on 4/27/23 at 10:20 a.m., indicated to float heels and encourage resident to wear pressure relieving boots. During an interview on 4/26/23 at 9:32 a.m., CNA 17 indicated she was unaware of any wounds or treatments for Resident 85. During an interview on 4/26/23 at 11:35 a.m., LPN 18 indicated she had done a treatment to Resident 85's ankle, but she was not aware of an order for pressure relieving boots. 3.1-40(a)(1)		System changes: • Orders were reviewed and revised as needed for pressure relieving boots. • Education provided on following Physician Orders, as well as documentation of services provided in the clinical record. 4) How the corrective actions will be monitored: • Director of Nursing is the responsible party for this Plan of Correction with Executive Director oversight. • Director of Nursing/designee will audit and observe 5 residents with pressure relieving boots 2 times weekly to ensure treatments are provided as ordered and documented. • Results of audits will be reviewed in morning clinical meeting weekly as well as 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:5-25-2023	
F 0802 SS=F Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with			

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	the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, interview, and record review, the facility failed to ensure dietary staff were competent to perform kitchen essential duties. This deficient practice had the potential to impact 118 of 119 residents. Findings include: During an interview on 4/23/23 at 9:23 a.m., Cook 16 indicated the Dietary Manager quit a week prior. The Administrator managed the kitchen due to the vacancy. During an observation on 4/25/23 at 11:33 a.m., the Maintenance Director indicated he had filled in as the Dietary Supervisor for the last three days. The kitchen was not kept in a sanitary manner. Staff should have completed a cleaning log check-off each day to ensure the kitchen cleaning was done each day, but it had not been done. He was unable to provide the kitchen cleaning logs. A bottom shelf on the table to the	F 0802	F 802F Sufficient Dietary Support Personnel 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.	05/25/2023

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	left of the sink remained with significant various food debris, where clean food trays were stored up on their edge. The bottom panel off of the range remained in the floor with brown thick baked on debris. The steam table remained with dried food spatters on the sides of the steam table and brown residue around the knobs on the sides. The double convection oven remained with thick black food debris inside on the top and bottom. Baked-on food was on the inside and outside of the convection oven doors. The inside of the microwave had dried food debris inside. The four food delivery carts were soiled and had a thick light pink fluffy substance around the inside bottom ledges of the food tray carts, with dried splashed and food particles on the ledges where the food trays sat. He noticed how dirty the food carts were on 4/24/23. The carts needed to be power washed. Freezer B remained with a sticky dirty floor, six dessert cups on the floor, two expired and damaged dessert cups on the lower rack, and a deteriorated sticky box on the floor under the rack. The freezer should have been kept clean, free of items on the floor, and free of damaged or expired products. During an interview on 4/25/23 at 12:06 p.m., Cook 15 indicated the last dietary manager had not required staff to document any scheduled kitchen cleaning and the frequency in which it was done. Damaged or expired dietary products should have been disposed of immediately when damaged or expired. During an interview on 4/26/23 at 9:35 a.m., Dietary Aide 14 indicated Cook 16 trained him when she had time, but they were always low staffed and very busy, so she did not have a lot of time to spend with him for training. No one trained him to check the dishwasher temperatures		1) Immediate actions taken for those residents identified: • No resident was identified to have been adversely affected. • The kitchen was immediately cleaned of food debris where food trays are stored, Range was cleaned of baked on debris, Steam table cleaned, convection oven cleaned, microwave cleaned, food delivery carts were cleaned, Freezer B was cleaned and damaged or expired products disposed of. 2) How the facility identified other residents: • Any resident residing in the facility had the potential to have been affected, however no resident was identified. 3) Measures put into place/ System changes: • Kitchen/Dietary was cleaned • Education provided to dietary staff on the components of F812 A. Sanitation B. Meals/recipes. C. Cleaning logs/schedules and standards. D. Documentation requirements. E. Dish machine operation. Handling sanitized dishware. G. Dish machine water temperatures. H. Sanitizer concentration logs. • Dietary orientation checklists will be completed. • New Dietary contracted service	

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	or the sanitizer solution in the rinse cycle with the sanitizer test strips. He was unaware what temperature was required for the wash and rinse cycle on the dishwasher. He would know if the temperature was not appropriate based on how warm the dishes felt when he removed them from the dishwasher. During an interview on 4/26/23 at 9:46 a.m. Dietary Aide 13 indicated Cook 16 provided her training. She did not remember training for checking the dishwasher temperature or dishwasher sanitizer with strips. She was unaware of the frequency in which these items should have been done. Review of the current facility Food Service Employee Orientation Checklist, provided by the Human Resources Director on 4/26/23 at 10:46 a.m., indicated it lacked information regarding dishwasher temperature monitoring, dishwasher sanitizer monitoring, or any associated logs. Review of Cook 16's Food Service Employee Orientation Checklist indicated her 2/14/23 checklist was not completed until eight months after her hire date. Cook 16 then trained Dietary Aide 13 on 2/23/23 and Dietary Aide 14 on 3/17/23. A current facility policy, dated 9/1/21, titled "General Food and Nutrition Services," and provided by the Maintenance Director on 4/26/23 at 12:01 p.m., indicated the following: "...STANDARD: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. GUIDELINE: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner... 2. The Dining Services Director will		vendor starting 5-22-2023. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. • Audits will be conducted 3 times weekly per Executive Director/designee to determine menus are being followed (to include breakfast, lunch and dinner). • The Executive Director/designee will randomly, (three times weekly) review dietary prep, service, and dining areas • The Executive Director/designee will observe dietary sanitation and cleaning schedules to include temps and operation of dish machine 3 times weekly to include all meals. • Identified areas of concern will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% or above compliance rate • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 5-25-2023	

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	ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces... 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces...." A current policy, dated 9/1/21, titled "QRT Warewashing," provided by the Maintenance Director on 4/26/23 at 12:01 p.m., indicated the following: "Standard: All dishware, service ware, and utensils will be cleaned and sanitized after each use. Guidelines: 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. 2. All dish machine water temperature will be maintained in accordance with manufacturer recommendations... 3. Temperature and/or sanitizer concentration logs will be completed, as appropriate...." Cross reference F812. 3.1-20(h)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, and distributed in a safe and sanitary manner. This deficient practice had the potential to impact 118 of 119 residents who recieved meals from the facility kitchen. Findings include: During an interview on 4/23/23 at 9:23 a.m., Cook 16 indicated the Dietary Manager quit a week prior. The Administrator managed the kitchen due to the vacancy. During a kitchen observation on 4/23/23 at 9:23 a.m., the following was observed: a. Dried food was noted baked on the sides of the steam tables and around the temperature adjustment knobs on the side of the steam table with a brown appearance. b. Inside the free standing refrigerator, a package of unidentified lunch meat was opened and wrapped in plastic wrap on the second shelf. It lacked an opened date. c. Inside the microwave, dried food was	F 0812	F812 E Food Procurement, Store/Prepare/Serve-Sanitary The facility respectfully requests a desk review 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 the areas identified: • The dried food noted baked to steam table and food knobs were cleaned. • Refrigerator was cleaned, and lunch meat was discarded.	05/25/2023

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	splattered on the top, bottom, and sides. d. A shelf under the food preparation table, to the left of the sink, had moderate scattered food debris where clean food trays were stored on their side. e. Another food preparation table, to the right of Freezer B, contained moderate scattered debris on the bottom shelf where wraps were stored. f. A metal panel, from below the oven doors on the range, rested on the floor in front of the oven with baked-on brown residue. g. The double convection oven was in use during the observation. The insidev bottom of the double ovens were heavily soiled with thick, black, baked-on food residue. Baked-on brown splatters were on the inside of the oven door glass, causing it to be very difficult to see through the glass. The doors of the oven had baked-on brown splatters around the stainless portion. h. Walk-In Freezer B contained a vanilla ice cream dessert cup on the floor, just inside the freezer door, and to the left. On the floor underneath the racks were three vanilla dessert cups, two chocolate dessert cups and one orange dessert cup with product dates unable to be visualized. The floor was sticky with a significantly deteriorated box stuck to the floor in the freezer under the rack. A damaged chocolate dessert cup, best by date 2/15/23, was upside down on the bottom shelf of the freezer, with chocolate ice cream exposed to contaminants. An orange sherbet dessert cup, best by date 1/6/23, was sticky and upside down on the bottom shelf of the freezer.		• The microwave was cleaned. • The food prep tables were cleaned. • The range was cleaned of baked on residue. • The convection oven was cleaned. • Walk in Freezer was cleaned and removed of expired foods. • The delivery carts were cleaned. • An updated temperature log was hung. • Sanitizer strips were provided. • A dishwasher temperature log and sanitizer log were hung. 2) How the facility identified other areas. • Any resident residing in the facility had the potential to have been affected, however no resident was identified. 3) Measures put into place/ System changes: • Education provided Kitchen/Dietary on components of F812. • Education provided to dietary staff on A. Sanitation B. Meals/recipes. C. Cleaning logs/schedules and standards. D. Documentation requirements. E. Dish machine operation. F. Handling sanitized dishware. G. Dish machine water temperatures. H. Sanitizer concentration logs. • Dietary orientation checklists will	

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	i. Two food delivery carts contained dried food debris on the inside of the racks where the food trays rested. The inside walls had dried splashes noted on each side. A thick, dried, pink - colored residue was on the front bottom ledge of both carts. j. The dishwasher was cycled. The wash cycle temperature was 108 degrees Fahrenheit. The rinse cycle was 120 degrees. The dishwasher temperature log and sanitizer log for April hung on the clean dish racks to the right of the dishwasher and lacked any documentation for the month of April 2023. During an interview on 4/23/23 at 9:48 a.m., Cook 16 indicated the panel from the bottom of the range fell off approximately one week ago. The panel contained a brown baked-on residue. During an interview on 4/23/23 at 9:53 a.m., Cook 16 indicated they used the double convection oven to cook in and maintain food temperatures each day. During an interview on 4/23/23 at 10:39 a.m., Dietary Aide 13 indicated she was unaware if the dishwasher was a high or low temperature dishwasher. She was operating the dishwasher and had done so for the past month and a half. She was not aware she should have checked the dishwasher temperatures, or tested the dishwasher sanitizer. She had never documented the dishwasher temperatures, nor used the strips to test the dishwasher during the rinse cycle. During an interview on 4/23/23 at 10:44 a.m., Dietary Aide 14 indicated he also operated the dishwasher. The sanitizer and rinse aid buckets connected to the low temperature dishwasher		be completed. • New Dietary contracted service vendor starting 5-22-2023. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. • Audits will be conducted 3 times weekly per Executive Director/designee to determine menus are being followed (to include breakfast, lunch and dinner). • The Executive Director/designee will randomly, (three times weekly) review dietary prep, service, and dining areas • The Executive Director/designee will observe dietary sanitation and cleaning schedules to include temps and operation of dish machine 3 times weekly to include all meals. • Identified areas of concern will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% or above compliance rate is achieved x3 • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 5-25-2023	

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	were empty during the observation. The facility was completely out of the rinse aide and sanitizer solution. He was unable to find any test strips to check the sanitizer levels anywhere. He continued to wash the dishes and stack them on the clean dish rack to the right of the dishwasher without the use of any sanitizer. Dietary Aide 14 knew the machine had been out of sanitizer for the last hour. He was unaware they were out of test strips to test the dishwasher and had not notified anyone they had run out. He was unaware if the dishes he stacked on the clean shelf in the last hour would be recleaned and sanitized before residents were served meals on the dishes. Training had not been provided to check or log the dishwasher sanitizer during the rinse cycle nor the dishwasher temperatures. The April dishwasher logs had not been completed any days in April. During an interview on 4/23/23 at 10:49 a.m., the Administrator indicated he sent someone to get sanitizer testing strips and sanitizer, but he was not aware the sanitizer was completely empty for the dishwasher. Dishes should have been rewashed and sanitized. During an observation on 4/25/23 at 11:33 a.m., the Maintenance Director indicated he had filled in as the Dietary Supervisor for the last three days. The kitchen was not kept in a sanitary manner. Staff should have completed a cleaning log check-off each day to ensure the kitchen cleaning was done each day, but it had not been done. He was unable to provide the kitchen cleaning logs. A bottom shelf on the table to the left of the sink remained with significant various food debris, where clean food trays were stored up on their edge. The bottom panel off of the range remained in the floor with brown thick			

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	baked on debris. The steam table remained with dried food spatters on the sides of the steam table and brown residue around the knobs on the sides. The double convection oven remained with thick black food debris inside on the top and bottom. Baked-on food was on the inside and outside of the convection oven doors. The inside of the microwave had dried food debris inside. The four food delivery carts were soiled and had a thick light pink fluffy substance around the inside bottom ledges of the food tray carts, with dried splashed and food particles on the ledges where the food trays sat. He noticed how dirty the food carts were on 4/24/23. The carts needed to be power washed. Freezer B remained with a sticky dirty floor, six dessert cups on the floor, two expired and damaged dessert cups on the lower rack, and a deteriorated sticky box on the floor under the rack. The freezer should have been kept clean, free of items on the floor, and free of damaged or expired products. During an observation on 4/25/23 at 11:53 a.m., the Maintenance Director indicated the low temperature dishwasher wash cycle was 112 degrees and the rinse cycle was 120 degrees. It should have been a minimum of 120 degrees for both cycles. Sanitizer test strips were not available to test the sanitizer in the rinse cycle. The dishwasher temperature log and sanitizer log remained blank for the month of April. He was unable to determine if the sanitizer levels or temperatures were within acceptable parameters for the month of April because it was not documented. This was the manner in which the facility determined if dishes were maintained in a sanitary manner to serve food. He indicated this had the potential to impact all of the resident who ate meals prepared in the kitchen.			

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	During an interview on 4/25/23 at 12:06 p.m., Cook 15 indicated the last dietary manager had not required staff to document any scheduled kitchen cleaning and the frequency in which it was done. Damaged or expired dietary products should have been disposed of immediately when damaged or expired. During an interview on 4/26/23 at 9:35 a.m., Dietary Aide 14 indicated Cook 16 trained him when she had time, but they were always low staffed and very busy, so she did not have a lot of time to spend with him for training. No one trained him to check the dishwasher temperatures or the sanitizer solution in the rinse cycle with the sanitizer test strips. He was unaware what temperature was required for the wash and rinse cycle on the dishwasher. He would know if the temperature was not appropriate based on how warm the dishes felt when he removed them from the dishwasher. During an interview on 4/26/23 at 9:46 a.m. Dietary Aide 13 indicated Cook 16 provided her training. She did not remember training for checking the dishwasher temperature or dishwasher sanitizer with strips. She was unaware of the frequency in which these items should have been done. A current facility policy, dated 9/1/21, titled "General Food and Nutrition Services," and provided by the Maintenance Director on 4/26/23 at 12:01 p.m., indicated the following: "...STANDARD: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. GUIDELINE: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner... 2. The Dining Services Director will			

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	ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces... 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces...." A current facility policy, dated 11/20/21, titled "Resident food - Safe Storage," provided by the Corporate Environmental Manager on 4/26/23 at 9:50 a.m., indicated the following: "...Purpose: To ensure that resident food items are stored in a manner that is sanitary and safe for consumption and to prevent contamination and spoilage. Guidelines: ...Food items, condiments and liquids that are in the original containers shall follow the expiration date on the container... Food items, condiments and liquids that are not in the original containers should be discarded 3 days after the date labeled on the container... Foods which are outdated or are not labeled and dated shall be discarded daily when cleaning...." A current policy, dated 9/1/21, titled "QRT Warewashing," provided by the Maintenance Director on 4/26/23 at 12:01 p.m., indicated the following: "Standard: All dishware, service ware, and utensils will be cleaned and sanitized after each use. Guidelines: 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. 2. All dish machine water temperature will be maintained in accordance with manufacturer recommendations... 3. Temperature and/or sanitizer concentration logs will be completed, as appropriate...." 3.1-21(i)(3)			

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F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how			

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	the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.			

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	(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff			

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	participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.			

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	§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on observation, interview, and record review, the facility failed to ensure there was timely communication maintained between the facility and the hospice provider for 1 of 1 residents reviewed for hospice services. (Resident 85) Findings include: Resident 85's clinical record was reviewed on 4/21/23 at 3:03 p.m. Diagnoses included Alzheimer's disease, muscle wasting, and chronic pain. The resident was admitted to hospice services on 2/23/23. A current care plan, initiated 2/23/23, indicated the resident received hospice services. Interventions included, hospice staff to collaborate with the facility to provide comfort care for the resident through the next review period. During a review of the hospice documentation on 4/26/23, the binder lacked any communication log notes from the nursing staff since 3/29/23. The last documentation of a nursing visit was dated 4/3/23. During an interview, on 4/26/23 at 11:00 a.m., LPN 3 indicated communication between facility staff and hospice staff occurred through the hospice	F 0849	F849 D Hospice Services This facility requests paper compliance of all citations 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Hospice company providing care for resident #85 was contacted and documentation notes were provided. 2.How did the facility identified	05/25/2023

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	binder. She indicated the binder was not up-to-date, and she was not sure the last time hospice staff had visited the resident. A review of a current policy and service agreement, titled, "Nursing Facility Hospice Service Agreement," provided by the Administrator on 4/27/23 at 11:54 a.m., indicated the following: "...Services to be provided by Hospice...Manner of Communication:..All communications between the Hospice and Nursing Facility pertaining to the care and services provided to the Resident Patient shall be documented in the Residents Patient's clinical record...."		other residents? • Audit conducted to identify those residents utilizing Hospice Services. Contact was made with Hospice companies and documentation notes were provided as needed. 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 and social services were educated on maintenance of communication between the facility and the Hospice provider. • Weekly calls to Hospice provider per Director of Nursing/designee to ensure documentation has been provided to the facility related to hospice visits. • Documentation will be kept in the Hospice Communication binder for easy access. 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? • The responsible party for those residents identified is the Director of Nursing/designee. • Audits conducted on 3 Hospice residents weekly to determine documentation has been provided. • The results of these audits will be reviewed in Quality Assurance meeting monthly x6 months or until an average of 90% compliance or greater is achieved	

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			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: 5-25-2023	
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			

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	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. §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.			

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	Based on observation and interview, the facility failed to ensure staff completed hand hygiene during medication administration for 1 of 3 staff observed during medication administration. (QMA 5) Findings include: During a medication administration observation on 4/26/23 at 8:53 a.m., QMA 5 was observed preparing medications for Resident 60. She failed to sanitize her hands prior to pulling the residents medications from the medication cart and while handling the medication cup. She placed her right index finger inside the cup when setting it on top of the medication cart. She did not sanitize her hands prior to, or after, administering the medications to the resident. At 9:07 a.m., QMA 5 began to prepare medications for Resident 83. She obtained a medication cup using her index finger and thumb to hold the cup, with her index finger inside the cup. Following preparation of the medication, she placed her right hand, with her palm resting on the top of the medication cup, to move them to the resident's room and administered the medication. QMA 5 went to the back up medication supply to obtain an ordered medication that was not in the medication cart. She placed the medication into a medication cup and at no time did she sanitize her hands. She administered the medication to the resident. During an interview on 4/26/23 at 12:37 p.m., the DON indicated the QMA should sanitize her hands before and after administration of medication. The medication cups should be handled on the outside and not touching the palm of the hand during transport to the resident.	F 0880	F 880 D Infection Prevention and Control The facility respectfully 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: • Immediate education provided to QMA #5 regarding medication administration and hand hygiene. • No resident was identified to have been affected. 2) How the facility identified other residents: • Any resident had the potential to be affected, however no resident was identified. 3) Measures put into place/ System changes: • In servicing was provided to facility licensed staff on infection	05/25/2023

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BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy, revised 11/2022, titled "Medication Administration," and provided by the Corporate Nurse Consultant on 4/26/23 at 12:45 p.m., indicated the following: "...INTENT: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines...PROCEDURE: 1. Hand hygiene is performed prior to handling any medication...." 3.1-18(l)		control/ hand hygiene during medication administration per the Director of Nursing. 4) How the corrective actions will be monitored: • The Director of Nursing /Infection Preventionist/Designee will observe 2 medication passes weekly to include all shifts to determine hand hygiene compliance. • Identified areas of concern will be addressed immediately through 1-1 education and or disciplinary action. • Staff will be educated upon hire and at least annually on infection control practices, medication administration and hand hygiene. • Results of above reviews will be reported to QAPI monthly for 6 months or until compliance is met at 100% for 3 months when the QA Committee will review for trending or patterns and make recommendations as required to the plan of correction. 5) Date of compliance: 5-25-2023	