STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00375882 and IN00375480. Complaint IN00375882 - Substantiated. Federal/state deficiencies related to the allegations are cited at F842. Complaint IN00375480 - Substantiated. Federal/state deficiencies related to the allegations are cited at F842. Survey dates: March 21, 22, 23, 24, 25 and March 28, 2022 Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 10 Medicaid: 49 Other: 14 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 4, 2022.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the facility Recertification and State Licensure with a Complaints (IN003755480, IN00375882) on 3/28/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv			

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

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

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Bldg. 00	Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such			

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	information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure the physician's orders for Cardiopulmonary Resuscitation (CPR) were listed on resident profiles, failed to ensure physician's orders were obtained for resident code status and failed to have an Advanced Directive on file for 3 of 4 residents reviewed for code status. (Resident 186, 38 and 12) Findings include: 1. The record for Resident 186 was reviewed on 03/21/22 at 4:44 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease which causes obstructed airflow from the lungs), bradycardia (slow heart rate) and epilepsy. There was no code status found on the resident's profile. There was no order for the resident's code preference found in the resident's orders. 2. The record for Resident 38 was reviewed on 03/28/22 at 4:22 p.m. Diagnoses included, but were not limited to, malignant neoplasm of prostate (a cancerous tumor), secondary malignant neoplasm of the bone and acute/chronic heart failure. A physician's order, dated 11/26/21, indicated the resident was a full code. A document, titled "INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)," provided by the Clinical Support Nurse on 03/25/22 at 12:13 p.m., indicated Resident 38 had	F 0578	**F578** 1.Resident # 186, the facility reviewed to ensure there was a current Post and code status order in resident's chart. The code status is listed in the resident's profile. Resident #38 has been discharged Resident #12, the facility reviewed to ensure there was a current POST and code status order in the resident's chart. The code status is listed in the resident's profile. 2.All current residents have the potential to be affected by this deficiency. The Director of Nursing or Designee will complete an audit for all residents to ensure there ensure a physician's order has been obtained for resident code status, a POST form is on file and matches the most recent physician order and the code status is listed in the profile of Point Click Care (PCC). 3. The Director of Nursing or designee will educate the Licensed Nurses, Social Service and Admissions staff on the facility policy: General Code Status, to include the process for completing a POST, obtaining physician's order for the desired	04/29/2022

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	signed the form on 03/03/22 and chose do not attempt resuscitation/DNR.3. The record for Resident 12 was reviewed on 03/21/2022 at 12:20 p.m. Diagnoses included, but were not limited to, essential (primary) hypertension, major depressive disorder and unspecified asthma. There was no Advance Directive/Living Will on file, no code status in the medical record and no physician's order to indicate Do Not Resuscitate (DNR). During an interview, on 03/21/22 at 4:52 p.m., the Director of Nursing (DON) indicated if a resident did not have an order indicating their preference for CPR or not to have CPR they would be treated as a full code. During an interview, on 03/24/2022 at 11:20 a.m., the DON indicated there was a Code Status on record. The DON attempted to locate the record but could not find it. During an interview, on 03/24/2022 at 1:44 p.m., the Clinical Support Nurse (CSN) indicated the code status should be on the electronic medical record profile page of the residents to direct the facility staff if there was an emergency. There should be a written order for the code status. A current facility policy, titled "General Code Status," dated 5/11/2018 and provided by the DON on 3/24/2022 at 1:28 p.m., indicated "...Two basic code categories will be entered in the electronic medical record to guide staff for appropriate emergency treatments...Proper documentation and a physician/provider medical order is required for DNR status...." 3.1-4(f)(5)		code status and updating the resident's record/profile in PCC 4. The following audits and / or observations for all new admissions will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then weekly for 8 weeks to ensure compliance: audit residents to ensure there ensure a physician's order has been obtained for resident code status, a POST form is on file and matches the most recent physician order and the code status is listed in the profile of Point Click Care (PCC). The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility,			

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	the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to ensure a Beneficiary Protection Notice was provided within 48 hours of the loss of benefits for 1 of 3 residents reviewed for beneficiary. (Resident 296) Finding includes: A document, titled "SNF Beneficiary Protection Notification Review," provided by the Director of Nursing (DON) on 03/23/22 at 8:30 a.m., indicated Resident 296's last covered day of Part A (Medicare Part A) was on 11/22/21. The form indicated verbal consent was given by the resident's representative on 11/22/21. During an interview, on 03/23/22 at 9:21 a.m., Social Service Worker (SSW) 5 indicated the therapy department would give social services a discharge date within 48 hours and Social Services should issue the beneficiary notice within 48 hours. During the same interview, on 03/23/22 at 9:21	F 0582	**F 582**: 1.Resident # 296 had no negative outcome as a result in this alleged deficient practice. 2. All current residents how have Medicare have the potential to be affected by this deficiency The Social Service Director or designee will review all residents receiving Medicare Part A benefits with Therapy and MDS to ensure any resident with a planned last covered day is scheduled to receive their Beneficiary Protection Notice within 48 hours of the loss of benefits. 3.The ED or Designee will educate the Business Office Manager, Social Service Department, MDS, and Therapy department on the following facility policy: Non-Coverage and Advanced	04/29/2022

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	a.m., SSW 6 indicated the form should have been signed on 11/20/21. A current facility policy, titled "Non-coverage and Advanced Beneficiary Notices Policy," dated as reviewed on 07/21/20 and provided by the Director of Nursing on 03/25/22, indicated "...This notice will be provided at least 2 days in advance of the last covered day to allow for adequate time to appeal, if the beneficiary so chooses...." 3.1-4(f)(3)		Beneficiary Notices, to include ensuring that a Beneficiary Protection Notice is given within 48 hours of the loss of benefits for any resident who receives Medicare. 4. The following audits and / or observations for will be conducted by the Executive Director or designee for 5 Medicare charts 1 times a week for 8 weeks, 3 Medicare charts a week for 8 weeks, then 1 Medicare chart a week for 8 weeks to ensure compliance: audit residents to ensure there ensure that the Beneficiary Protection Notice was given within 48 hours of the loss of benefits. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care			

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	of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to ensure the development of a baseline	F 0655	**F 655** 1.For Resident # 66 the care plan	04/29/2022

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	care plan for oxygen use, suctioning and tracheotomy care was completed for 1 of 1 resident reviewed for baseline care plans. (Resident 66) Finding includes: The record for Resident 66 was reviewed on 03/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, malignant neoplasm of esophagus, hypertension and absence of larynx. A physician's order, dated 02/04/22, indicated to suction tracheotomy for increased secretions, use sterile technique three times a day and as needed. A physician's order, dated 02/06/22, indicated oxygen use at 6 liters via nasal cannula with humidification. There were no care plans for suctioning, tracheotomy care and oxygen use found in the record. During an interview, on 03/25/22 at 8:30 a.m., the Director of Nursing (DON) indicated the resident had an order for oxygen at 6 Liters/min via nasal cannula with humidification. A new order was obtained from the Nurse Practitioner on 03/23/22 at 2:00 p.m., which indicated oxygen to be at 3 liters via trach mask with humidification. Oxygen may be triturated up to 6 liters to maintain saturations above 90%. She was not aware the resident did not have care plans for oxygen, suctioning or trach care. She indicated there should have been care plans. During an interview, on 03/25/22 at 2:33 p.m., the		was reviewed to ensure it reflected the residents use of oxygen, suction, and tracheostomy care. 2.Any resident admitted within the last 21 days are at risk. The Director of Nursing or designee will audit all residents who have been admitted within the past 21 to ensure a baseline care plan is developed and implemented with the minimum healthcare instructions necessary to properly care for a resident, such as initial goals based on admission orders, MD orders, diet orders, therapy services and social service. 3. The Director of Nursing or designee will educate the Licensed Nurses on the facility policy: Baseline Care Plan / 48 hour Care Plan. 4. The following audits and / or observations for all new admissions will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then weekly for 8 weeks to ensure compliance: audit residents to ensure a baseline care plan is developed and implemented with the minimum healthcare instructions necessary to properly care for a resident, such as initial goals based on admission orders, MD orders, diet orders, therapy	

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	Clinical Support Nurse indicated the resident did not have a care plan for oxygen, suctioning or trach care. A current facility policy, titled "Baseline Care Plan/48 Hour Care Plan," received from the DON on 03/22/22 at 8:41 a.m., indicated "...The policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional; needs and concerns of the residents. The safety of residents...A 48 hour care plan is the initial care plan that is created upon admission to the facility to address specific immediate needs with a focus on safety...the baseline or 48 hour care plan will include at a minimum: to address safety concerns...to address resident-specific health needs...to prevent decline or injury including but not limited to falls and elopement...the baseline care plan is updated/revised until the comprehensive care plan is completed...the nurse will initiate the baseline care plan once the admission assessment has been completed...." 3.1-35(a)		services and social service. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to			

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	attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview and record review, the facility failed to develop a care plan which addressed pain and a resident's preference to remain in bed (Resident 46) and failed to develop a comprehensive care plan for oxygen use, suctioning and trach care (Resident 66) for 2 of 3 residents reviewed for care plans. 1. During an observation, on 03/21/22 at 10:42 a.m., Resident 46 was observed lying in bed, eyes	F 0656	**F 656** 1.Resident #46 care plan was reviewed and updated to include the residents' current preference to remain in bed. Resident #66 care plan was reviewed and updated to include resident's oxygen use, suctioning and trach care.	04/29/2022

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	closed and resting. During an observation and interview, on 03/21/22 at 3:49 p.m., Resident 46 was observed in bed. He indicated he had pain in both legs all the time and the pain kept him in bed. The resident displayed a pain expression, was shaking and moaning. During an observation, on 03/23/22 at 11:00 a.m., Resident 46 was observed lying in bed with the television on. Resident 46 appeared to be sleepy. He did not appear to be in distress or pain. He indicated he did receive his pain medication and it had been helpful. During an observation, on 03/24/22 at 8:53 a.m., Resident 46 was observed resting in bed, no distress was noted. During an observation, on 03/25/22 at 2:17 p.m., Resident 46 was observed resting in bed with his eyes closed. During an observation, on 03/28/22 at 10:48 a.m., Resident 46 was observed resting, in bed, his television was on. He denied discomfort. The record for Resident 46 was reviewed on 03/28/22 at 10:51 a.m. Diagnoses included, but were not limited to, weakness, depressive disorder and heart failure. There was no care plan for pain, interventions for pain or the resident's preference to remain in bed. During an interview, on 03/28/22 at 10:49 a.m., LPN 7 indicated Resident 46 refused to get out of bed. At that time, she attempted to find the pain care plan and the care plan for resident's choice to remain in bed. She was unable to access the		2.All residents who have pain, preference to stay in bed, oxygen, suctioning and/or trach care have the potential to be affected by this deficiency. The Director of Nursing or designee will audit all residents who have pain, preference to stay in bed, oxygen, suctioning and/or trach care to ensure the care plan is up to date. 3. The Director of Nursing or designee will educate the Licensed nursing staff on the following facility policy: Plan of Care Overview, to include updating the care plan on residents who have pain, preference to stay in bed, oxygen, suctioning and/or trach care. 4. The following audits and / or observations for 5 residents will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then weekly for 8 weeks to ensure compliance: audit residents who have pain, preference to stay in bed, oxygen, suctioning and/or trach care to ensure the care plan is up to date The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then	

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	155790	A. BUILDING 00 B. WING	03/28/2022

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	information. During an interview, on 03/28/22 during the exit conference which began at 6:20 p.m., the Director of Nursing indicated there were no care plans for pain or the resident's preference to remain in bed.2. The record for Resident 66 was reviewed on 3/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, malignant neoplasm of esophagus, hypertension and absence of larynx. A physician's order, dated 2/4/22, indicated to suction the trach for increased secretions, use sterile technique three times a day and as needed. A physician's order, dated 2/6/22, indicated oxygen use at 6 liters via nasal cannula with humidification. There were no care plans for suctioning, trach care and oxygen use. During an interview, on 03/25/22 at 8:30 a.m., the Director of Nursing (DON) indicated the resident had an order for oxygen at 6 Liters/min via nasal cannula with humidification. A new order was obtained from the Nurse Practitioner on 3/23/22 at 2:00 p.m., which indicated the oxygen was to be at 3 liters via trach mask with humidification. The oxygen may be triturated up to 6 liters to maintain saturations above 90%. She was not aware the resident had no care plans for oxygen, suctioning or trach care. She indicated there should have been care plans. During an interview, on 3/25/22 at 2:33 p.m., the Clinical Support indicated the resident did not have a care plan for oxygen, suctioning and trach		randomly thereafter for further recommendation	

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	care. A current facility policy, titled "Plan of Care Overview," dated as reviewed on 05/30/19 and provided by the Director of Nursing on March 28, 2022, indicated "...the Plan of Care...is the written treatment record provided for a resident that is resident focused and provides for optimal personalized care..." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the			

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	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to document care plan meetings for 2 of 3 residents reviewed for care plans and revision. (Resident 71 and Resident 12) Finding includes: 1. During an initial interview, on 03/21/22 at 10:50 a.m., Resident 71 indicated he had not had a structured care plan meeting. The record for Resident 71 was reviewed on 03/21/22 at 2:46 p.m. Diagnosis included, but were not limited to, acute kidney failure, type 2 diabetes and paranoid schizophrenia. There were no notes found in the record to indicate a care plan meeting had been held. During an interview, on 03/28/22 at 8:34 a.m., Social Service Worker (SSW) 6 indicated she was not able to find information on a care plan meeting for Resident 71. Care plan meetings were done every three months. She thought the previous SSW had spoken with Resident 71's guardian, but she was unable to find any notes to indicate it had been done. She was also unable to find initial care plan meeting notes. The previous SSW did not document any meetings or phone calls. 2. During an observation, on 03/23/22 at 10:02 a.m., Resident 12's portable oxygen tank flow rate was set at 2 liters per minute through nasal cannula. During an observation, on 03/24/22 at 10:16 a.m., Resident 12's portable oxygen tank was connected to flow at 2 liters per minute through nasal cannula.	F 0657	**F 657:** 1.Resident #71 and Resident #12, a care plan meeting will be completed. 2.All residents have the potential to be affected by this deficiency. The Social Service Director or designee will audit all resident's charts to ensure a care plan meeting has been completed and attendance offered to the resident and resident representative. If no meeting information can be found for the previous 3 months, the Social Service director and/or designee will contact the resident and/or representative to see if they are interested in having a care plan meeting and if so, the meeting will be scheduled within the next 30 days. 3. The Executive Director or designee will educate the Social Services and MDS Department on the following facility policy: Plan of Care Overview, to include a review of their responsibilities of ensuring the care plan meeting are completed as scheduled and documented in PCC. 4. The following audits and / or observations for 5 resident charts will be conducted by the Executive Director or designee 5 times a	04/29/2022

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	During an observation, on 03/24/22 at 10:20 a.m., LPN 3 checked the oxygen tank, indicated it was empty and had been set at 2 liters per nasal cannula. LPN 3 removed the portable oxygen tank from the room, gave it to one of the CNAs to re-fill the tank. The record for Resident 12 was reviewed on 03/21/2022 at 12:20 p.m. Diagnoses included, but were not limited to, essential (primary) hypertension, major depressive disorder and unspecified asthma. A physician's order, dated 03/01/2022, indicated the resident was to receive supplemental oxygen (one) liter per minute through nasal cannula to keep oxygen saturation greater than 94% as needed for shortness of breath. During the record review, on 03/21/2022 at 12:20 p.m., Resident 12 did not have a revised care plan to monitor, document and receive oxygen therapy at 1 liter per minute through nasal cannula to keep oxygen saturation greater than 94% During an interview, on 03/24/22 at 12:30 p.m., the Director of Nursing (DON) indicated the resident's care plan should have been updated to show the new supplemental oxygen order written on 03/01/2022 at 11:44 a.m. During an interview, on 03/24/22 at 12:30 p.m., the DON indicated the resident received oxygen from the wall and not from the portable tank. The DON indicated it was the expectation the nurses check the resident's oxygen to ensure the resident was receiving oxygen when needed. A current facility policy, titled "Plan of Care		week for 8 weeks, 3 charts a week for 8 weeks, then 1 chart a week for 8 weeks to ensure compliance: audit resident's charts to ensure a care plan meeting has been completed and attendance offered to the resident and resident representative The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	Overview," dated 7/26/2018 and provided by the DON on 3/28/2022 at 3:49 p.m., indicated "...Resident/representative will have the right to participate in the development and implementation of his/her own PoC (Plan of Care)...The facility will review care plans quarterly and/or with significant changes in care ...Care plan document are resident specific/resident focused...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure dressing changes were completed per a physician's order for 2 of 3 residents reviewed for non-pressure wound care. (Resident 62 and 75) Findings include: 1. During an observation of Resident 62, on 03/24/22 at 8:46 a.m., a dressing was observed on her left shin. The lower left corner of the dressing was peeled up and there was a brown stain in the center of the dressing. The date on the dressing was 03/22/22.	F 0684	**F 684:** 1.Resident # 62 and Resident #75, dressing change was completed and TAR signed 2.Any resident with a wound has the potential to be affected by this deficiency. The Director of Nursing or designee will complete an audit of all residents with wound treatments to ensure the last treatment complete was per MD order. Any dressings noted to not have been changed per the	04/29/2022

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	The record for Resident 62 was reviewed on 03/24/22 at 2:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes, polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body) and other chronic pain. A physician's order, dated 03/22/22, indicated to clean the open area on the left shin with normal saline, pat dry and apply DD (dry dressing) one time a day. The Medication and Treatment Administration Record, for March 2022, indicated the dressing to the left shin had been signed off as completed for 03/23/22. During an interview, on 03/24/22 at 9:01 a.m., RN 1 indicated the dressing was to be changed daily. 2. During an observation of Resident 75, on 03/22/22 at 9:20 a.m., he was found to have a dressing on both lower extremities. The dressings were dated 03/18/22. At that time, Resident 75 indicated he thought the dressings were to be changed daily. The record for Resident 75 was reviewed on 03/22/22 at 2:05 p.m. Diagnoses included, but were not limited to, type 2 diabetes, paraplegia and chronic heart failure. A physician's order, initiated on 03/01/22, indicated to clean the left lower leg with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an abdominal dressing, wrap with kerlix and to secure it with Coban, in the afternoon for wound care. A physician's order, initiated on 03/01/22,		MD order will have their dressing change and MD notified. 3.The Director of Nursing or designee will educate all Licensed Nurse on the following facility policy: Skin and Wound Management Overview, to include completing dressing changes and documentation per MD order. 4. The following audits and / or observations for 5 residents will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: audit of all residents with wound treatments to ensure the last treatment complete was per MD order The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	indicated to clean the right lower leg with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an abdominal dressing, wrap with kerlix and to secure it with Coban, in the afternoon for wound care. The Medication and Treatment Administration Record, for March 2022, indicated the dressings/wound care, to both legs, had been completed and signed off on March 19, 20, and 21, 2022. On 03/22/22 at 1:48 p.m., LPN 2 viewed the dressing date and verified it was 03/18/22. At that time, she indicated the dressing change was moved to her shift and she would address it after the resident had his lunch. During an interview, on 03/22/22 at 2:05 p.m., the Director of Nursing indicated the resident did refuse care. The nursing notes were reviewed on 03/22/22 at 2:05 p.m. There was no documentation of the resident refusing his wound care from March 18 to March 21, 2022. A current facility policy, titled "Skin Care & Wound Management Overview," dated as reviewed on 10/05/21 and provided by the Director of Nursing on 03/25/22 at 8:20 a.m., indicated "...Skin care and wound management program includes, but is not limited to...Application of treatment protocols based on clinical "best practice" standards for promoting wound healing...Daily monitoring of existing wounds...." 3.1-37(a)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents were monitored during medication administration and to ensure medications were not left unattended for 2 of 2 residents reviewed for accident hazards. (Resident 63 and 66) Findings include: 1. During an observation, on 03/21/22 at 11:00 a.m., Resident 63 was lying in bed with a medication cup on the over the bed table. The medication cup was filled with red liquid. She indicated the medication was on the table all night. The record for Resident 63 was reviewed on 03/21/22 at 12:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, depressive episodes and anxiety disorder. There was no self-medication assessment and no physician's order for self-medication administration located in the record. A physician's order, dated 7/6/20, indicated Robitussin 100 mg (milligrams)/5 ml(milliliters)	F 0689	**F689:** 1.Resident #63 and Resident #66, medications at bedside were removed immediately 2.All residents have the potential to be affected by this deficiency. The Director of Nursing or designee completed a full house audit to ensure no medications were left at bedside. 3.The Director of Nursing or designee will educate the Licensed Nurses and QMAs on the following facility policies: Medication Administration and Resident Self-Administration of Medication, to include the expectation of ensuring the resident consumes the medication prior to walking away. In addition, the Licensed nurses will be educated on making sure a Self -Administration of Medication Evaluation is completed for any resident who desires to take their own meds prior to leaving	04/29/2022

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	Syrup give 10 ml by mouth every 6 hours as needed for cough. During an interview, on 03/21/22 at 11:00 a.m., LPN 2 indicated she did not give the resident the medication. LPN 2 indicated it looked like cough medication and should never have been left with the resident. During an interview, on 03/25/22 at 2:21 p.m., the Clinical Support nurse indicated the resident did not have a self-medication assessment completed. 2. During an observation, on 03/22/22 at 11:00 a.m., Resident 66 was sitting on his bed. He appeared to be having difficulty breathing. He was requesting an aerosol treatment. He opened his bedside dresser and showed me a package containing 3 vials of Ipratropium-Albuterol Solution 0.5-2.5 (3) ml/3 ml (milliliters). The resident did not know who gave him the medication. He indicated he did his own aerosol treatments. The record for Resident 66 was reviewed on 03/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, hypertension and absence of larynx (the hollow muscular organ forming an air passage to the lungs and holds the vocal cords). There was no self-medication assessment and no physician's order for self-medication administration located in the record. A physician's order, dated 02/03/22, indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) ml (milliliters) /3 ml inhale orally every 3 hours as needed for shortness of breath and wheezing via		medications with them at bedside. 4. The following audits and / or observations for 5 residents will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: observation of residents to ensure no medication is left at the beside. If medication is found at the bedside, will review to ensure a self -administration of medication evaluation is complete. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	nebulizer. During an interview, on 03/22/22 at 11:10 a.m., LPN 2 indicated she did know the resident had medication in his bedside dresser. She did not think he had a self-administration assessment, and he was not supposed to have medication in his room. During an interview, on 03/25/22 at 2:21 p.m., the Clinical Support Nurse indicated the resident did not have a self-medication assessment completed. A current facility policy, titled "Medication Administration," dated as revised 12/14/07, indicated "...The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer...Administer medication only as prescribed by the provider...Medications must be poured just prior to administering per resident...Do not administer medications prepared by others...Never leave medications unattended...Remain with resident until the medication is swallowed...Do not leave medication at bedside...Medications will be administered within the time frame of one hour before up to one hour after time ordered...." A current facility policy, titled "Resident Self-Administration of Medications," dated as revised 08/01/16, indicated "...this facility to provide resident centered care that safeguards the resident's right for self-administration of their own medication that supports resident dignity and self-determination...The facility will not require or compel any residents to administer their own medication if they do not desire to do so or cannot safely do so...On admission, the facility			

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	will assess the resident for safety through an IDT Care planning team prior to the resident exercising their right of self-administration of drugs within 7 days after the comprehensive assessment is completed as required by regulations...IDT team will assess for safety or self-administering of medication including the following...." 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated, failed to ensure sterile technique and proper hand hygiene was followed while providing tracheotomy care and failed to administer oxygen as ordered for 3 of 3 residents reviewed for respiratory care. (Resident 7, 66 and 12). Findings include: 1. During an observation of Resident 7, on 03/21/22 at 11:32 a.m., the resident was on oxygen using a nasal cannula. The oxygen line had not been dated to show when it had last been changed.	F 0695	**F695:** 1.Resident #7 has been discharged. Resident #66 – oxygen tank was filled and proper tracheotomy suctioning was completed using sterile technique and hand hygiene. Resident #12 - resident was connected to a full oxygen tank immediately 2.All residents who receive respiratory care, oxygen and/or suctioning are at risk for this deficiency. The Director of Nursing or	04/29/2022

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BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(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
	The record for Resident 7 was reviewed on 03/23/22 at 11:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma and acute respiratory failure with hypoxia. A physician's order, initiated on 03/13/22, indicated to change the nasal cannula and to initial and date the tubing every Sunday. A care plan, initiated on 06/29/21, indicated Resident 7 was on 3 liters of oxygen via nasal cannula and to change the tubing per facility policy. During an interview, on 03/21/22 at 11:35 a.m., LPN 8 indicated the oxygen tubing should have been labeled with a date.2. During an observation, on 03/23/22 at 10:14 a.m., Resident 66 was sitting on his bed coughing and wheezing. The resident was wearing a tracheotomy mask over his decannulated stoma (an artificial opening made into a hollow organ leading to the trachea). He stated he was having a hard time breathing. He needed to be suctioned and wanted an aerosol treatment. During an observation, on 03/23/22 at 10:20 a.m., LPN 2 returned with supplies and the Infection Preventionist (IP). LPN 2 cleaned the over the bed table and put her suction kit on the table. She then put on gloves, a gown and a face shield without sanitizing or washing her hands. She took her face shield off and put on a N95 mask without sanitizing her hands. She opened the suction kit and removed her clean gloves. LPN 2 removed the sterile gloves from the package and put on the sterile gloves. She did not wash or sanitize her hands prior to putting on her sterile gloves. She put the suction catheter in her right hand. She		designee completed an audit of all residents on oxygen, who have a trach or have respiratory care to ensure oxygen tubing is changed and dated within 7 days, resident is not connected to an empty Oxygen tank and licensed nurses are using sterile technique and proper hand hygiene while performing tracheotomy suctioning / care. 3.The Director of Nursing or designee will educate the Licensed on the following facility policies: Supplemental Oxygen Using Nasal Cannula and Tracheotomy Suctioning, to include emphasis on changing and dating all oxygen tubing each week as ordered, ensuring oxygen tanks remain full when in use, sterile technique is used and proper hand hygiene during tracheotomy suctioning. The Director of Nursing or designee will train the nursing staff on monitoring the oxygen levels in the oxygen tanks. The Director of Nursing or designee will complete a skills check off with the Licensed Nurses to ensure they can competently complete respiratory care such as suctioning of patients with a trach. Special attention will be paid to sterile procedures and hand washing. All newly hired licensed nurses will have skills check off completed to	

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	turned the suction machine on touching the catheter and her sterile glove on the suction machine. The nurse took the dirty catheter and approached the resident. LPN 2 was stopped and asked if she was going to use the cannula to suction the resident. The IP told the nurse she broke the sterile field and cannot use the same suction catheter. LPN 2 removed a suction kit out of the resident's dresser and without sanitizing her hands she put on her sterile gloves. She inserted the suction catheter down the resident's stoma and pulled it out. The cannula had approximately 2.5 inches of blood on the end of the catheter. LPN 2 did not take the residents oxygen saturations, vital signs or assess his lungs anytime during suctioning the resident. LPN 2 indicated she checked his oxygen saturations earlier today and it was 93%. The record for Resident 66 was reviewed on 03/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, malignant neoplasm of esophagus, hypertension and absence of larynx. A physician's order, dated 02/4/22, indicated to suction the trach for increased secretions by using sterile technique three times a day and as needed. During an interview, on 03/23/22 at 10:20 a.m., LPN 2 indicated she should have washed her hands before starting the procedure and after removing the gloves. During an interview, on 03/28/22 at 10:50 a.m., the Assistant Director of Nursing (ADON) indicated she checked LPN 2 off on a form, titled "Tracheal Suctioning Check Off Training," dated 03/23/22 at		enure they have the knowledge and skills to manage respiratory care and trachs. 4. The following observations for 1 Licensed Nurse will be conducted by the Director of Nursing or designee 3 times a week for 8 weeks, 2 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: observation of Licensed Nurse to ensure competently completes respiratory care / suctioning of patients with a trach. Special attention will be paid to sterile procedures and hand washing The following audits and / or observations for 3 residents with oxygen will be conducted by the Director of Nursing or designee - 5 times a week for 8 weeks, 2 times a week for 8 weeks, then 1x a week for 8 weeks to ensure compliance: observation that resident is not connected to an empty Oxygen tank. The following audits and / or observations for 5 residents with oxygen will be conducted by the Director of Nursing or designee - 5 times a week for 8 weeks, 2 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: observation that oxygen tubing is changed and dated within 7 days	

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	9:30 a.m. She indicated LPN 2 came to her and the Infection Preventionist (IP) and indicated she was going to do suctioning. The ADON and IP went over the procedure guide with LPN 2. The IP assisted LPN 2 during the suctioning. The ADON indicated the staff was expected to know how to do different tasks when they are hired and before working on the unit. LPN 2 was not checked off during orientation. They check off staff when they are unsure on how to do certain tasks. 3. During an observation, on 03/23/22 at 10:02 a.m., Resident 12's oxygen nasal cannula was connected to a portable oxygen tank at 2 liters per minute. The oxygen tank level was low. During an observation, on 03/24/22 at 10:16 a.m., Resident 12's portable oxygen tank was empty. The resident's oxygen nasal cannula was connected to an empty portable oxygen tank which had been set at 2 liters per minute. The resident checked their oxygen level with a personal pulse oximeter machine and it was 90%. The record for Resident 12 was reviewed on 03/21/2022 at 12:20 p.m. Diagnoses included, but were not limited to, essential (primary) hypertension, major depressive disorder and unspecified asthma. A physician's order, dated 3/1/2022, indicated the resident was to receive supplemental oxygen (one) liter per minute through a nasal cannula to keep the oxygen saturation greater than 94% as needed for shortness of breath. During an interview, on 03/24/22 at 10:17 a.m., Resident 12 indicated the oxygen level was low when the night shift nurse checked the oxygen level. The night shift nurse told the resident to use the oxygen. The resident was informed the		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	oxygen tank was empty. The resident indicated she was not aware the tank was empty and she thought she was receiving oxygen because the tube was connected to the tank. During an observation and interview, on 03/24/22 at 10:20 a.m., LPN 3 indicated it was the responsibility of the nurse to ensure the resident received oxygen as ordered. The resident would use the oxygen and sometime would refuse to use the oxygen. LPN 3 checked the oxygen tank and indicated it was empty. The oxygen was set at 2 liters per minute. During an interview, on 03/24/22 at 12:30 p.m., the Director of Nursing (DON) indicated Resident 12 received oxygen from the wall and not from the portable tank. The DON indicated it was the expectation the nurses checked the resident's oxygen to ensure the resident was receiving oxygen when needed. A current facility policy, titled "Supplemental Oxygen using Nasal Cannula," dated 3/20/2018 and provided by the DON on 3/23/2022 at 8:28 a.m., indicated "...Oxygen is considered a "medication"...including physician order, and placed on the MAR, a nurse or RT (Respiratory Therapist) will administer the oxygen as prescribed...." A current facility policy, titled "Tracheotomy Suctioning," received from the Clinical Support nurse on 03/25/22 at 9:30 a.m., indicated "...The purpose of this policy is to provide guidance for the skilled and competent nurse and respiratory therapist to provide a clear airway with adequate oxygenation for residents that are unable to effectively clear their secretions from their airway which may comprise their pulmonary status. This			

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	policy is not a step-by-step procedure as each resident's care will be based upon an assessment and their medical needs, the resources available at the time of the procedure in consideration of emergency needs...Obtain sterile water or sterile normal saline, suction kit with catheter and sterile gloves...perform hand hygiene...Don PPE, mask, gown, gloves and goggles...prepare bedside table if able by wiping down with disinfectant...position resident in semi-fowler's position...auscultate the resident's lung bilaterally...this will establish that suctioning is required and give a baseline for after suctioning...open suction catheter kit. Don sterile gloves...connect suction catheter to tubing...turn on the suction machine...Post Procedure...turn off the suction machine. Disposable of supplies. Remove gloves, goggles and mask, perform hand hygiene. Auscultate lung bilaterally...." A current facility policy, titled "Supplemental Oxygen using Nasal Cannula," dated as reviewed on 02/14/22 and provided by the Director of Nursing on 03/23/22 at 8:28 a.m., indicated "...Nasal cannula and tubing will be labeled and dated when opened...Nasal cannula's and tubing are changed weekly...and labeled with the date opened...." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to monitor blood sugars for 2 of 5 residents reviewed for unnecessary medications (Resident 7 and 75). Findings include: 1. The record for Resident 7 was reviewed on 03/23/22 at 11:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma and type 2 diabetes. A physician's order, initiated on 10/18/21, indicated to administer Novolog (an insulin) per sliding scale: 201 to 250=1 unit, 251-300= 2 units, 301-350 = 3 units, 351-400 = 4 units and 401 and greater = 5 units. The Medication/Treatment Administration Record, for March 2022, indicated no blood sugars were recorded on March 14 at 5:00 p.m., March 20 at 8:00 a.m., and March 20 at 12:00 p.m.	F 0757	**F757:** 1.Resident #7 has been discharged. Resident # 75 was reviewed to ensure that next schedule BS and insulin were completed as ordered. 2.All residents who receive blood sugar monitoring orders and insulin orders have the potential to be affected by this deficiency. The Director of Nursing or designee will audit all resident with blood sugar orders to ensure results are documented. Any missed documentations for the past 72 hours, the MD will be notified. 3.The Director of Nursing or designee will educate the	04/29/2022

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	2. The record for Resident 75 was reviewed on 03/22/22 at 2:05 p.m. Diagnoses included, but were not limited to, type 2 diabetes, paraplegia and chronic heart failure. An undated physician's order indicated to administer Novolog per sliding scale: 201-250-0 unit, 251-300=4 units, 351-400=8 units, 401-450 = 10 units, 451-500 = 12 units and 501-550 =14 units. The Medication/Treatment Administration Record, for March 2022, indicated no blood sugars were recorded on March 4 at 4:00 p.m., March 7 at 4:00 p.m., March 15 at 8:00 a.m. and 11:00 a.m., and March 19 at 8:00 a.m., 11:00 a.m. and 4:00 p.m. During an interview, on 03/28/22 during the exit conference beginning at 6:20 p.m., the Division Infection Preventionist indicated nursing was expected to follow the physician's orders. A policy for physician's orders was provided by the Director of Nursing on 03/28/22 at 8:41 a.m. The policy only addressed obtaining and transcribing orders. 3.1-48 (a)(3)		Licensed Nurses and QMAs on guidance of following MD orders for obtaining blood sugars and documenting the results on the MAR. 4.The following audits and / or observations for 5 residents will be conducted by the Director of Nursing or designee - 5 times a week for 8 weeks, 2 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: audit resident with blood sugar orders to ensure results are documented The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;			

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	§483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview and record review, the facility failed to ensure recipes were followed when staff did not prepare food which were compliant with the established dietician-approved recipes to ensure nutritional adequacy for 2 or 2 residents with physicians orders for puree diets. Findings include: During an observation of the puree diet preparation, on 03/22/22 at 11:04 a.m., the facility menu indicated chicken taco filling and carrots was to be served on the lunch meal. Dietary Manager (DM) indicated there were currently 2 residents in the facility receiving a puree diet. The DM retrieved an undetermined amount of chicken taco meat which had been placed in a metal tray stored in the oven. Then placed the chicken taco filling in the reservoir of the blender. When asked, the DM was unable to voice the amount of	F 0803	**F803:** 1.The Registered Dietician educated the Dietary Manager immediately on the proper recipe for pureeing food and the next scheduled meal was monitored for compliance to ensure the recipe was followed. The Registered Dietician completed an audit for all staff working in the kitchen as a cook to ensure they were educated immediately on the recipe for how to puree food. 2.All residents who receive pureed food have the potential to be affected by this deficiency. 3.The Registered Dietician or	04/29/2022

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	chicken in the container. The DM indicated he had been doing this for a long time and can "eyeball" the ingredients. The DM added 1/2 teaspoon of chicken base in a metal container and added an undetermined amount of water. The DM then added the liquid into the blended chicken taco filling. The DM indicated he blended the chicken until it reached the consistency of "pudding". The DM was observed to scrape the side of the reservoir and view the consistency of the mixture. The chicken taco filling was then removed from the blender reservoir and placed on a plate. The DM was then observed to remove a container of carrots from the oven. He placed 2 scoops of carrots into the blender reservoir and turned the blender on. When questioned regarding the amount of carrots he had placed in the blender reservoir, the DM stated 2 scoops. The DM using the scoop poured the carrots on the same plate with the chicken taco filling. The DM did not add any liquids to the carrots. The carrots appeared to have several small lumps. During the puree process observation, the DM was interviewed regarding recipes for the foods he was preparing. The DM indicated they do not have a recipe book they follow. The facility used a program called meal tracker. During an interview, on 03/24/22 at 9:05 a.m., the dietician indicated they have a recipe book. The kitchen was to follow the facilities recipes. The facility did not have a policy for preparing pureed food. The cooks were to follow the "Food Guidelines for Preparation of Pureed Foods." During an interview, on 03/24/22 at 2:01 p.m., the dietician stated if protein was weighed at 3 oz,		designee will educate the dietary cooks on the facility policy for: Food Guidelines for Preparation of Pureed Foods, to include the proper recipe to pureed food. 4.The following audits and / or observations for 1 dietary cook will be conducted by the Registered Dietician or designee - 5 times a week for 4 weeks, 3 times a week for 8 weeks, then 1 time a week for 12 weeks to ensure compliance: observation of dietary cook preparing meal to ensure proper recipe for pureeing food is followed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	mixed in the blender and a thinning agent (i.e. broth or thickener) was added, the scoop size per serving size should be increased to maintain the nutritional value of the protein (i.e. go up from 3 oz scoop to 4 oz scoop each serving) Recipes for chicken taco filling and carrots were received and reviewed on 03/22/22 at 2:00 p.m. The recipe, titled "Carrots, Sliced," noted for pureed. The notes at the bottom of the page indicated to measure out the desired number of servings into a food processor. Blend until smooth. Follow directions on food thickener guidelines of specific product used in the facility for liquid and thickener measurements. The liquid and thickener measurements are approximate and slightly more or less may be required to achieve desired pureed consistency. A current facility policy, titled "Food Guidelines for Preparation of Pureed Foods," received by the Executive Director on 03/22/22 at 2:00 p.m., indicated "...foods should be of a smooth texture. Regular foods can be pureed to a smooth texture without lumps unless the food is already in a smooth form or texture such as pudding or plain yogurt...Directions. Put small pieces of cooked foods in processor/robocoupe. Add small amount of liquids, begin w/(with) 2-3 TB...Blend until pureed-smooth texture w/o lumps adding small amount of liquid until correct consistency...." 3.1-20(a) 3.1-20(i)(1)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure a unit refrigerator did not contain expired food, sealed items, unlabeled items and staff food for 1 of 3 units. (2000 Unit) Findings include: During an observation of food storage on the 2000 Unit, on 03/23/22 at 12:01 p.m., with LPN 8 in attendance the following items were noted: a. A ham sandwich labeled 03/18/22 at 10:00 a.m., with a use by date of 03/21/22 by 10:00 a.m. b. A ham sandwich wrapped in plastic, with the date 03/05/22, written in black on the wrap. c. A large rectangle plastic bin containing lettuce with another small plastic container containing onion on top of the lettuce was loosely wrapped	F 0812	**F812:** 1.Resident Refrigerators in the dining room and on all hallways were immediately audited. All undated, unlabeled, unsealed and staff food removed immediately. 2.All residents have the potential to be affected by this deficiency. 3.The ED or designee will educate the facility staff, including but not limited to kitchen staff, on the facility policy: Storage of Resident Food, to include ensuring that no staff food is put in the resident refrigerators, all food and drinks are labeled with name and date when placed in the	04/29/2022

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	in plastic and open to air on the sides. d. A 1/4 full gallon of milk without an open date. e. A 5 pound container of cottage cheese which had been opened and did not have an open date. f. A two-quart plastic container 1/8 full labeled tea and dated 02/22/22. The liquid was yellow. g. One container of yogurt was found open and without an open date. h. One piece of French bread open to air on top of a container, with an orange substance inside, labeled 03/14/22 and with a resident's name. i. A take out container of food labeled with CNA 9's name. j. A container of chicken labeled with LPN 8's name. A sign was displayed on the refrigerator and indicated "...All Items Placed in this refrigerator MUST BE LABELED AND Dated...." A sign was displayed on the refrigerator and indicated "...Resident Food Items Only...All Items MUST have name and date...Any food items noted to not be labeled & dated will be disposed of immediately...Non resident food items will be discarded immediately...." During an interview, on March 23, 2022 at 12:10 p.m., LPN 8 indicated the ham sandwiches were old and should have been discarded and the container of chicken was hers. She brought it in on Monday night and should have taken it home. During an interview, on March 23, 2022 at 12:12 p.m., CNA 9 indicated she asked another CNA to place her food in the break room refrigerator and the CNA must have misunderstood. A current facility policy, titled "Storage of Resident Food," dated as reviewed on 04/20/2017		refrigerator, food and drinks are sealed and food and drinks are removed by the expiration date. 4.The following audits and / or observations for all resident - unit refrigerators will be conducted by the ED or designee - 5 times a week for 8 weeks, 3 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: observation to ensure that no staff food is put in the resident refrigerators, all food and drinks are labeled with name and date when placed in the refrigerator, food and drinks are sealed and food and drinks are removed by the expiration date The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	155790	A. BUILDING 00 B. WING	03/28/2022

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	and provided by the Director of Nursing on 03/23/22 at 3:53 p.m., indicated "...Refrigerator/freezers for storage of foods brought in...will be properly maintained and...food not for immediate consumption...will be...labeled for storage to be consumed for a later time...staff will...discard food when non-safe...The dietary staff will monitor refrigerator contents for... safety and reserve the right to dispose of expired, unsafe foods...Fresh...vegetable must be in a closed sealable storage container...The dietary staff will monitor refrigerator storage areas for...food monitoring for outdated, unsafe or otherwise food unfit for consumption...." 3.1-21(i)(3)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep			

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	confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;			

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	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure the Medication/Treatment Administration Records were signed off and contained accurate information by the nursing staff for 5 of 5 residents reviewed for complete and accurate records. (Resident 62, 75, 187, 79 and 81) Findings include: 1. During an observation of Resident 62, on 03/24/22 at 8:46 a.m., a dressing was observed on her left shin. The lower left corner of the dressing was peeled up and there was a brown stain in the center of the dressing. The date on the dressing was 03/22/22. The record for Resident 62 was reviewed on 03/24/22 at 2:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes, polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body) and other chronic pain. A physician's order, dated 03/22/22, indicated to clean the open area on the left shin with normal saline, pat dry and apply DD (dry dressing) one time a day. The Medication and Treatment Administration Record for March 2022 indicated the dressing to the left shin had been signed off as completed for 03/23/22. During an interview, on 03/24/22 at 9:01 a.m., RN 1	F 0842	**F842** 1.Resident #62: dressing was changed, and TAR signed immediately Resident # 75: dressing was changed, and TAR signed immediately, and Medications on MAR were immediately reviewed to ensure all were given as ordered. Resident # 187 Medications on MAR were immediately reviewed to ensure all were given as ordered Resident # 79: dressing was changed, and TAR signed immediately Medications on MAR were immediately reviewed to ensure all were given as ordered Resident # 81: Medications on MAR were immediately reviewed to ensure all were given as ordered 2.All residents have the potential to be affected by this deficiency. 3.The Director of Nursing or designee will educate the Licensed Nurses and QMAs 2 on the facility policy: Clinical Documentation Standards, to include the expectation administering medications and completing treatments as ordered,	04/29/2022

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	indicated the dressing was to be changed daily. 2. During an observation of Resident 75, on 03/22/22 at 9:20 a.m., he was found to have a dressing on both lower extremities. The dressings were dated 03/18/22. At that time, Resident 75 indicated he thought the dressings were to be changed daily. On 03/22/22 at 1:48 p.m., LPN 2 viewed the dressing date and verified it was 03/18/22. At that time, she indicated the dressing change was moved to her shift and she would address it after the resident had his lunch. The record for Resident 75 was reviewed on 03/22/22 at 2:05 p.m. Diagnoses included, but were not limited to, type 2 diabetes, paraplegia and chronic heart failure. A physician's order, initiated on 03/01/22, indicated to clean the left lower leg with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an abdominal dressing, wrap with kerlix and to secure it with Coban, in the afternoon for wound care. A physician's order, initiated on 03/01/22, indicated to clean the right lower leg with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an abdominal dressing, wrap with kerlix and to secure it with Coban, in the afternoon for wound care. The Medication and Treatment Administration Record, for March 2022, indicated the dressings/wound care, to both legs, had been completed and signed off on March 19, 20, and 21, 2022.		and documenting those administrations on the MAR/TAR. 4.The following audits and / or observations for all residents will be conducted by the Director of Nursing - 5 times a week for 8 weeks, 3 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: audit MARs to validate the resident medications have been administered and treatments have been completed. Follow up will occur for any missed documentation that is found. Re-education will be completed for any nurse who is non-compliant with documentation. Will follow the plan of correction audit for F 684 to monitor dressing change compliance: The following audits and / or observations for 5 residents will be conducted by the Director of Nursing or designee 5 times a week for 8 weeks, 3 times a week for 8 weeks, then 1 time a week for 8 weeks to ensure compliance: audit of all residents with wound treatments to ensure the last treatment complete was per MD order The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then	

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	An undated physician's order indicated to clean the left great toe with normal saline, pat dry, paint the wound with betadine and leave open to air once a day. There was no documentation in the Medication/Treatment Administration Record for March 14, 2022 or March 15, 2022. An undated physician's order indicated to clean the right dorsal foot with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an abdominal pad, wrap with kerlix and secure with Coban in the afternoon. There was no documentation in the Medication/Treatment Administration Record for March 04, 2022. An undated physician's order indicated to clean the right great toe with normal saline, pat dry, apply calcium alginate to the wound bed and cover with a bandaid in the morning. There was no documentation in the Medication/Treatment Administration Record for March 14 and March 15, 2022. An undated physician's order indicated to give Flomax (a medication for urine retention) 0.4 mg every evening. There was no documentation in the Medication/Treatment Administration Record for March 19, 2022 at 8:00 p.m. An undated physician's order indicated to give Eliquis (a blood thinner) 5 mg twice a day. There was no documentation in the		randomly thereafter for further recommendation	

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	Medication/Treatment Administration Record for March 19, 2022 at 6:00 p.m. An undated physician's order indicated to give Juven (a nutritional powder supplement) twice a day. There was no documentation in the Medication/Treatment Administration Record for March 19, 2022 at 6:00 p.m. An undated physician's order indicated to give guaifenesin (a cough medication) twice a day. There was no documentation in the Medication/Treatment Administration Record for March 19, 2022 at 9:00 p.m. 3. The record for Resident 187 was reviewed on 03/23/22 at 2:22 p.m. Diagnoses included, but were not limited to, pulmonary edema, morbid obesity and polyneuropathy. An undated physician's order indicated to give furosemide (a diuretic) 20 milligrams (mg) once a day in the morning. The order was discontinued on 03/04/22 at 10:45 a.m. There was no documentation in the Medication Administration Record to show if the medication was given, not given or discontinued. An undated physician's order indicated to give pantoprazole (a medication for reflux) 40 mg once a day in the morning. The order was discontinued on 03/04/22 at 10:44 a.m. There was no documentation in the Medication Administration Record to show if the medication was given, not given or discontinued.			

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	An undated physician's order indicated to give simvastatin (a medication for high cholesterol) 40 mg once a day in the morning. The order was discontinued on 03/04/22 at 10:24 a.m. There was no documentation in the Medication Administration Record to show if the medication was given, not given or discontinued. An undated physician's order indicated to give valsartan 80 mg once a day in the morning. The order was discontinued on 03/04/22 at 10:43 a.m. There was no documentation in the Medication Administration Record to show if the medication was given, not given or discontinued. An undated physician's order indicated to apply triad cream to the sacrum every day and evening shift. There was no documentation in the Medication Administration Record to show if the treatment had been completed on March 09, 2022 for the day shift. An undated physician's order indicated to give gabapentin (a medication for neuropathy) 600 mg three times a day. There was no documentation in the Medication Administration Record to show if the medication was given on March 08, 2022 at 12:00 p.m., and March 15, 2022 at 12:00 p.m. An undated physician's order indicated to monitor for pain every shift. There was no documentation in the Medication			

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	Administration Record to show the monitoring was completed on March 09, 2022 on the day shift, March 03, 2022 on the night shift, and March 12, 2022 on the night shift. An undated physician's order indicated to monitor for signs of COVID-19 symptoms. There was no documentation in the Medication Administration Record to show the monitoring was completed on March 03, 2022 on the night shift, March 09, 2022 on the day shift, March 12, 2022 on the night shift, and March 15, 2022 on the day shift. An undated physician's order indicated to give hydralazine (a medication for hypertension) 25 mg every six hours. There was no documentation in the Medication Administration Record to show if the medication was given on March 04, 2022 at midnight, March 08, 2022 at 12:00 p.m., March 13, 2022 at midnight and March 15, 2022 at 12:00 p.m.4. The record for Resident 79 was reviewed on 3/24/22 at 3:15 p.m. Diagnoses included, but were not limited to, fracture of the shaft of right femur, dementia, bipolar disorder, contracture of the right hand, anxiety disorder, hypertension and history of a pulmonary embolism. A physician's order, dated 08/12/21, indicated to give Xarelto 20 mg tablet and was not signed off on the MAR for the following dates: 2/21/22 and 3/8/22 at 5:00 p.m. 5. The record for Resident 81 was reviewed on 03/24/22 at 3:30 p.m. Diagnoses included, but were not limited to, fracture of lower end of right humerus, infection and inflammatory right hip			

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	prosthesis, type 2 diabetes mellitus, atrial fibrillation, biventricular heart failure, depressive disorder, pacemaker and anxiety disorder. A physician's order, dated 09/02/21, indicated to give Eliquis 5 mg tablet and was not signed off on the MAR for the following dates: 02/08/22, 02/14/22 at 8:00 a.m., and 02/07/22, 02/21/22 and 03/08/22 at 8:00 p.m. During an interview, on 03/28/22 at 8:44 a.m., the Director of Nursing indicated she expected medications and treatments to be completed and the nurses were to check documentation to ensure it was completed. A current facility policy, titled "Clinical Documentation Standards," dated 08/31/18 and received by the DON on 03/25/22 at 8:28 a.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. Safety is a primary concern for our residents, staff, and visitors...This facility uses both electronic medical records and paper medical records. A complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual resident is known, and a plan of care has been identified to meet the care needs identified in the medical record...Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record...." This Federal tag relates to Complaints IN00375480 and IN00375882.			

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	3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;			

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	(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.			
	Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infection including the Covid-19 virus, when the	F 0880	**F 880** **1.Corrective actions accomplished for those residents found to be affected**	04/22/2022

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	facility failed to ensure the correct Personal Protective Equipment was used in an isolation room, items from a housekeeping cart brought into an isolation room either remained in the room or were cleaned prior to placing back into use on the cart, failed to ensure hand hygiene was performed before putting on and after removing gloves and failed to ensure a sterile field was kept during a sterile procedure for 5 of 5 randomly observed staff members. (RN 1, Housekeeper 10, Nurse Practitioner, QMA 11 and LPN 2) Findings include: 1. During a random observation, with the Corporate Support Nurse (CSN), on 03/23/22 at 10:24 a.m., RN 1 was observed wearing a surgical mask and putting on an isolation gown. She tied the gown at the back, but did not tie the gown at the neck. She then donned gloves. She was not observed to have performed hand hygiene prior to donning the gloves. She then entered a contact/droplet precaution room. She did not change her mask to an N-95 mask. At that time, the CSN indicated hand hygiene was to be performed prior to donning gloves. During an interview, on 03/23/22 at 10:31 a.m., RN 1 indicated she did not know she needed to tie her gown at both the back and the neck and she should have put on a N-95 Mask. 2. a. On 03/23/22 at 10:34 a.m., Housekeeper 10 exited the isolation room in full Personal Protective Equipment (PPE), and with his gloved hand dipped a cleaning rag he had carried out of the room, into a bucket, on his cart and went back into the room. At 10:35 a.m., he exited the room again, went to his cart and retrieved a dry mop		**by the alleged deficient practice:** RN1, Housekeeper 10, NP, QMA 11 and LPN 2 were immediately educated on the alleged deficient practices. **2.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. 3.The DON or designee will complete the following: Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Policy: USE OF PPE WHILE IN THE FACIITY CDC: PPE sequence Competency: PPE Competency Validation Donning and Doffing Staff involved will be educated, with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene. Follow CDC guidance and facility policy. Ensure Hand Hygiene items, including soap and water or ABHS are available at all times. Policy: General Hand Hygiene Competency: AAPACN Hand	

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	155790	A. BUILDING 00 B. WING	03/28/2022

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	and entered the room. During the observation, on 03/23/22 at 10:37 a.m., Housekeeper 10 exited the room in full PPE and put his dry mop back onto his cart. During an interview, with the Housekeeping Supervisor on 03/23/22 at 11:17 a.m., he indicated Housekeeper 10 was not aware of the protocols in place. b. During the same observation, on 03/23/22 at 10:41 a.m., with the CSN in attendance, the Nurse Practitioner (NP) donned PPE, but kept her surgical mask on, preformed hand hygiene, put on gloves and entered the isolation room. At 10:41 a.m., the NP exited the room wearing the surgical mask. During an interview, on 03/23/22 at 10:43 a.m., the CSN indicated she had told the NP to put on the correct mask for the isolation room. The Housekeeping supervisor had also been notified of the observation with Housekeeper 10. 3. During a medication administration observation, on 03/24/22 at 8:33 a.m., with QMA 11 and the Director of Nursing, the QMA was observed to enter a resident's room, to check the resident's blood pressure, without performing hand hygiene, before or after exiting the room. While QMA 11 was discussing the blood pressure result with the DON, the QMA was observed to touch her mask. She was not observed to perform hand hygiene after touching the mask. The Director of Nursing left the area. At that time, QMA 11 indicated hand hygiene was to be performed after each resident care and after touching a facemask. She indicated her face mask slipped every time she talked and		Hygiene Competency Licensed Nurses will be education on suctioning techniques and sterile procedures Policy: Tracheostomy Suctioning Competency: DON will complete a skills check off with Licensed Nurses **4.Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **5.How the corrective measures will be monitored to ensure the**	

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	the mask fell. The Director of Nursing returned to the area and placed Alcohol Based Hand Rub (ABHR) on the cart.4. During an observation, on 3/23/22 at 10:20 a.m., LPN 2 was suctioning the resident using sterile technique. LPN 2 cleaned the over the bed table and put on gloves, a gown and a face shield without sanitizing or washing her hands. She took her face shield off and put on a N95 mask. She took off her gloves and put on her sterile gloves without sanitizing or washing hands. The LPN used her right hand holding the suction cannula and turned on the suction machine. Without changing her sterile glove, she approached the resident to start suctioning. LPN 2 was stopped and asked if she was going to use the cannula to suction the resident. LPN 2 did not say anything, and the Infection Preventionist told LPN 2 she broke the sterile field and would have to use a new cannula. LPN 2 removed her gloves and without washing her hands, she put on another pair of sterile gloves and began suctioning the resident. After suctioning the resident, LPN 2 removed her gloves and left the resident's room without washing or sanitizing her hands. The record for Resident 66 was reviewed on 03/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, malignant neoplasm of esophagus, hypertension and absence of larynx. A physician's order, dated 02/04/22, indicated to suction the trach for increased secretion's and use sterile technique three times a day and as needed. During an interview, on 03/22/22 at 2:51 p.m., LPN 2 indicated she should have sanitized her hands before putting on gloves and after removing them.		**alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure staff performed hand hygiene at appropriate times, such as before donning/after doffing PPE, after touching facemask, before entering/after leaving a resident room, between glove change. Ensure staff don / doff the correct PPE appropriately before entering / when exiting an isolation room Ensure Licensed Nurses correctly execute suctioning procedure and adhere to sterile procedure	

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	A facility sign posted on the isolation room indicated "...DROPLET/CONTACT...N95 Mask required when entering room..." A current facility policy, titled "Standard Precautions," dated as revised 04/01/17 and received from the Director of Nursing on 3/23/22 at 2"44 p.m., indicated "...the cleaning of hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (that is alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis...It is the policy if the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident's. Practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs...When to perform Hand Hygiene...after contact with blood, body fluids or excretions, mucus membranes...after glove removal...." A current facility policy, titled "USE OF PPE WHILE IN THE FACILITY," dated as updated 03/02/22 and provided by the Director of Nursing on March 23, 2022 at 2:44 p.m., indicated "...EMPLOYEES must wear a surgical mask at all times...Additional source control is required when entering yellow or red rooms..." 3.1-18(b) 3.1-18(l)		2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. Infection Control Practices Ensure staff performed hand hygiene at appropriate times, such as before donning/after doffing PPE, after touching facemask, before entering/after leaving a resident room, between glove change. Ensure staff don / doff the correct PPE appropriately before entering / when exiting an isolation room Ensure Licensed Nurses correctly execute suctioning procedure and adhere to sterile procedure **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	