DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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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 IN00380583, IN00385817 and IN00386765. Complaint IN00380583 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00385817 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00386765 - Unsubstantiated due to lack of evidence. Survey dates: August 7, 8, 9, 10 and 11, 2022. Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 109 Total: 109 Census Payor Type: Medicare: 8 Medicaid: 87 Other: 14 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/15/22.	F 0000	="" p=""> /p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 9/6/22.	
F 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

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	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as			

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	required under this subpart. Based on interview, observation and record review, the facility failed to ensure the resident's dignity was maintained related to the use of a "recycled" palm guard with someone else's name on it. (Resident 6) Finding includes: Interview with Resident 6's sister on 8/8/22 at 3:04 p.m. indicated she was "getting stiff in the left hand". She also indicated that staff had pulled a splint from a deceased roommate and used it on her sister. She had requested new splint when she had met with staff at the annual evaluation on 7/18/22. On 8/8/22 at 3:25 p.m., the resident was observed in bed and her sister was in the room. A palm guard was observed to the resident's left hand with another resident's name written on it in black marker. Record Review for Resident 6 was completed on 8/9/22 at 10:28 a.m.. Diagnoses included, but were not limited to, cerebral infarction (stroke), contracture, and spina bifida (spinal birth defect in which spinal cord fails to develop or close properly). The Admission Minimum Data Set (MDS) assessment indicated the resident had a severe cognitive and physical impairment and required extensive 2+ assistance with bathing, bed mobility, and transferring. Nurse's Notes, dated 7/18/22 at 10:30 a.m., indicated, "Resident has been noted to have a decrease in left hand range of motion. Resident would benefit from OT for splinting and range of	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 6 was given a new palm protector on 8/11/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with physician orders to wear splints have the potential to be affected by alleged deficient practice. Director of Therapy or Designee will ensure that all residents with current physician orders are wearing appropriate splints related to alleged deficient practice. New splints will be provided as needed. Corrections to orders will be made as needed. W**hat measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Executive Director (ED) or Designee will in-service therapy team on proper procedure for issuing splints to residents. Daily observational rounds will be conducted x 4 weeks or until compliance with palm protectors is achieved by the Director of Nursing/Designee.` **How the corrective action(s)**	09/06/2022

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	motion." Occupational Therapy notes, dated 7/18/22 through 8/8/22, indicated therapeutic interventions daily, including the use of a resting hand splint and use of palm guard to maintain the resident's range of motion and functionality. Interview with the Director of Therapy (DOT) on 8/11/22 at 9:16 a.m. indicated Resident 6 was assessed for left hand palm guard and Occupational Therapy trialing of a resting hand splint for 7 hours per day (day shift) on 7/18/22 with a trial period starting the same week. The DOT indicated there were no orders until the trial was complete. There was a care plan meeting on 7/22/22 following the evaluation on 7/18/22 with the resident's sister present and she was satisfied with the plan. A follow up interview and observation with the DOT on 8/11/22 at 10:15 a.m., confirmed the palm guard had another resident's name written on it in black marker. The other resident's name was visibly written on the outside of the palm guard. The DOT indicated the facility usually washed and recycled the palm guards and there should not have been another resident's name on it. 3.1-3(t)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** To ensure ongoing compliance with this corrective action the Director of Nursing (DNS) or Designee will check all splints daily x4 weeks then 3x's/week x4 weeks and then monthly for at least 6 months. If 100% compliance is not achieved and action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
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			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 2 of 7 residents reviewed for non-pressure related skin conditions. (Residents 13 and 77) Findings include: 1. On 8/7/22 at 1:43 p.m., Resident 13 was observed lying in bed. The resident had large dark purple discolorations on the tops of both of his hands. On 8/9/22 at 1:41 p.m., Resident 13 was observed lying in bed. The dark purple discolorations to the tops of both his hands remained. Record review for Resident 13 was completed on 8/8/22 at 2:50 p.m. Diagnoses included, but were not limited to, hypertension, stroke, hemiplegia (partial paralysis on one side of the body), and anxiety. The Significant Change Minimum Data Set (MDS) assessment, dated 5/10/22, indicated the resident had memory problems. The resident required an extensive assist of 2+ people for bed mobility and a limited assist of 1 person for dressing and personal hygiene. A Weekly Skin Assessment, dated 8/8/22, indicated no bruising. The record lacked any documentation to indicate his skin discolorations had been assessed or	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 13 and 77 had head to toe assessments completed by the wound nurse at time of survey and proper documentation and monitoring was put into place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with skin discolorations have the potential to be affected by the alleged deficient practice. DNS of Designee will conduct skin sweeps of all residents to ensure that skin discolorations are being monitored per policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS or Designee will in-service all nursing staff regarding the assessment of skin discoloration, documentation, and monitoring. Monthly skin sweeps will continue per policy. IDT/Designee will review shower sheets and weekly	09/06/2022

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	monitored. Interview with the Wound Nurse on 8/9/22 at 1:44 p.m., indicated she measured resident's discolorations when they were observed. She was unaware he had any discolorations on his hands. Follow up interview with the Wound Nurse on 8/9/22 at 2:25 p.m., indicated she assessed the resident's discolorations and they would be monitored. The nurses should have noticed the discolorations and assessed them.2. On 8/7/22 at 10:11 a.m., Resident 77 was observed to have a purple discoloration and a dressing on the back of her right hand. On 8/8/22 at 2:43 p.m., Resident 77 was observed sitting in her wheelchair. There was a medium sized dark red/purple discoloration between her back of her hand, located on her first finger between her first and second knuckle. There was no dressing observed today. Resident 77's record was reviewed on 8/8/22 at 2:42 p.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and chronic obstructive lung disease. The Quarterly Minimum Data Set assessment, dated 6/21/22, indicated the resident was cognitively impaired. She was a limited, one person assist with dressing, needed supervision with one person assist with eating, toileting and transfers she was an extensive two person assist and for bathing, she was totally dependent with one person assist. A Nurse Progress Note, dated 8/4/22 at 10:53 a.m., indicated the resident had fallen in a another		assessments for identification of new discolorations in clinical meeting daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “wounds and skin management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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resident's room. A full assessment was competed and no redness or bruising noted.

The Follow Up Nurse Progress Notes, dated from 8/4/22 at 9:29 p.m. through 8/6/22 at 1:47 p.m., did not indicate any skin discolorations.

The resident's Shower Report, dated 8/5/22 at 6-2 (no specific time noted), noted that she had a purple/blue bruise with no new concerns and there was bruising on both hands. The CNA had initialed and signed the shower report, the Charge Nurse signature area was blank.

A bathing task was completed in the computer as the resident was totally dependent on staff for bathing on 8/7/22 at 11:15 p.m.

Interview with the Wound Nurse on 8/9/22 at 3:30 p.m., indicated she was aware that the resident had fallen. She had not been notified of any discolorations.

A Nurse Progress Note, dated 8/10/22 at 12:55 p.m., indicated the resident had bruising noted to the back of both of her hands. The areas were dark red/purple in color.

A Wound Management Note, dated 8/10/22 at 1:06 p.m., indicated the resident had a bruise on the back of her right hand on her right pointer finger between the first and second knuckles, with a description of the size of 2 by 1.5 cm (centimeters), and purple/red discoloration. Also on the back of her right hand, a 2 by 2 cm, purple/red bruise was observed.

Interview with the Wound Nurse on 8/10/22 at 1:15 p.m., indicated the resident's hands were assessed. Bruising was noted and document on

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	her hands . No one had told her about the discolorations and they should have been noted in Nurse Progress Notes as well for her follow-up post a fall. A policy titled, "Skin Management Program," was provided on 8/9/22 by the Director of Nursing. This current policy indicated, "....Procedure for Wound Prevention:...6. Any skin discolorations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible or assessing all skin alterations by the direct caregiver the shift reported....Procedure for alterations in skin integrity--pressure and non-pressure,...5. The wound nurse/designee will be notified of alterations in skin integrity...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent			

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	new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure dietician recommendations were implemented and had follow up for 1 of 6 residents reviewed for pressure ulcers. (Resident 41) Finding includes: On 8/7/22 at 10:50 a.m., Resident 41 was observed lying in bed with her eyes closed. She had an air mattress in place to her bed and pressure offloading boots on her feet. Record review for Resident 41 was completed on 8/9/22 at 3:05 p.m. Diagnoses included, but were not limited to, stage IV sacral pressure ulcer, hypertension, and type 2 diabetes mellitus. The Significant Change Minimum Data Set (MDS) assessment, dated 6/6/22, indicated the resident had one stage IV pressure ulcer and two stage II pressure ulcers. A Care Plan, updated 6/20/22, indicated the resident had increased nutrient needs due to skin impairment. The interventions included, to provide supplementation to aid in wound healing as ordered. The most recent Wound Management Pressure Ulcer Assessments, dated 8/8/22, indicated the resident had a stage II pressure ulcer to the bottom of her left foot measuring 1.3 cm (centimeters) x 0.5 cm x 0.1 cm. She also had a stage IV pressure ulcer to her sacrum measuring 3.8 cm x 3.0 cm x 0.2 cm. A Registered Dietician (RD) Review Note, dated 6/9/22 at 12:34 p.m., indicated the resident had	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 41 continued on the Juven per physician order on 8/9/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with pressure ulcers have the potential to be affected by the alleged deficient practice. All residents with pressure ulcers will have physician orders related to dietician recommendations reviewed by DNS/Designee for accuracy. Corrections will be made as necessary. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS or Designee will in-service nursing staff regarding the policy for dietician recommendations. New dietary recommendations/orders will be reviewed daily by DNS/Designee for implementation. **How the corrective action(s) will be monitored to ensure the**	09/06/2022

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	pressure ulcers and recommended starting active liquid protein 30 milliliters twice a day. A Progress Note, dated 6/24/22 at 2:42 p.m., indicated a Physician's Order was received to discontinue Juven (a wound healing supplement) and begin active liquid protein. The Medication Administration Record (MAR), dated 6/2022, lacked documentation the active liquid protein had been implemented. Interview with the Director of Nursing on 8/10/22 at 10:12 a.m., indicated the Juven had been discontinued but she could not find that any Physician's Order had been entered for the active liquid protein and it was not started. 3.1-40(a)(2)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** To ensure ongoing compliance with this corrective action the RD/Designee will be responsible for completing the QAPI Audit tool “dietician recommendations” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence			

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	unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure palm protectors were in place as ordered for 2 of 3 residents reviewed for limited range of motion. (Residents 31 and 25) Findings include: 1. On 8/7/22 at 1:13 p.m., Resident 31 was observed lying in bed. The resident's left hand was in a fist. No palm protector or splint was observed. On 8/8/22 at 2:50 p.m., Resident 31 was observed lying in bed. The resident' left hand was in a fist. No palm protector or splint was observed. On 8/9/22 at 9:13 a.m., Resident 31 was observed lying in bed. The resident's left hand was in a fist. No palm protector or splint was observed on the resident. Record review for Resident 31 was completed on 8/8/22 at 3:14 p.m. Diagnoses included, but were not limited to, anemia, hypertension, hemiplegia (partial paralysis on one side of body), and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/27/22, indicated the resident was cognitively moderately impaired. The resident required a total 2+ assist for bed mobility, and toilet use. He required a total 1 assist for dressing and personal hygiene. The resident had an impairment on both sides of his upper and lower extremities for a functional limitation in range of motion.	F 0688	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 31 and Resident 25 had palm protectors in place on 8/10/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who have physician orders for palm protectors have the potential to be affected by the alleged deficient practice. Director of Therapy or Designee will ensure that all residents with current physician orders for palm protectors have them in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff will be in-serviced on ROM and mobility including applying palm protectors as ordered. Daily observational rounds will be conducted x 4 weeks or until compliance with palm protectors is achieved by the DNS/Designee. **How the corrective action(s)**	09/06/2022

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	A Care Plan, dated 11/22/10 and revised on 5/23/22, indicated the resident required assistance with bed mobility, transfers, eating and toilet use due to impaired mobility, diagnosis of left hemiplegia, contractures of hand and feet, dementia, chronic pain, depression, and muscle weakness. An intervention included for a left hand palm protector with finger separators at all times. It may be removed for hygiene. The August 2022 Physician's Order Summary indicated an order for: - palm protector with finger separator to be worn at all times except during hygiene care Interview with LPN 2 on 8/9/22 at 9:16 a.m., indicated the resident should have his palm protector in place. She went into the resident's room and removed the palm protector from the closet and tried to place it on the resident's hand. She indicated the palm protector did not fit very well and she could not get it in between his fingers. She would let therapy know so they could evaluate the palm protector.2. On 8/8/22 at 10:00 a.m., Resident 25 was observed lying in bed. Both hands were closed in fists and arms were crossed over his chest. There were no palm protectors in place. On 8/9/22 at 10:22 a.m., Resident 25 was observed lying in bed. His arms were at his sides and both hands were closed in fists. There were no palm protectors in place. The resident's record was reviewed on 8/9/22 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and unspecified joint contractures. The Quarterly Minimum Data Set (MDS)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** To ensure ongoing compliance with this corrective action the Director of Nursing (DNS) or Designee will check all splints daily x4 weeks then 3x's/week x4 weeks and then monthly for at least 6 months. If 100% compliance is not achieved and action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	155166	A. BUILDING 00 B. WING	08/11/2022

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	assessment, dated 5/23/22, indicated the resident was cognitively impaired. He required staff assistance for all activities of daily living (ADLs) and had impaired range of motion on both sides to both the upper and lower extremities. The Occupational Therapy Discharge Summary, dated 2/18/22, indicated the resident had received therapy for upper extremity positioning and splint training. Right hand edema had been controlled using positioners to elevate the upper extremity and staff had been instructed on using a palm guard to preserve skin and joint integrity. A Physician's Order, dated 4/20/22, indicated the resident was to wear a right palm protector at all times. Interview with LPN 5 on 8/9/22 at 10:47 a.m., indicated the right palm protector was not in place. She had been looking for it but hadn't found it yet. A facility skills validation, titled, "Splinting Device-Application", received as current from the Director of Nursing, indicated "...6. Apply splint according to therapy recommendations and/or aide assignment sheet..." 3.1-42(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			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 4 residents reviewed for oxygen. (Resident 13) Finding includes: On 8/7/22 at 1:43 p.m., Resident 13 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate in between 1 and 1.5 liters. On 8/8/22 at 3:03 p.m., Resident 13 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate in between 1 and 1.5 liters. Record review for Resident 13 was completed on 8/8/22 at 2:50 p.m. Diagnoses included, but were not limited to, hypertension, stroke, hemiplegia (partial paralysis on one side of the body), and anxiety. The Significant Change Minimum Data Set (MDS) assessment, dated 5/10/22, indicated the resident had memory problems. The resident required an extensive assist of 2+ people for bed mobility and a limited assist of 1 person for dressing and personal hygiene. The resident received oxygen therapy. A Care Plan, dated 6/21/22 and revised on 8/5/22, indicated the resident required hospice care related to end of life. An intervention included for oxygen as ordered.	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 13 had oxygen flow rate adjusted to 2 liters on 8/8/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with physician orders for oxygen have the potential to be impacted by this deficient practice. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit will be reviewed and ensure administration of oxygen per physician order. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS/Designee will in-service nursing staff on policy for Oxygen Therapy and Devices. Daily observational rounds will be conducted x 4 weeks or until compliance with palm protectors is achieved by the Director of	09/06/2022

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	The August 2022 Physician's Order Summary indicated and order for: - Oxygen at 2 liters per nasal cannula every shift Interview with LPN 1 on 8/8/22 at 3:05 p.m., indicated the resident's oxygen should be set at 2 liters and she would go and correct the flow rate. A facility policy titled, "Oxygen Therapy and Devices" and received as current from the Director of Nursing on 8/9/22, indicated, "...Initiation of Oxygen 1. Verify Physician order 7. Apply device to the patient with appropriate liter flow...." 3.1-47(a)(6)		Nursing/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “oxygen therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was properly stored under sanitary conditions in the freezers and refrigerators in the Kitchen. (Main Kitchen) Findings include: During the initial tour of the kitchen on 8/7/22 at 9:30 a.m. with the Cook, the following was observed: 1. Walk in Cooler/Refrigerator: - 3 boxes of food were stored stacked up to the ceiling from the top shelf - fresh oregano was stored in an open, plastic bag underneath and up against the cooling fan, the bag was warm to touch. 2. Freezer: - 4 boxes were stored stacked up to the ceiling from the top shelf Interview with the Cook at the time of the observation indicated food items were to be stored 6" from ceiling/sprinklers in storage areas, such as dry storage, refrigerators and freezers. Per the facility's Food Storage policy, revised on	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Items were stored properly on 8/8/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that receive food from the facility have the potential to be affected by alleged deficient practice. All areas where food is stored will be audited to ensure products are being stored per policy. Corrections will be made as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Culinary Manager/Designee will in-service all culinary staff on Food	09/06/2022

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	6/21/22 and received on 8/10/22 as current from the Administrator, food should be stored a minimum of 6" from the floor and 18" below sprinkler heads, overhead pipes, or other contamination. 3.1-21(i)(3)		Storage Policy. Daily observational rounds will be conducted x 4 weeks or until compliance with food storage by Culinary Manager/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** To ensure ongoing compliance with this corrective action, Culinary Manager will complete AM Walk Through audits daily x4 weeks, then weekly x4 weeks and monthly for at least 6 months. If 100% compliance is not achieved, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following			

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	elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based 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			

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	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 a random observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19 related to the use of personal protective equipment (PPE) in an isolation room. (South Hall, Activity Aide 1) Finding includes: During a random observation on 8/8/22 at 9:18 a.m., Activity Aide 1 entered Resident 44's room to deliver a newspaper. The Activity Aide was only wearing a surgical mask. At that time, a sign on the resident's door indicated "Droplet/Contact Isolation. Proper Personal Protective Equipment (PPE): an isolation gown, protective eye wear, a N95 face mask and gloves to both hands before entering." There was also a PPE bin located right outside the door. Interview with Activity Aide 1 at that time, indicated she was unaware the resident was in	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Activity aide was immediately educated on proper infection control practice regarding when to don and doff PPE. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents at the facility have the potential to be affected by alleged deficient practice. The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation, and QA	09/06/2022

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	isolation and did not see the signage on the door. Interview with the Infection Preventionist on 8/8/22 at 9:21 a.m., indicated Resident 44 had tested positive for COVID-19 that morning and was placed in isolation. The aide should have put on the appropriate PPE before entering the room to deliver the newspaper. An updated and current facility policy titled, "Resident Policy for COVID-19", and received from the Director of Nursing on 8/10/22, indicated, "...Residents Suspected, or Confirmed with COVID-19 1. Upon resident identified as close contact or presenting with symptoms of COVID-19 the physician will be notified for resident assessment which will include COVID-19 testing and orders should be received for Droplet/Contact Precautions until further observation and evaluation...." 3.1-18(b)		tools. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the “PPE” observational rounds tool to observe for proper PPE donning prior to entering an isolation room. The consultant IP will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. PPE observation tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. The IP/designee will be responsible for the completion of the “Infection Control” QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months	

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			the QAPI committee will re-evaluate the continued need for the audit.	