STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155523	A. BUILDING 00 B. WING	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 STATE ROAD 46 ELLETTSVILLE, IN 47429

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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 IN00407899 and IN00408310. Complaint IN00407899 - No deficiencies related to the allegations are cited. Complaint IN00408310 - Federal/State deficiencies related to the allegations are cited at F755. Survey dates: May 16, 17, 18, 19, and 22, 2023 Facility number: 000558 Provider number: 155523 AIM number: 100267550 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 2 Medicaid: 46 Other: 8 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 25, 2023.	F 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.***	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

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

Jacqueline Routt 06/16/2023

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

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	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the written Notice of Transfer or Discharge was given to the resident and the resident representative for 4 of 6 residents reviewed for hospitalization. (Resident 25, Resident 15, Resident 42 and Resident 35) Findings include: 1. On 5/16/23 at 3:00 p.m., Resident 25's clinical record was reviewed. The diagnosis included, but was not limited to, encephalopathy (a disease of the brain). Resident 25's progress notes indicated the resident was sent to the hospital on 3/24/23. The clinical record lacked documentation of written Notice of Transfer or Discharge forms being provided to the resident and the resident representative. During an interview on 5/19/23 at 11:50 a.m., the Administrator indicated the Notice of Transfer or Discharge forms were not sent to the resident	F 0623	F623 1. Immediate action taken Resident numbers 25,15,35, and 42 all returned to the facility with no barriers presented. Resident and or responsible parties identified, have all been informed of their transfer and or discharge writes in written and verbal form as of 6/12/2023. 2. How the facility identified other similar concerns Any resident who transfers or discharges from the facility can be affected by the alleged deficient practice. A facility wide audit was completed on 6/9/2023 to identify the need for further notification. All residents are to be informed of the Discharge and or Transfer policy during the resident council meeting scheduled on 6/29/2023. 3. Measures put into place/	06/23/2023

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	representatives in writing and they had not kept a copy of the forms that would have went with the resident to the hospital. 2. On 5/18/23 at 10:51 a.m., Resident 15's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 8/12/22, 9/2/22, 1/17/23, and 2/13/23. There was no documentation the resident or resident's representative had been provided the written Notice of Transfer or Discharge. During an interview on 5/22/23 at 2:41 p.m., the Executive Director indicated the Notice of Transfer or Discharge had been provided to the resident when he was sent to the hospital. 3. On 5/19/23 at 10:25 a.m., Resident 35's clinical record was reviewed. The diagnoses included, but were not limited to, left hip fracture and dementia. Resident 35's progress note, dated 3/27/23 at 9:10 p.m., indicated she was found on the floor laying on her left side. She was sent to the emergency room for an evaluation. The clinical record lacked documentation of a Notice of Transfer or Discharge for the transfer on 3/27/23. 4. On 5/18/23 at 2:00 p.m., Resident 42's clinical record was reviewed. The diagnoses included, but were not limited to, right hip fracture and vascular dementia. Resident 42's progress note, dated 2/28/23 at 11:36 a.m., indicated she was sent to hospital for an evaluation of right hip. The clinical record lacked documentation of a Notice of Transfer or Discharge for the transfer on 2/28/23.		system changes All Licensed nursing staff were re-educated with an in-service on the Discharge and or Transfer forms and use by the DON/ADON on 5/23/2023. Residents will be provided with a copy of the transfer and discharge policy upon all transfers and/or discharges by licensed nurses or designee. 4. How the corrective action will be monitored DON or designee will complete a random audit of all transferred and or discharged residents to ensure the policy has been provided. The audit will be completed 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 time a week for 4 weeks, then monthly x 3 months to ensure substantial compliance. Any concerns noted will b The results of the audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	On 5/22/23 at 3:05 p.m., the Executive Director provided the facility policy, "Notice of Transfer or Discharge Policy," dated 4/30/20 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."1. Before the resident is transferred or discharged, Social Service or a designee will notify the resident and resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...7. A copy of the notice of transfer or discharge will be kept in the resident's medical record...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)			

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	(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 4 of 6 residents reviewed for hospitalization. (Resident 25, Resident 15, Resident 42 and Resident 35) Findings include: 1. On 5/16/23 at 3:00 p.m., Resident 25's clinical record was reviewed. The diagnosis included, but was not limited to, encephalopathy (a disease of the brain). Resident 25's progress notes indicated the resident was sent to the hospital on 3/24/23. The clinical record lacked documentation of the written notification that specified the facility's bed-hold policy were provided to the resident or the resident representative. During an interview on 5/19/23 at 11:50 a.m., the Administrator indicated the bed-hold policy forms were not sent to the resident representatives in writing and they had not kept a copy of the forms that would have went with the residents to the hospital. 2. On 5/18/23 at 10:51 a.m., Resident 15's clinical record was reviewed. The progress notes indicated the resident was sent to the hospital on 8/12/22, 9/2/22, 1/17/23, and 2/13/23.	F 0625	F625 1. Immediate action taken Resident numbers 25,15,35, and 42 all returned to the facility with no barriers presented. Resident and or responsible parties identified, have all been informed of the bed hold policy in written and verbal form as of 6/12/2023. 2. How the facility identified other similar concerns Any resident who discharges from the facility has the potential to be affected by the alleged deficient practice. A facility wide audit was completed on 6/9/2023 to identify the need for further notification. All residents are to be informed of the Bed Hold policy during the resident council meeting scheduled on 6/29/2023. 3. Measures put into place/ system changes All Licensed nursing staff were re-in serviced on the Bed Hold policy on 5/23/23. Licensed nursing staff or designee will provide a copy of the Bed Hold policy upon all transfers and or discharges.	06/23/2023

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	Review of the resident's clinical record revealed no documentation that a written notice that specified the facility's bed-hold policy permitting the resident to return and resume resident in the facility was provided to the resident or resident's representative. During an interview on 5/22/23 at 2:41 p.m., the Executive Director indicated the bed-hold policy was sent to the hospital with the resident. 3. On 5/19/23 at 10:25 a.m., Resident 35's clinical record was reviewed. The diagnoses included, but were not limited to, left hip fracture and dementia. Resident 35's progress note, dated 3/27/23 at 9:10 p.m., indicated she was found on the floor laying on her left side. She was sent to the emergency room for an evaluation. The clinical record lacked documentation of the bed hold policy was provided to the resident or the resident's representative. 4. On 5/18/23 at 2:00 p.m., Resident 42's clinical record was reviewed. The diagnoses included, but were not limited to, right hip fracture and vascular dementia. Resident 42's progress note, dated 2/28/23 at 11:36 a.m., indicated she was sent to the hospital for an evaluation of right hip. The clinical record lacked documentation of the bed hold policy was provided to the resident or the resident's representative. On 5/22/23 at 3:05 p.m., the Executive Director provided the facility policy, "Bed Hold," dated 4/29/22 and indicated this was the policy currently		4. How the corrective action will be monitored DON or designee will complete a random audit of all transferred and or discharged residents to ensure the Bed Hold policy has been provided. The audit will be completed 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 time a week for 4 weeks, then monthly x 3 months to ensure substantial compliance. The results of the audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	being used by the facility. A review of the policy indicated..."2. A copy of the facility Bed Hold Policy Review and Notice will be provided to the resident and/or resident representative at the time of transfer or in cases of emergency transfer, within 24 hours. Attempts to notify the resident representative will be documented in the progress notes in cases where the facility was unable to notify the representative...." 3.1-12(a)(25) 3.1-12(a)(26)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set assessment for 1 of 18 residents reviewed in the final sample. A diuretic medication and contractures were inaccurately coded. (Resident 39) Findings include: During an observation on 5/18/23 at 9:55 a.m., Resident 39 was observed to be lying in bed. She had contractures (stiffness) of the right and left hand. Resident 39 was able to open the right hand but not the left. Resident 39's clinical record was reviewed on 5/22/23 at 12:11 p.m. The diagnosis included, but was not limited to, Parkinson's disease. Resident 39's Quarterly Minimum Data Set (MDS) assessment, dated 4/24/23, lacked documentation of the resident taking a diuretic during the 7 day	F 0641	F641 1) Immediate actions taken for those residents identified: Resident 39's assessment was modified and submitted to CMS. 2) How the facility identified other residents: Residents residing in the facility have the potential to be affected by the alleged deficient practice. 10% of MDS (Minimum Data Set) submissions in the last 30 days have been audited for accuracy; any discrepancies identified have been corrected and re-submitted to CMS. 3) Measures put into place/System changes: In-service was provided to the MDS coordinator on 6/15/2023 to ensure accuracy of all assessments prior to submission.	06/23/2023

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	look back period of 4/18/23 through 4/24/23. The MDS assessment indicated the resident had no impaired mobility to the hands. Current physician orders, dated 5/22/23, indicated Resident 39's orders included, but were not limited to, furosemide (a diuretic) 20 mg (milligrams) 1 tablet once a day. A review of the Medication Administration Record (MAR) for Resident 39 indicated the resident was given a diuretic during the 7 day look back period of 4/18/23 through 4/23/23. During an interview on 5/22/2023 at 12:01 p.m., the MDS nurse indicated the MDS was coded in error for Resident 39's not taking a diuretic and for not having an impairment to the hands. Both of those should have been coded Yes. During an interview on 5/22/23 at 2:51 p.m., the Administrator indicated the facility does not have a policy on the MDS. They use the RAI (Resident Assessment Instrument) manual. A review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, Section N0410G indicated, "... Diuretic: Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) and, Section G0400A indicated, ... Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury ..." 3.1-31(d)		4) How the corrective actions will be monitored: The DON/Designee will complete an audit of 10% of MDS submission weekly x 6 months to ensure submissions are accurate and coded correctly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure drug records were in order, and an account of controlled drugs was maintained for 1 of 3 residents reviewed for pharmaceutical	F 0755	F755 1. Immediate actions taken for those residents identified Resident B's narcotic	06/23/2023

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	services.(Resident B) Findings include: On 5/18/23 at 11:40 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, necrotizing facscitis and osteomyelitis. A an open ended physician's order with a start date of 4/18/23, indicated the resident was prescribed hydrocodone-acetaminophen (an opioid analgesic) 7.5-325 mg (milligrams) as needed every 4 hours for pain. The controlled drug record for 4/19/23 through 5/3/23 indicated hydrocodone-acetaminophen 7.5-325 mg was dispensed for administration on the following dates and times: - 4/22/23 at 10:00 a.m., 5:00 p.m., and 9:15 p.m. - 4/23/23 at 12:30 a.m., 6:00 a.m., and 8:00 p.m. - 4/24/23 at 12:30 a.m., 4:30 a.m., 10:30 a.m., 4:00 p.m., and 8:00 p.m. - 4/25/23 at 12:30 a.m., 5:00 a.m., and 8:00 p.m. - 4/27/23 at 12:00 a.m. and 11:15 a.m. The MAR (Medication Administration Record) for 4/1/23 through 4/30/23 indicated hydrocodone-acetaminophen 7.5-325 mg was administered on the following dates and times: - 4/22/23 at 9:20 a.m. and 5:12 a.m. - 4/23/23 at 6:19 a.m. and 8:57 a.m. - 4/24/23 at 10:31 a.m. and 3:48 a.m. - 4/25/23 no administrations - 4/27/23 at 11:22 a.m. There was a discrepancy between the controlled drug record and the MAR for 8 doses of		administration is currently being documented appropriately on both the EMAR and the narcotic count sheet. 2. How the facility identified other residents Any resident who receives controlled substances has the potential to be affected by the alleged deficient practice. Audit was completed on residents who receive a controlled substance to ensure documentation was completed and accurate. 3. Measures put into place/System changes: DON/ADON re-educated licensed staff on 5/23/2023 with emphasis on documentation required when administering a controlled substance. DON/ADON will ensure documentation is complete and accurate on controlled substance administration. 4. How the corrective actions will be monitored: DON/Designee will complete a random audit of 3 residents 5 days a week for 4 weeks, then 3 residents 3 days a week for 4 weeks, then 3 residents weekly for 4 weeks, then 3 residents monthly x 3 months to ensure documentation is completed and accurate for controlled substance administration. The results of these audits will be reviewed in Quality Assurance	

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	hydrocodone-acetaminophen 7.5-325 mg, indicating 8 dispensed doses were not administered to the resident and were unaccounted for. During an interview on 5/22/23 at 11:20 a.m., the Executive Director indicated there was a discrepancy between the controlled drug record and the MAR that indicated 8 dispensed doses of the medication were unaccounted for and were not administered to the resident or not documented as being administered to the resident. On 5/22/23 at 3:00 p.m., the Executive Director provided the Medication Administration Controlled Substances policy, undated, and indicated this was the policy used by the facility. A review of the policy indicated, "...current controlled medication accountability records and audit records are kept by the facility...any discrepancy in a controlled substance medication is reported to the Director of Nursing immediately. The Director of Nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies...if a major discrepancy or pattern of discrepancies occurs or if there is apparent criminal activity, the Director of Nursing notifies the Administrator..." This Federal tag relates to Complaint IN00408310. 3.1-25(b)(3)		Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The			

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	facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility failed to ensure STAT X-ray was completed timely for 1 of 3 residents reviewed for accidents. (Resident 35) Findings include: On 5/19/23 at 10:25 a.m., Resident 35's clinical record was reviewed. The diagnoses included, but were not limited to, left hip fracture and dementia. A Fall Event, dated 3/26/23 at 6:50 a.m., indicated Resident 35 had a witnessed fall. She tripped on the floor. She didn't sleep well and had been pacing the hallway. She "bumped" into the laundry barrel then tripped. Resident's 35 progress notes indicated the following: - On 3/26/23 at 9:20 p.m., Resident 35 was limping on her left leg and was complaining of left groin pain. An X-ray of the left hip and pelvis was requested. - On 3/27/23 at 6:30 a.m., Resident 35 was changed due to incontinence. She was observed to be "yelling" due to pain. She was awaiting the a stat hip X-ray.	F 0776	F776 Radiology/ Other Diagnostic Services 1. Immediate action taken for those residents identified The medical director was notified of Resident 35's clinical condition and the resident was transferred to the hospital for evaluation and treatment. 2. How the facility identified other residents. Any resident who requires radiology services has the potential to be affected by the alleged deficient practice. A facility wide audit was conducted to determine the timeliness of radiology services and no other findings were noted. 3. Measures put into place/System changes: Facility licensed staff were re-educated on 5/23/23 concerning the need to notify the MD for further instruction if STAT x-rays cannot be obtained within the recommended time frame set forth by the radiology provider.	06/23/2023

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	The Radiology Order, dated 3/26/23 at 9:54 p.m., indicated STAT-Immediately X-ray of left hip and pelvis. The Radiology Report of the left hip, dated 3/27/23 at 2:10 p.m., indicated acute left hip fracture. Resident 35's progress notes lacked documentation of physician being notified of STAT X-ray not being completed within 2 hours of being order and how to proceed. During an interview on 5/19/23 at 2:26 p.m., the Executive Director (ED) indicated a STAT X-ray should be completed within two hours. If the X-ray technician could not get to the facility within 2 hours, the facility would need to call the physician to see how to proceed. The clinical record lacked documentation of notification the physician of the STAT x-ray not being completed within the 2 hours and how to proceed. On 5/22/23 at 3:05 p.m., the ED provided the facility's policy, "Laboratory & Radiology Services and Reporting," dated 2/1/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...3. Urgent services will be ordered STAT by the practitioner...b. Typically, 4-5 hours for collection and results to be provided to the community...v. If services cannot be completed and results received timely related to policy/contract the practitioner will be notified for additional orders on how to proceed..." 3.1-49(g)		The Licensed staff will ensure that the Medical Director is notified of any delay in radiology services for further instruction. 4. How the corrective action will be monitored; DON or designee will complete a random audit of 3 residents for timeliness of STAT x rays with MD follow up of 3 days a week x 4 weeks, then two days a week x 4 weeks, then one day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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

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	(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 implement infection control practices for 1 of 3 residents reviewed for urinary catheters. A urinary catheter drainage bag and tubing was on the floor. (Resident 25) Findings include:	F 0880	F880 Infection control 1. Immediate action taken for those residents identified Resident 25's urinary catheter bag was replaced upon identification and secured to the wheelchair in a manor to adhere to the infection control practice.	06/23/2023

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	On 5/16/23 at 12:42 p.m., Resident 25 was observed to be up in a wheelchair while the urinary catheter drainage bag sat on the floor. On 5/16/23 at 2:24 p.m., Resident 25 was observed to be rolling in the hallway in a wheelchair while the urinary catheter drainage bag was dragging on the floor. On 5/19/23 at 9:34 a.m., Resident 25 was observed to be up in a wheelchair while the urinary catheter tubing sat on the floor. On 5/22/23 at 9:34 a.m., Resident 25 was observed to be up in a wheelchair while the urinary catheter tubing sat on the floor. Resident 25's clinical record was reviewed on 5/16/23 at 3:00 p.m. The diagnoses included, but were not limited to, acute kidney failure and obstruction and reflux uropathy. Current physician orders, dated 5/22/23, indicated Resident 25's orders included, but were not limited to: catheter size 16 FR (french) 10 cc (cubic centimeter), present for obstruction and reflux uropathy. A care plan, initiated on 5/19/23, and current through target date 8/19/23, for Resident 25 indicated, "... Problem: Indwelling Catheter ... Goal: will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection ... avoid placing bag or tubing on floor ..." During an interview on 5/22/23 at 11:59 a.m., the Social Services Director indicated the urinary catheter drainage bag and tubing should not be		2. How the facility identified other residents. Any resident with a foley catheter has the potential to be affected by the alleged deficient practice. A facility wide audit was conducted for all residents that have foley catheter to ensure that the bag and tubing was secured in a manner that would prevent deficient infection control practices. No other findings were identified at this time. 3. Measures put into place/System changes: Direct Care staff were re-educated on the infection control practice with emphasis on foley catheter care and placement. 4. How the corrective action will be monitored: he DON or designee will complete a random audit of all catheter bags to ensure they a properly secured to prevent deficient infection control practices 3 days a week x 4 weeks, then two days a week x 4 weeks, then one day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	on the floor. On 5/22/23 at 3:05 p.m., the Administrator provided the untitled facility policy, undated, and indicated it was the policy currently being used by the facility for catheter care. A review of the policy did not indicate keeping the urinary catheter drainage bag and tubing off of the floor. 3.1-18(b)(1)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure an environment in good repair for 7 of 10 residents reviewed for environment. Wheelchair arm pads and window curtains were in disrepair. (Resident 5, Resident 23, Resident 25, Resident 32, Resident 44, Resident 53, and Resident 50) Findings include: 1. On 5/18/23 at 1:25 p.m., Resident 44 was observed in her room in her wheelchair. The covering on the left wheelchair armpad was cracked, revealing the underlying white padding. 2. On 5/18/23 at 2:40 p.m., Resident 53 was observed in his room in his wheelchair. The covering on both wheelchair armpads was cracked, revealing the underlying white padding. 3. On 5/19/23 at 2:10 p.m., Resident 5 was observed sitting in the resident lounge in his wheelchair. There was no right arm pad on the	F 0921	F921 Safe/ Functional/ Sanitary/ Comfortable Environment 1. Immediate actions taken for those residents identified New arm rests and/ or window coverings for residents 5, 23, 25, 32,44,53, and 50 have been ordered for replacement. 2. How the facility identified other residents; A facility wide audit has been conducted on all resident wheelchairs and window coverings to ensure 100% compliance. Other identified window coverings and wheelchair arm rests have been ordered for replacement for those identified. 3. Measures put into place/ system changes The Maintenace Director was re-educated on ensuring the residents environment is in good	06/23/2023

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	wheelchair, and the resident was resting his arm on the metal bar where the pad should have been. 4. On 5/16/23 at 12:20 p.m., the window curtains in the room of Resident 23 and Resident 32 were observed to have tears in them. 5. On 5/16/23 at 2:20 p.m., the window curtains in the room of Resident 50 were observed to have tears in them. 6. On 5/17/23 at 3:14 p.m., the window curtains in the room of Resident 25 were observed to have tears in them. During an interview on 5/22/23 at 1:50 p.m., the Executive Director indicated the wheelchair pads and window curtains were in need of repair. On 5/22/23 at 3:00 p.m., the facility Executive Director provided the Indiana Residents Rights, dated 4/1/20, and indicated these were the resident's rights currently used by the facility. A review of the policy indicated, "...you have the right to a safe, clean, comfortable, and homelike environment..." 3.1-19(f)		repair with emphasis on wheelchair arm pads and window coverings. 4. How the corrective action will be monitored; The Maintenance Director or designee will randomly audit 5 wheelchairs and 3 window coverings, 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 x a week for 4 weeks then monthly x 3 months to ensure substantial compliance. Any concerns noted will be addressed and corrected. Results of the audit will be reviewed at the monthly QAPI meetings. Action Plan will be written by the QAPI committee, if any patterns/ trends/ noncompliance identified The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	