| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00430614.<br><br>Complaint IN00430614 - No deficiencies related to the allegations are cited.<br><br>Survey dates: May 8, 9, 10, 13, 14, and 15, 2024.<br><br>Facility number: 000449<br>Provider number: 155568<br>AIM number: 100290350<br><br>Census Bed Type:<br>SNF/NF: 50<br>Total: 50<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 37<br>Other: 11<br>Total: 50<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 30, 2024. | F 0000 | | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>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. | | | |

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

Sheila Huskey | Executive Director | 06/14/2024

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | §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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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 required under this subpart.<br>Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity for 1 of 1 resident reviewed for dignity (Resident 4).<br><br>Findings include: | F 0550 | **F 550 Resident Rights/Exercise of Rights**<br>It is the practice of this facility to ensure residents are treated with dignity and respect.<br>**What corrective action(s) will** | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | During a dining observation on 5/8/24 at 11:50 a.m., the Speech Language Pathologist (SLP) was observed to be standing at Resident 4's left side, assisting him with eating and drinking. She was not observed to sit down while assisting him.<br><br>Resident 4's record was reviewed on 4/15/24 at 11:21 a.m. His diagnoses included, but were not limited to, paraplegia (loss of muscle function in the lower body), lack of coordination (poor muscle control), contracture of muscles (permanent shortening of a muscle causing deformity), abnormal posture (involuntary abnormal position of the body), and mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions).<br><br>A comprehensive care plan, last reviewed 5/13/24, indicated resident had a problem with activities of daily living (ADL) that started 1/19/23 and needed assistance with ADL's, including eating, with an intervention approach to assist resident with eating as needed.<br><br>During an interview on 5/15/24 at 11:50 a.m., the Director of Nursing (DON) indicated that on 5/8/24, during lunch, Resident 4 was receiving his quarterly screening to determine if there was a need for therapy services. When he was being assisted with eating it was not a swallow study and if anyone was assisting him with eating, she hoped that they would be sitting in a chair like they would with normal assisting. She indicated that the SLP answers should not be any different.<br><br>During an interview on 5/15/24 at 1:15 p.m., the SLP indicated when she completed quarterly evaluations, she would occasionally assist residents with eating and drinking and she would | | **be accomplished for those residents found to have been affected by the deficient practice:**<br>Psychosocial assessment completed on Resident 4 without any findings. Staff are sitting down when providing assistance with eating.<br>**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:**<br>Any resident receiving assistance with meals has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents that require assistance with meals. All residents identified in this audit will be reviewed and ensure that staff are sitting while assisting residents at meals.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service all staff on Resident Rights on or before 6/28/2024<br>DNS/designee will conduct daily rounds to ensure staff are sitting while assisting residents at meals.<br>**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** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | be sitting down next to them while working with them. It was an evaluation just to lay eyes on them to see how they are doing and determine if there were any indicators that would warrant them to be picked up for therapy.<br><br>On 5/15/24 at 1:51 p.m., the DON provided a document, updated 3/15/17, titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Respect and dignity. You have the right to be treated with respect and dignity, including ... the right to reside and receive services in the facility with reasonable accommodation of your needs and preferences...."<br><br>3.1-3(v)(1) | | **into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Resident Rights” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the 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.<br>**By what date the systemic changes will be completed:**<br>Compliance Date: 6/28/2024 | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | 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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 1 of 3 residents reviewed for care plan meetings (Resident 7), and the facility failed to ensure an oxygen care plan was implemented for 1 of 3 residents reviewed for care plans (Resident 15).<br><br>Findings include:<br><br>1. During an interview, on 5/10/24 at 10:22 a.m., Resident 7 indicated he did not remember being invited to or attending a care plan meeting. He did not recall when the last one was.<br><br>Resident 7's record was reviewed on 5/14/24 at 9:45 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident had moderate cognitive impairment.<br><br>Census information indicated the resident was admitted to the facility on 3/5/18.<br><br>A Social Service Director (SSD) note, dated 8/29/23, indicated a care plan meeting was conducted on this day for Resident 7.<br><br>A SSD note, dated 2/22/24, indicated a care plan | F 0657 | **F657-Care Plan Timing and Revision**<br>**It is the practice of this facility to provide care plan meetings for the residents and their representatives and that care plans are implemented for residents receiving oxygen care.**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 7 and their representative were invited to a care plan meeting that was held on June 6, 2024.<br>Resident 15 had a care plan for oxygen therapy implemented.<br>**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:**<br>All residents have the potential to be affected by this finding.<br>Audit of all residents residing in the facility will be completed on or | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | meeting was conducted on this day for Resident 7.<br><br>Resident 7's record lacked documentation of a quarterly care plan meeting being conducted for the last year from May 2023 to May 2024. The resident had two care plan meetings for the entire year.<br><br>During an interview, on 5/14/24 at 10:33 a.m., the SSD indicated she could not find where Resident 7 had quarterly care plan meetings for the last year. She indicated they should be conducted quarterly, and she would normally send invites to the resident representatives via mail or by phone.<br><br>During an interview, on 5/14/24 at 11:45 a.m., the Director of Nursing (DON) indicated care plan meetings should be conducted quarterly.<br>2. A. On 5/09/24 at 10:52 a.m., during an observation and interview, Resident 15 was sitting in a wheel chair in his room. The portable oxygen tank meter flow gauge was set on 2 liters (L) and being administered to the resident by a nasal canula (NC). The resident indicated it should have been on 3 L.<br><br>On 05/13/24 at 11:30 a.m., during routine observation, the resident was sitting in the dining room. The portable oxygen tank meter flow gauge was set on 2L and being administered by a NC.<br><br>On 5/14/24 at 10:19 a.m., during routine observation, the resident was sitting in his wheelchair in his room. The portable oxygen meter flow gauge was set on 2L and being administered through a NC.<br><br>On 5/14/24 at 10:22 a.m., during an interview with LPN 9, the LPN indicated she was not sure what | | before 5/31/2024 to ensure that they have had a care plan meeting within the last 90 days.<br>All residents residing in the facility that receive oxygen therapy have been reviewed to ensure that their care plans are up to date on or before 5/24/2024.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Social Service / IDT will be in-serviced on ensuring residents and their representatives are invited to a care plan meeting at least quarterly.<br>MDSC will be in-serviced on ensuring care plans are implemented for residents receiving oxygen therapy.<br>Social Service/designee will ensure residents and representative are invited to care plan meetings through the verification of the MDS schedule and care plan invitation schedule.<br>ED/designee will ensure care plan meetings are held and reviewed weekly through verification of the MDS schedule.<br><br>**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** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 oxygen should be set at.<br><br>On 05/14/24 at 10:27 a.m., during an interview with the Director of Nurses (DON). The DON verified the oxygen for Resident 15 is ordered to be set on 3L per NC and administered continually.<br><br>On 5/14/24 at 10:35 a.m., the medical record for Resident 15 was reviewed. Diagnoses included but were not limited to. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24.<br>Physician orders included but were not limited to: Change oxygen tubing and humidity. Clean concentrator and filter. Once A Day on Sun dated 2/23/2024, oxygen at 3 liters per nasal cannula every shift dated 5/07/2024.<br><br>An admission care plan dated 2/26/24 lacked documentation of a care plan for oxygen use.<br><br>On 5/13/24 at 10:00 a., During an interview with Registered Nurse (RN) 23, she indicated the resident did not have a care plan for oxygen use or impaired gas exchange.<br><br>An admission Minimum Data Set Assessment (MDS) dated 3/1/24 indicated the resident was on oxygen during the initial look back period.<br><br>On 5/14/2024 at 1:26 p.m., the Director of Nursing (DON) provided a document titled, "IDT Comprehensive Care Plan Policy," dated 8/23, and | | **into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The MDSC/designee will be responsible for completing the QAPI Audit tool “Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the 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.<br>**By what date the systemic changes will be completed: 6/28/24.** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process ...Purpose ...Improve relationships between resident, families and or representative, and facility caregivers through understanding of resident's social history, culture and preferences to enhance the resident's life ...Procedure ...Resident, resident's representative, or others as designated by the resident will be invited to care plan review ...Care plan problems, goals and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment ...."<br><br>3.1-35(d)(2)(B) | | | |
| F 0689 SS=E Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation and interview, the facility failed to ensure hot water temperatures were maintained within safe range for 5 of 7 residents reviewed for accidents (Resident 49, 36, 5, 29, and 208).<br><br>Findings include: | F 0689 | **F689 Free of Accident Hazards/Supervision/Devices**<br>**It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as possible.** | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | During random observation on 5/9/24 at 9:30 a.m., the public bathroom sink water was too hot to hold hands under for more than a few seconds without burning the skin.<br><br>During random observation on 5/9/24 at 11:01 a.m., Residents 49's and 36's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running at one and two minutes read 130.1 degrees Fahrenheit (F).<br><br>During an interview on 5/9/24 at 11:19 a.m., Resident 5 indicated the water was too hot when she washed her hands. Residents 5's and 29's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running one minute read 132.3 degrees F, and after running two minutes read 134.2 degrees F.<br><br>During random observation on 5/9/24 at 11:31 a.m., Resident 208's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running one minute read 128 degrees F, and after two minutes read 130 degrees F.<br><br>During an interview on 5/9/24 at 11:55 a.m., the Administrator (ADM) indicated they recently had the water heater replaced that provided hot water to the Resident rooms and indicated they would need to adjust the hot water temperatures right away. She also indicated that their Maintenance Supervisor was new and had just started on 5/8/24.<br><br>During an interview on 5/9/24 at 11:59 a.m., the Maintenance Supervisor indicated he was not | | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 49, 36, 5, 29, and 208 water temperatures have been adjusted and are being maintained within a safe range.<br>**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:**<br>All residents have the potential to be affected by hot water temperatures.<br>Water temperatures have been checked daily to ensure that they are maintained within a safe range.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Maintenance Director was educated by ED/Designee regarding checking and monitoring water temperatures in resident rooms on 5/17/2024.<br>Maintenance Director will put water temperatures in our Tels program weekly and ED will monitor for compliance.<br>**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** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | able to locate temperature logs yet and indicated he had checked the water temperatures that morning, noticed they were running high but did not document them. He indicated there were two water heaters in the building, one for kitchen and laundry, one for resident rooms and the temperatures should read below 120 degrees F. During the interview, the ADM provided login information to access TELS (an online platform used to track maintenance tasks) to the Maintenance Supervisor.<br><br>On 5/9/24 at 12:09 p.m., the faucet water temperatures were checked with the Maintenance Supervisor. He indicated he was not sure how to calibrate the thermometer and the water temperatures were to be between 100-120 degrees F. He read Residents 49's and 36's water temperature, in less than one minute, reached 134.4 degrees F. Resident 208's water temperature reached 129 degrees at one minute.<br><br>On 5/14/24 at 11:52 a.m., the Maintenance Supervisor indicated he was still unable to locate temperature logs from before 5/8/24 but learned there were three hot water heaters in the building, one for each resident wing, after having a plumber come out the evening of 5/9/24.<br><br>On 5/14/24 at 1:18 p.m., the Maintenance Supervisor provided water temperature logs for the last 30 days. No temperature logs were provided for between 4/23/24-5/9/24.<br><br>During an interview on 5/14/24 at 1:50 p.m., the ADM indicated they did not have a policy related to monitoring water temperatures or temperature guidelines and that the TELS program notifies maintenance when temperatures should be checked weekly. | | **into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Director/designee will be responsible for completing water temps randomly, daily times 4 weeks then the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.<br><br>**By what date the systemic changes will be completed: 6/28/2024** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | During an interview on 5/15/24 at 10:27 a.m., the ADM indicated the former Maintenance Supervisors last day was 4/26/24 and that nobody had been checking the water temperatures after he left until the new Maintenance Supervisor started she was not sure how long the temperatures had been running high.<br><br>3.1-45 (a)(1)<br>3.1-45 (a)(2) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>Based on observation, interview, and record review, the facility failed to ensure catheter care and placement of catheter equipment for 1 of 1 residents reviewed for catheter care. (Resident 15)<br><br>Findings include:<br><br>On 5/8/24 at 11:07 a.m., during main dining room meal observation, Resident 15 sat in his wheelchair. The catheter bag was completely in contact with floor touching wheel of wheelchair dignity bag (a cloth bag covering the urinary drainage bag) was not completely covering bag and urine was visible.<br><br>On 5/08/24 at 11:21 a.m., during routine observation, observed catheter bag had continued to be in contact with the floor coming out of the dignity bag resident continues to pull on tubing causing bag to go up and down. touching the floor, his shoes, and wheel of wheelchair.<br><br>On 5/08/24 at 11:28 a.m., during routine observation, observed Resident 15 pick up catheter bag and placed it in his lap. The resident continued to touch the drainage bag tubing with hands while in the drainage bag continued to be in his lap. | F 0690 | **F690- Bowel/Bladder Incontinence, Catheter**<br>It is the practice of this facility to ensure residents with catheters receive appropriate treatment and services.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 15 had a securement device placed for tubing and dignity bag was repositioned to ensure not touching the floor.<br>**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:**<br>Any resident that requires a catheter has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents with catheters. All residents identified in this audit will be reviewed and ensure that catheter tubing is secured correctly, and dignity bag is in place and positioned correctly. | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | On 5/08/24 at 11:34 a.m. during routine observation, Licensed Practical Nurse (LPN) 9 picked up the drainage bag from Resident 15's lap and placed drain bag into the dignity bag and left dining room with resident to fix the placement of the bag and tubing.<br><br>On 5/13/24 at 11:43 a.m., observed Resident 15 sitting in dining room waiting on meal. The urinary drainage bag was within the dignity bag under the wheelchair. The dignity bag was touching floor.<br><br>On 5/13/24 1:00 p.m., interview with the Director of Nurses (DON). She indicated the foley catheter drainage bag and tubing must not be touching the floor and the drainage dignity bag should be off the floor.<br><br>On 5/14/24 at 10:00 a.m., during an observation and interview with Resident 15 noted he no longer had a urinary drainage bag. The resident indicated he had a urinary leg drainage bag, but he liked the other one better. He indicated he did not like the feeling of the straps from the leg bag around his leg.<br><br>On 5/14/24 at 11:00 a.m., the medical record for Resident 15 was reviewed. Diagnosis included but were not limited to: Essential (primary) hypertension (high blood pressure) dated 2/23/24. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24. | | **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service nurses on Catheter Care on or before 6/28/24<br>DNS/designee will conduct daily rounds to ensure catheter tubing is secured correctly and dignity bag is positioned correctly. Will do audit tool for daily catheter tubing secured correctly and dignity bag is positioned correctly for one week.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Catheter Care” 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<br>**By what date the systemic changes will be completed:**<br>**Compliance Date: 6/28/20204** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | Physician orders included but were not limited to: 02/26/2024 Store collection bag inside a protective dignity pouch dated 2/26/24, Suprapubic Catheter dated 4/24/2024. Catheter orders: Change Super Pubic Foley catheter and urinary drainage bag as needed for dislodgement, leakage or occlusion dated 2/23/24, Cath orders: Foley catheter care, Catheter securement device in place, Every Shift dated 2/23/24.<br><br>A care plan, dated 2/26/2024, indicated the Resident requires an indwelling urinary related to bladder/prostate mass. Interventions included but were not limited to: Do not allow tubing or any part of the drainage system to touch the floor dated 2/26/24.<br><br>An admission Minimum Data Set Assessment (MDS), dated 3/1/24, indicated the resident had a foley catheter during the initial look back period.<br><br>On 5/13/24 at 2:45 p.m., the DON provided a document titled, "Suprapubic Catheter Care," dated, 12/2012 and indicated it was the policy currently being used by the facility. The policy indicated, "...Established suprapubic catheter ...6. Check drainage bag and tubing placement ...."<br><br>On 5/13/24 at 2:45 p.m., the DON provided a document titled, "Catheter Care (Urinary)," dated, 05/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure steps ...14. Replace catheter in securement device ...."<br><br>3.1-41(a)(1) | | | |
| F 0695 SS=D | 483.25(i)<br>Respiratory/Tracheostomy Care and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| Bldg. 00 | Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided to 2 of 2 residents reviewed for respiratory services (Residents 15 and 8).<br><br>Findings include:<br><br>A. On 5/09/24 at 10:52 a.m., during an observation and interview, Resident 15 was sitting in a wheel chair in his room. The portable oxygen tank meter flow gauge was set on 2 L (Liters) and being administered to the resident by a nasal canula (NC). The resident indicated it should have been on 3 L. The resident indicated he was not getting any air. CNA 7 remove portable oxygen tank from the resident and failed to place resident on an oxygen concentrator (a device that converts ambient room air to a higher concentration of level of oxygen) that was in his room. Certified Nurse Aide (CNA) 7 spoke to Licensed Practical Nurse (LPN) 9. The CNA failed to inform the nurse the residents oxygen concentrator was not on.<br><br>On 5/09/24 at 10:56 a.m., during an interview with CNA 7, she indicated she would normally not remove a resident from portable oxygen without placing the resident on an oxygen concentrator. | F 0695 | **F - 695 Respiratory/Tracheostomy Care and Suctioning**<br><br>It is the practice of this facility to ensure that a Licensed Nurse stays with a resident while they are receiving nebulizer treatment. Also, that a resident portable 02 not be disconnected without placing them on a concentrator in their room.<br><br>**What corrective action(s) will be** | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | She continued to proceed to fill station to refill portable oxygen tank.<br><br>On 5/09/24 at 10:58 a.m., during an interview with LPN 9 she indicated CNA 7 did not inform her she had removed the portable oxygen tank from Resident 15. She indicated she observed the CNA with the portable tank, and she knew the resident would not be receiving oxygen until she turned the concentrator on. She indicated she was going to place Resident 15 on the concentrator, but she was busy with medication pass. She acknowledged a resident should be changed to a concentrator when the portable tank was removed.<br><br>On 5/13/24 at 11:30 a.m., during a routine observation, the resident was sitting in the dining room. The portable oxygen tank meter flow gauge was set on 2L and being administered by a NC.<br><br>On 5/14/24 at 10:19 a.m., during routine observation, the resident was sitting in his wheelchair in his room. The portable oxygen meter flow gauge was set on 2L and being administered through a NC.<br><br>On 5/14/24 at 10:22 a.m., during an interview with LPN 9, the LPN indicated she was not sure what the oxygen should be set at.<br><br>On 05/14/24 at 10:27 a.m., during an interview with the Director of Nurses (DON), the DON verified the oxygen for Resident 15 was ordered to be set on 3L per NC and administered continually.<br><br>On 5/14/24 at 10:35 a.m., the medical record for Resident 15 was reviewed. Diagnoses included but were not limited to. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms | | **accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 15 lungs have been assessed and has had no identified issues with administration of 02 on 5/09/24. Resident is receiving oxygen per MD orders.<br>Resident 8 Lungs have been assessed and has had no identified issues with administration of Nebulizer treatment on 5/16/2024.<br>**How other residents having the potential to be affected by the same deficient** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24.<br><br>Physician orders included but were not limited to: Change oxygen tubing and humidity. Clean concentrator and filter. Once A Day on Sunday dated 2/23/2024, and oxygen at 3 liters per nasal cannula every shift dated 5/07/2024.<br>Admission care plan, dated 2/26/24, lacked documentation of a care plan for oxygen use.<br><br>On 5/13/24 at 10:00 a.m., during an interview with Registered Nurse (RN) 23, she indicated the resident did not have a care plan for oxygen use or impaired gas exchange.<br><br>An admission Minimum Data Set Assessment (MDS) dated 3/1/24 indicated the resident was on oxygen during the initial look back period.<br><br>B. On 5/10/24 at 10:40 a.m., during an observation and interview with Resident 8, observed the resident lying in bed with head of bed elevated. Resident had removed nebulizer mask and laid it on the bed. LPN 6 removed the nebulizer treatment mask from the residents bed and placed it in a bag without cleaning the medication chamber. LPN 6 failed to assess the resident after the administration of the breathing treatment. The resident indicated the nurse did not assess her lungs before or after nebulizer treatment and indicated sometimes the nurses did assess and sometimes they did not. | | **practice will be identified and what corrective action(s) will be taken:**<br>RN 23 has been educated that all residents on 02 need oxygen use or impaired gas exchange care plan has been added.<br>LPN 6 and 16 have been educated on policy and procedures of medication administration of Nebulizer treatment and proper cleaning, storage and use of PPE. They will then complete a skills competency with DNS/Designee.<br>**What measures will be put into place or what systemic changes will be made to ensure that the** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | On 5/10/24 at 10:55 a.m., during an interview with LPN 6, she indicated she provided a nebulizer treatment to Resident 8 and indicated she did not assess the resident after the treatment. She did not wear personal protective equipment (PPE) to administer the treatment and she did not stay in the room during the treatment.<br><br>On 5/13/24 at 11:46 a.m., during an interview with LPN 16 she indicated when nebulizer treatment completed she wiped out the nebulizer medication chamber with a paper towel and then placed it in a bag after it had dried. She indicated she assessed the resident before and after nebulizer treatment.<br><br>On 5/13/24 at 11:57 a.m., during routine observation and interview with Resident 8, observed the resident lying down in bed. The nebulizer mask and medication chamber was laying on top of a dry paper towel. The nebulizer equipment was not bagged. The resident indicated the nurse did not assess her before or after nebulizer treatment today.<br><br>On 5/13/24 at 1:00 p.m., the medical record for Resident 8 was reviewed. Diagnoses included but were not limited to: Chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems). Dated 10/02/2018, pulmonary hypertension (a condition that affects the blood vessels in the lungs), Type 2 diabetes mellitus with unspecified complications (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/19/2024, Generalized anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), Acute and chronic respiratory failure (a serious condition that makes it difficult to | | **deficient practice does not recur:**<br>DNS/Designee will complete nebulizer treatment all nurses to receive nebulizer skills competency. All staff to be educated on respiratory care and oxygen flow.<br>DNS/designee will round each shift to ensure oxygen flow is provided per MD order.<br>DNS/Designee will provide education on Nebulizer treatments to all Nurses.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | breathe on your own. Respiratory failure develops when the lungs can't get enough oxygen into the blood) dated 5/18/2023, and chronic pain syndrome dated 6/04/2020.<br><br>Physician orders included but were not limited to: Albuterol sulfate solution for nebulization; 2.5 mg /3 mL (milliliters)(0.083 %); amount: 1 unit dose inhalation as needed at bedtime for shortness of breath or respiratory distress daily 2/01/2024, Ipratropium-albuterol solution for nebulization; 0.5 mg (milligrams)-3 mg (2.5 mg base)/3 mL; amount: 0.5 mg - 3 mg; inhalation, three Times A Day dated 2/01/2024, Change nebulizer tubing/set, Once A Day on Sunday dated 2/22/2022, Change oxygen tubing and humidity and clean concentrator and filter once a day on Sunday dated 4/09/2020. Oxygen at 5 liters per nasal cannula every shift dated 6/01/2023.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 2/27/24, indicated the resident received oxygen and respiratory treatments during the look back period.<br><br>A care plan, dated 10/4/18, indicated the resident has impaired gas exchange and received continual oxygen and nebulizer treatments as ordered.<br><br>On 5/10/24 at 1:27 p.m., the Director of Nursing provided an undated document, titled, "Oxygen Concentrator", and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose ...To provide oxygen for therapeutic use by utilizing a concentrator that converts ambient air to a higher concentration of level of oxygen. It is commonly used to provide oxygen therapy ...Procedure ...1. Verify and understand the physicians order ...9. Adjust the flow meter control to the knob to the flow stetting | | **program will be put into place:**<br>On-going compliance with this corrective action will be monitored through the facility Quality Assurance and performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the Skills Competency and CQI tool for oxygen flow and for Nebulizer Treatment weekly for 4 weeks and monthly for at least 6 months. If the threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up.<br><br>**By what date the systemic changes will be completed: 6/28/24** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | prescribed by the physician ...."<br><br>On 5/10/24 at 1:27 p.m., the Director of Nursing (DON) provided a document, titled, "Nebulizer (small volume Nebulizer-SVN Medicated Aerosol Therapy)," dated 9/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure steps ...12. Stay with the resident during the entire medication administration ...14 .... b. Rinse with saline or wipe with alcohol c. Air dry on paper towel d. Once dry, place in plastic bag ...."<br><br>3.1-47(a)(4)<br>3.1-47(a)(5)<br>3.1-47(a)(6) | | | |
| F 0740<br>SS=D<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br><br>Based on observations, interview, and record review, the facility failed to provide mental health services to 1 of 4 residents reviewed (Resident 48).<br><br>Findings include:<br><br>On 5/09/24 at 2:30 p.m., during an observation and | F 0740 | **F740 Behavioral Health Services**<br>**It is the practice of this facility to provide mental health services for residents to maintain the highest practicable physical, mental, and psychosocial well-being.**<br>**What corrective action(s) will** | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | interview with Resident 48, the resident was very confused, crying indicated she was not supposed to be married to her husband and she wanted to leave the facility. The staff indicated she was an elopement risk and had been trying to leave the facility. She often went to the front but did not attempt to leave the exit next to her room. The resident became more agitated while interviewing and distressed about wanting to leave. Ended the interview due to evident distress of the resident.<br><br>On 5/14/24 at 1:45 a.m., the medical record for Resident 48 was reviewed. Diagnoses included but were not limited to: Essential (primary) hypertension (high blood pressure) dated 9/19/2023, dementia, severe, with other behavioral disturbance (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) dated 9/19/2023, Depression dated 9/19/2023, Hyperlipidemia (high cholesterol) dated 9/19/2023, Psychotic disorder with delusions due to known physiological condition (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) dated 9/19/2023.<br><br>Physician Orders included but were not limited to: Donepezil at Bedtime 9/19/2023, Sertraline tablet; 100 mg (milligrams); amount: 100 mg; oral Twice A Day 4/23/2024, Wander-guard- check every shift for placement and proper functioning. Check skin under wander guard every shift.<br><br>A care plan, dated 2/13/2024, indicated behavioral symptoms. Resident experiences the following behavior expressions: tearfulness, paranoia, short temper, history of delusions, yelling at others, exit seeking. Resident has a diagnosis of depression with a treatment of psychoactive medication. | | **be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 48 and their representative have agreed for resident to be seen by behavioral health services and has been evaluated by the facility psychiatric provider.<br>Resident 48 has had her medications reviewed.<br>Recommendations from behavioral health services are added to resident 48 plans of care.<br>Resident 48 will remain on behavioral health services as needed. Will assess quarterly, with significant changes, and annually with resident and representative.<br><br>**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:**<br>All residents have the potential to be affected that require behavioral health services.<br>Audit of all residents residing in the facility will be completed on or before 6/28/2024 to ensure that if they need behavioral health services they have been offered.<br>Residents and representatives that decline behavioral health services will be care planned for decline and re-assessed as needed, quarterly, with significant changes, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, indicated the resident had not shown any behavior symptoms during the look back period.<br><br>Documentation within the medical record indicated several entries of behaviors including agitation and exit seeking.<br><br>On 5/14/24 at 1:16 p.m., during an interview with the Social Services Director, regarding Resident 48, she indicated the resident did not try to exit any of the side doors she only tries to go out the front door. She indicated the facility was in the process of getting her seen by Psychiatric Services. She indicated the primary physician was apprehensive about working with psychological medications and prefers psychiatric services to oversee the medications. She indicated the family has been reluctant to allow psychiatric services to see her. She acknowledged the resident needed to be seen but she did not have any documentation regarding discussion with the family about services.<br><br>The medical record lacked documentation of consultation with family.<br><br>On 5/15/2024 at 9:00 a.m., the Director of Nursing (DON) provided a document, titled, "Behavioral Health," dated 10/22, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...It is the policy of this facility to ensure that each resident receive the necessary behavioral healthcare and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being ...Procedure ...2. Residents will be assessed for Behavioral Health needs using Social Services Assessment, | | and annually.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>Social Service has been educated on ensuring that all residents have been offered behavioral health services. Residents or representatives that decline services will have care plan in place for decline and re-assessed as needed, quarterly, with significant changes, and annually. Social Services to complete education with all staff on behavioral health services and policy; to notify MD, IDT, and representatives as needed, when residents are experiencing increased behavioral needs and potential need for increase or start of behavioral health services as intervention.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The SSD/designee will be responsible for completing the QAPI Audit tool “BEHAVIOR MANAGEMENT” weekly for 4 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | which is completed upon admission, annually and with significant change. Residents will be referred to Behavioral Health providers when needed for situations such as, mental health disorders, psychotropic medication management, behavior intervention development ...and or adjustment or mood issues ...."<br><br>3.1-37<br>3.1-43 | | weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the 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.<br><br>**By what date the systemic changes will be completed: 6/28/2024** | |
| F 0759 SS=D Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5%, related to not administering medications in a safe and sanitary manner and failed to follow manufacturer's guidelines for 2 of 9 residents observed for medication administration (Residents 31 and 159), 2 errors were observed during 31 opportunities resulting in an error rate of 6.45%.<br><br>Findings include:<br><br>1. On 5/13/24 at 12:50 p.m., Licensed Practical Nurse (LPN) 16 was observed administering medications to Resident 31. While dispensing the resident's Creon (a medication to assist with pancreatic enzyme [protein that help speed up metabolism, or the chemical reactions in the body] ) from the medication bottle, the LPN touched the capsule with her ungloved finger, and continued | F 0759 | **F759 Free of Medication Errors Rate 5%**<br>**It is the practice of the facility to ensure medication error rates are not 5 percent or greater.**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 31 did not have any adverse effects related to medication being administered. Resident 31 is receiving medication per protocol. Resident 159 did not have any adverse effects related to insulin administration. Resident 159 is receiving meal with in 15 minutes | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | to administer the medication to the resident.<br><br>On 5/14/24 at 1:13 p.m., Resident 31's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, other chronic pancreatitis (a condition where the pancreas becomes permanently damaged from inflammation).<br><br>A physician's order, dated 8/16/22, indicated Creon (lipase-protease-amylase-pancreatic enzymes) capsule, delayed release (DR) 12,000-38,000-60,000 units, 1 capsule by mouth three times a day. Special instruction: To be given with food.<br><br>During an interview, on 5/14/24 at 1:09 p.m., the Director of Nursing (DON) indicated medications should never be administered if touched by the nurse with a bare hand.<br><br>On 5/14/24 at 1:26 p.m., the DON provided a document, with a revision date of 7/2023, titled, "Medication Administration (Medication Pass Procedure)," and indicated it was the skills competency for the nurses currently being used by the facility. The skill competency indicated, "...Procedure Steps: ...5. Medications are opened without contaminating...."<br><br>On 5/14/24 at 1:57 p.m., the DON provided a document, dated January 2022, titled, "General Dose Preparation and Medication Administration." and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...3...3.4. Facility staff should not touch the medication when opening a bottle or unit dose package...."<br><br>2. On 5/14/24 at 11:00 a.m., Licensed Practical | | after receiving fast acting insulin.<br><br>**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:**<br>All residents have the potential to be affected by the alleged deficient practice.<br>LPN 16 and LPN 9 were in-serviced on medication administration and administering fast acting insulin.<br>DNS/designee will in-service All Licensed Nurses and Qualified Medical Assistants on medication administration, and timing of fast acting insulin, and completed return demonstration skills validation on medication administration and insulin administration on or before 6/28/24.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>DNS/designee will complete Medication/Insulin administration rounding tool daily to ensure appropriate medication administration/insulin administration and meal provision per MD order.<br>DNS/designee will in-service All Licensed Nurses and Qualified Medical Assistants on medication | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | Nurse (LPN) 9 was observed performing a blood sugar reading on Resident 159. At the same time, the LPN indicated the resident blood sugar reading was 245 and per the physician's order, 3 units of insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) were to be administered.<br><br>On 5/14/24 at 11:10 a.m., 3 units of insulin lispro (a rapid acting insulin) were verified and administered in the right upper arm to the resident by LPN 9.<br><br>On 5/14/24 at 11:13 a.m., the resident was taken to the dining room for his lunch meal and provided a glass of water. A continuous meal service observation indicated the resident did not receive his lunch meal until 11:52 a.m.<br><br>On 5/14/24 at 1:18 p.m., Resident 159's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes (a disease that occurs when the blood glucose is too high) with hyperosmolarity (occurs in people with type 2 diabetes who experience very high blood glucose levels).<br><br>A physician's order, dated 5/3/24, indicated insulin lispro solution; 100 units/milliliter (ml), administer subcutaneous (SQ-under all layers of the skin), four times daily, per sliding scale.<br>If Blood Sugar is less than 70, call physician.<br>If Blood Sugar is 161 to 200, give 1 Unit.<br>If Blood Sugar is 201 to 240, give 2 Units.<br>If Blood Sugar is 241 to 280, give 3 Units.<br>If Blood Sugar is 281 to 320, give 4 Units.<br>If Blood Sugar is 321 to 360, give 5 Units.<br>If Blood Sugar is greater than 360, call physician.<br><br>During an interview, on 5/14/24 at 1:09 p.m., the | | administration, and timing of fast acting insulin, and completed return demonstration skills validation on medication administration and insulin administration.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Medication/Insulin Administration" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the 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.<br>**By what date the systemic changes will be completed: 6/28/24** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | Director of Nursing (DON) indicated residents who receive fast-acting insulin should get their meal within 15 minutes of receipt of the insulin.<br><br>On 5/14/24 at 1:26 p.m., the DON provided a document, with a revision date of 9/2023, titled, "Highlights of Prescribing Information," and indicated it was the manufacture's guidelines for the insulin lispro solution. The guidelines indicated, "...Dosage and Administration...Subcutaneous Injection: Administer Insulin Lispro by subcutaneous injection...within 15 minutes before a meal or immediately after a meal...."<br><br>3.1-48(c)(1) | | | |
| F 0812 SS=E Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | serve food in accordance with professional standards for food service safety.<br>Based on observations, interview, and record review, the facility failed to ensure proper food handling for 1 of 2 dining observations and the facility failed to ensure proper hand sanitization was performed during meal service for of 1 of 2 dining observations. This had the potential to affect 50 out of 50 residents who ate meals from the kitchen.<br><br>Findings include:<br><br>1a. During a dining observation, on 5/8/24 at 11:36 a.m., Certified Nurse's Aide (CNA) 12 was preparing drinks for the residents. She scooped the ice into 2 glasses and returned the ice scoop into the ice bucket. At 11:37 a.m., the Housekeeping Supervisor prepared a glass of fruit punch for a resident and placed the ice scoop back into the ice bucket that contained ice. At 11:56 a.m., the ice scoop remained in the ice bucket. At 11:57 a.m., another staff member approached the ice bucket and placed the ice scoop into an empty behind the ice bucket.<br><br>1b. During an observation of hall trays being served on 5/8/24 at 12:17 a.m., CNA 3 grabbed two empty plastic glasses off the cart and scooped ice into them. She obtained the ice from a plastic container that contained pitchers of water, milk, juice, and tea. The container of the pitchers was used to keep the drinks cold. The CNA served the two glasses to a resident with their lunch tray.<br><br>During an interview, on 5/13/24 at 11:11 a.m., the Dietary Manager indicated the ice scoop was to be placed in the clear plastic container on the cart. The ice scoop should not be placed in the ice bucket when not in use. She indicated the staff | F 0812 | **F812 Food Procurement, Store/Prepare/Serve-Sanitary**<br>**It is the practice of this facility to ensure that food is handled properly, and that hand sanitization is performed during meal service.**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident 47, 21, 18 did not have any effects related to the ice served or hand sanitizing. Housekeeping Supervisor, C.N.A. 3, C.N.A. 4, C.N.A. 5, C.N.A. 12 have all been in-serviced on food safety and hand sanitizing during meal service.<br><br>**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:**<br>All residents have the potential to be affected by this finding. Housekeeping Supervisor and staff, and all nursing staff have been in-serviced on food safety, obtaining ice for drinks and hand sanitizing during meal service.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient** | 06/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | should not use the ice from the container that had the pitchers in it. The ice in the containers was not for consumption and is only used to keep the drinks cold. She indicated staff had been educated before and the facility was working on a solution.<br><br>On 5/13/24 at 2:05 p.m., the Administrator provided a document, dated 2/02 with a revised date 5/23, titled, "Food Storage," and indicated it was the policy currently used by the facility. The policy indicated, " ...Scoops are not to be stored in the food. Scoops can be stored within the container using designated scoop storage space of they should be kept covered in a protected area near the containers ...."<br>2. On 5/08/24 at 11:37 a.m., during initial observation of the restorative dining room noon meal service. Observed Certified Nurse Aide (CNA 3) assisting residents with repositioning and with feeding residents. Observed CNA 3 assisting resident 47 by repositioning her and her wheelchair and setting up meal.<br><br>CNA 3 assisted Resident 21. She applied a clothing protector to the chest, repositioned the residents wheel chair and prepared meal tray.<br><br>CNA 3 assisted resident 21 to eat and reached over with the same hand and continued to assist resident 47 by feeding the residents. She then placed a clothing protector over the residents chest and assisted the resident to eat.<br><br>CNA 3 failed to sanitize her hands between residents. She continued to assist both residents to eat without sanitizing her hands between assisting each one and after repositioning each resident.<br><br>On 5/08/24 at 11:46 a.m., during interview with | | **practice does not recur:**<br>All staff will be in-serviced on food safety and hand sanitizing during meal service on or before 6/28/24. DNS/designee will observe each meal to ensure proper food handling, obtaining ice for drinks and proper hand sanitizing occurs per protocol.<br>**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:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Food Handling/Hand Sanitizing” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the 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.<br><br>**By what date the systemic changes will be completed: 6/28/24** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155568 | A. BUILDING 00<br>B. WING | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLIAMSPORT NURSING AND REHABILITATION | 200 SHORT ST<br>WILLIAMSPORT, IN 47993 |

| (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 |
|---|---|---|---|---|
| | CNA 4. She indicated she would sanitize her hands between residents while assisting them with their meal and when repositioning.<br><br>On 5/08/24 at 12:10 p.m., observed CNA 5 deliver a meal tray to resident 18. The CNA failed to sanitize her hands prior to passing meal tray.<br><br>On 5/13/2024 at 2:45 p.m., the Director of Nursing (DON) provided a document, titled, "Hand Hygiene Policy," dated 12/2021, and indicated it was the policy currently being used by the facility. The policy indicated, "...Definitions ...Alcohol-based hand rub (ABHR) (hand rubbing) - alcohol-containing preparation based designed for application for the hands to reduce number of viable microorganisms ...5. Moments of hand hygiene ...After touching a resident ...Healthcare personnel should use an alcohol based hand rub or wash with soap and water for the following clinical indications ...Immediately before touching a resident ...before having direct contact with a resident and or equipment ...After each resident contact and after contact with a residents belongings, environmental surfaces, touching items on the floor, and resident care equipment ...Ater touching self or clothing during meal service ...."<br><br>3.1-21(i)(1)<br>3.1-21(i)(3) | | | |