STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	09/24/2021

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SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00361266, IN00362077, IN00362236, IN00362293, IN00362699, IN00362714, IN00362911, IN00363091 and a COVID-19 Focused Infection Control Survey. Complaint IN00361266 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F725. Complaint IN00362077 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759 and F776. Complaint IN00362236 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F690, F691, and F725. Complaint IN00362293 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00362699 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00362714 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00362911 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F725. Complaint IN00363091 - Substantiated. Federal/State deficiency related to the allegation is cited at F725. Survey dates: September 21, 22, 23, and 24,	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on September 21, 22, 23, and 24, 2021.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA**	

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

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	2021 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 14 Medicaid: 63 Other: 16 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 1, 2021.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure residents were bathed per the plans of care for 3 of 5 residents reviewed for Activities of Daily Living. (Residents B, D, and K) Findings include: 1. The clinical record for Resident B was reviewed on 9/21/21 at 12:09 p.m. Diagnoses included, but were not limited to, left-sided hemiplegia (paralysis of one side of the body),	F 0677	F 677 ADL Care provided to Dependent Residents Corrective action for the residents found to have been affected by the deficient practice: Resident B was identified as being affected by the deficient practice. Resident D was identified as being affected by the deficient	10/20/2021

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	hypertension, and atrial fibrillation. The care plan, dated 7/26/21, indicated the resident had a self-care deficit and preferred his showers every Monday and Thursday night. Review of the residents bathing schedule lacked documentation of a shower on 9/2/21 (Thursday) and 9/9/21 (Thursday) During an interview on 9/24/21 at 11:27 a.m., the Director of Nursing indicated staff should be following the resident's plan of care. 2. The clinical record for Resident D was reviewed on 9/21/21 at 3:24 p.m. Diagnoses included, but were not limited to, hypertension and colostomy. The care plan, dated 10/6/20, indicated the resident had a self-care deficit, required physical assistance of one staff, and preferred to have her showers on Tuesday and Thursday. Review of the shower records indicated the resident received a bed bath on 8/24/21 and 8/31/21. The clinical record lacked documentation of the residents refusal of a shower on 8/24/21 and 8/31/21. 3. The clinical record for Resident K was reviewed on 9/22/21 at 12:19 p.m. Diagnoses included, but were not limited to, quadriplegia (paralysis) and sacral region pressure ulcer. The care plan, dated 1/28/21, indicated the resident had a self-care deficit, required staff assistance with bathing, and preferred her		practice. Resident K was identified as being affected by the deficient practice. Corrective action taken for those residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. An audit of shower/bathing for all residents has been completed to ensure a minimum of 2 shower/bathing days have been scheduled per the residents plan of care and preference. Any identified concerns have been immediately addressed. Measures/systemic changes put into place to ensure the deficient practice does not recur: The Administrator/DON/Designee held an in-service for nursing and direct care staff to provide education and expectations as it relates to “Personal Bathing and Shower” policy to include shower/bathing schedules, following the plan of care for bathing and honoring resident bathing preferences. Corrective actions to be	

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	showers on Wednesday and Sunday on day shift. Review of the bathing records indicated the resident received a bed bath on 9/1/21. The clinical record lacked documentation of the resident refusal of a shower. During an interview on 9/23/21 at 1:41 p.m., the resident indicated she preferred showers but was given bed baths during the outbreak because they were told they could not go out of their rooms. On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Personal Bathing and Shower" dated 5/2003. It included, but was not limited to, "It is the policy of this facility to provide resident centered care...Residents have the right to choose their schedules...." This Federal tag relates to Complaints IN00361266 and IN00362911 3.1-38(a)(2)		monitored to ensure the deficient practice will not recur: The DON/Unit Manager/Designee will audit showers/bathing schedule, bathing care plan and resident bathing preference for 2 residents 3 days a week x 4 weeks, then 2 residents 2 days a week x 4 weeks, then 2 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0686 SS=E Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical			

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	condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wound treatments were completed, as ordered by the physician, for 4 of 4 residents reviewed for pressure ulcers. (Residents D, K, L, and M) Findings include: 1. The clinical record for Resident D was reviewed on 9/21/21 at 3:24 p.m. Diagnosis included, but was not limited to, stage 4 pressure ulcer (ulcer that extends below the subcutaneous fat into you deep tissues like muscle, tendons, and ligaments) of the sacral region. The quarterly MDS (Minimum Data Set) assessment, dated 8/10/21, indicated the resident's cognition was intact. The care plan, dated 10/6/20, indicated the resident was at risk for pain due to a stage 4 pressure ulcer to the coccyx and to complete dressing changes as ordered. The wound evaluation report, dated 9/16/21, indicated the resident had a stage 4 pressure wound to the coccyx which measured 0.77 cm (centimeters) in length, .67 cm in width with a depth of .10 cm. The physician's order, dated 8/3/21, indicated to cleanse the stage 4 pressure ulcer with normal saline, pat dry, and apply skin prep (provides a protective film) to the periwound bed. Apply	F 0686	**F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D was identified as being affected by the deficient practice. Resident K was identified as being affected by the deficient practice. Resident L was identified as being affected by the deficient practice. Resident M was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents at risk for or who currently have wound treatments have the potential to be affected by the deficient practice. An audit of last 30 days for residents having wounds has been completed for review of treatment completion as ordered by the physician. **Measures/systemic changes put into place to ensure the deficient practice does not**	10/20/2021

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	collagen (treatment used for wound healing) into the wound bed, use an ABD (abdominal) pad to fill the void between the buttocks, and cover with border foam every day shift. Review of the August 2021 and September 2021 treatment administration record indicated the treatment was not completed on 8/12/21, 8/20/21, 8/27/21, 8/30/21, and 9/3/21. The physician's order, dated 9/14/21, indicated to cleanse the coccyx wound with normal saline, pat dry, apply collagen to the wound bed, and cover with a border foam dressing daily. The September 2021 treatment administration record indicated the treatment was not completed on 9/17/21 and 9/21/21. During an interview on 9/22/21 at 3:18 p.m.,, RN 3 indicated when a treatment was completed, the treatment administration record should be signed by whomever completed the treatment. 2. The clinical record for Resident K was reviewed on 9/22/21 at 12:19 p.m. Diagnosis included, but was not limited to, sacral region pressure ulcer. The care plan, dated 4/27/21, indicated the resident had impaired skin integrity and to administer treatments as ordered by the medical provider. The wound evaluation report, dated 9/16/21, indicated the resident had a stage 4 sacral wound which measured 6.89 cm in length, 4.54 cm in width with a depth of 3 cm. The physician's order, dated 8/3/21, indicated to		**recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Monitoring a Wound" and documentation of treatment completion on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Wound Nurse/Designee will audit 2 residents with wounds 3 days a week x 4 weeks, then 2 residents 2 days a week x 4 weeks, then 1 resident a week for 4 weeks to ensure the completion of the treatment per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Wound Nurse/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	cleanse the wound with wound cleanser, pat dry, pack the wound a normal saline wet to dry and cover with a foam dressing every shift. The August 2021 treatment administration record indicated the treatment was not completed on 8/5/21 night shift. The physician's order, dated 8/12/21, indicated to cleanse the wound with Dakin's (used to debride wounds), pat dry, pack with silver alginate and cover with a foam dressing every shift. The August 2021 and September 2021 treatment administration indicated the treatment was not completed on the following dates and shifts: -8/14/21 - night shift -8/16/21 - day or night shift -8/17/21 - night shift -8/18/21 - day shift -8/19/21 - day shift -8/23/21 - night shift -8/24-21 - day shift -9/01/21 - day shift -9/02/21 - day shift -9/05/21 - day shift -9/07/21 - day shift -9/08/21 - day shift -9/13/21 - day shift The physician's order, dated 9/14/21, indicated to cleanse the wound with wound cleanser, pat dry, place a Dakin's moist to dry dressing in the wound bed and cover with a bordered foam dressing twice daily. The September 2021 treatment administration record indicated the treatment was not completed on 9/17/21 on day shift.			

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	3. The clinical record for Resident L was reviewed on 9/22/21 at 1:14 p.m. Diagnosis included, but was not limited to, stage 4 pressure ulcer to the left ischium. The care plan, dated 2/23/21, indicated the resident had a pressure ulcer and to provide wound care per treatment order. The wound evaluation report, dated 9/16/21, indicated the resident had a stage 4 pressure ulcer to the left ischium which measured .44 cm in length, .76 cm in width with a depth of .30 cm. The physician's order, dated 8/12/21, indicated to cleanse the left ischium with wound cleanser, pat dry, apply calcium alginate and cover with a foam dressing every day and night shift. The August 2021 and September 2021 treatment administration record indicated the treatment was not completed on the following dates and shifts: -8/13/21 - day shift -8/17/21 - day shift -9/03/21 - night shift -9/04/21 - day shift -9/11/21 - day shift -9/15/21 - day shift -9/16/21 - day shift -9/17/21 - night shift -9/18/21 - day shift -9/19/21 - day shift 4. The clinical record for Resident M was reviewed on 9/22/21 at 1:30 p.m. Diagnosis included, but was not limited to, unstageable pressure ulcer to the coccyx.			

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	The care plan, dated 5/11/21, indicated the resident was a high risk for pressure ulcers and to provide skin care per facility guidelines. The wound evaluation report, dated 9/16/21, indicated the resident had an unstageable pressure ulcer to the coccyx which measured 4.6 cm in length, 4.67 cm in width with a depth of 0.2 cm. The physician's order, dated 8/11/21, indicated to cleanse the wound with normal saline, pat dry, apply medihoney to the wound and cover with a dry dressing every shift. Review of the August 2021 and September 2021 treatment administration record indicated the treatment was not completed on the following dates and shifts: -8/16/21 - day or night shift -8/17/21 - night shift -8/18/21 - day shift -8/19/21 - day shift -8/23/21 - night shift -8/24/21 - day shift -9/01/21 - day shift -9/02/21 - day shift -9/05/21 - day shift -9/07/21 - day shift -9/08/21 - day shift -9/13/21 - day shift The physician's order, dated 9/14/21, indicated to cleanse the coccyx with wound cleanser, pat dry, apply medihoney to the wound bed and cover with adhesive border foam daily. The September 2021 treatment administration record indicated the treatment was on completed			

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	on 9/17/21. A current copy of the document titled "Monitoring A Wound" dated 7/1/16, included, but was not limited to, "Policy...Each resident/patient is evaluated upon admission...Procedure...Implement wound treatments as ordered. This Federal tag relates to Complaint IN00362236 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §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. Based on interview and record review, the facility failed to ensure Foley catheter care was completed, as ordered by the physician, for 2 of 2 residents reviewed for Indwelling catheters. (Resident D and K) Findings include: 1. The clinical record for Resident D was reviewed on 9/21/21 at 3:24 p.m. Diagnosis included, but was not limited to, stage 4 pressure ulcer of the sacral region. The care plan, dated 9/8/21, indicated the resident had a Foley (indwelling) catheter related to impaired skin integrity and to provide catheter care every shift. The physician's order, dated 9/8/21, indicated to clean the Foley catheter with soap and water every shift. Review of the September 2021 TAR (treatment administration record) indicated the catheter care was not completed on 9/9/21 (night shift), 9/16/21 (day shift), or 9/17/21 (day shift). During an interview on 9/22/21 at 3:18 p.m., RN 3 indicated the TAR would be signed by the nurse	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D was identified as being affected by the deficient practice. Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with foley catheters have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having foley catheters has been completed to ensure foley catheter care has been completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not**	10/20/2021

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	to show care had been provided. 2. The clinical record for Resident K was reviewed on 9/22/21 at 12:19 p.m. Diagnoses included, but were not limited to, quadriplegia (paralysis), neurogenic bladder, and sacral region pressure ulcer. The care plan, dated 1/18/21, indicated the resident had an indwelling catheter and to provide catheter care every shift. The August 2021 and September 2021 TAR indicated to cleanse the indwelling urinary catheter every shift with soap and water. The clinical record lacked documentation of catheter care of the following dates and shifts: -8/19/21 - day shift -8/23/21 - night shift -9/01/21 - day shift -9/02/21 - day shift -9/05/21 - day shift -9/07/21 - day shift -9/08/21 - day shift -9/13/21 - day shift -9/17/21 - day shift On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Catheter Care" dated 10/13/2013. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident care that meets the...needs...of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...." This Federal tag relates to Complaint		**recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Catheter Care" and documentation of care provided per physician order on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 3 residents with catheters a week x 4 weeks, then 2 residents with catheters a week x 4 weeks, then 1 resident with a catheter a week for 4 weeks to ensure completion of catheter care per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	IN00362236 3.1-41(a)(2)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure colostomy care was provided, as ordered by the physician, for 2 of 2 residents reviewed for Colostomy care. (Residents D and K) Findings include: 1. The clinical record for Resident D was reviewed on 9/21/21 at 3:24 p.m. Diagnosis included, but was not limited to, colostomy status. Review of the August 2021 and September 2021 TAR (treatment administration record) indicated the resident's colostomy site was to be cleaned with soap and water every shift. The treatment administration record for August 2021 and September 2021 lacked documentation of colostomy care on the following dates and shifts: -8/12/21 - day shift -8/20/21 - day shift -8/27/21 - day shift	F 0691	**F 691 Colostomy, Urostomy, Ileostomy Care** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D was identified as being affected by the deficient practice. Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with colostomy have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having a colostomy has been completed to ensure colostomy care has been completed as ordered by the physician. Any identified concerns were immediately addressed.	10/20/2021

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	155659	A. BUILDING 00 B. WING	09/24/2021

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	-9/03/21 - day shift -9/04/21 - night shift -9/09/21 - night shift -9/16/21 - day shift -9/17/21 - day shift -9/21/21 - day shift During an interview on 9/22/21 at 3:18 p.m., RN 3 indicated the TAR would be signed by the nurse to show care had been provided. 2. The clinical record for Resident K was reviewed on 9/22/21 at 12:19 p.m. Diagnoses included, but were not limited to, quadriplegia (paralysis) and sacral region pressure ulcer. The care plan, dated 1/18/21, indicated the resident had an alteration in bowel elimination due to colostomy and to provide assistance with ostomy (artificial opening in an organ of the body, created during an operation such as a colostomy) care. The August 2021 and September 2021 TAR indicated to cleanse the ostomy site every shift with soap and water. The clinical record lacked documentation of colostomy care of the following dates and shifts: -8/05/21 - night shift -8/19/21 - day shift -8/23/21 - night shift -9/01/21 - day shift -9/02/21 - day shift -9/05/21 - day shift -9/07/21 - day shift -9/08/21 - day shift -9/13/21 - day shift -9/17/21 - day shift		**Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Colostomy Appliance Bag Change" and documentation of care provided per physician order on the TAR. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 3 residents with a colostomy a week x 4 weeks, then 2 residents with colostomy a week x 4 weeks, then 1 resident with a colostomy a week for 4 weeks to ensure completion of colostomy care per physician orders on the TAR. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Colostomy Appliance Bag Change" dated 10/31/13. It included, but was not limited to, "Policy...It is the policy of this facility to promote resident centered care by providing care to maintain the proper function of the colostomy and provide a comfortable and hygienic environment...." This Federal tag relates to Complaint IN00362236 3.1-47(a)(3)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not			

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	limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation and interview, the facility failed to ensure adequate staffing was provided to meet the needs of the residents for 10 of 12 residents reviewed (Residents B, D, H, R, G, K, P, Q, S, T). This deficient practice had the potential to affect 93 of 93 residents residing in the facility. Findings include: During an interview on 9/21/21 at 12:50 p.m., Resident B indicated he was supposed to get a shower yesterday and did not get one. When he turns his call light on, it takes over an hour to get answered. Sometimes the staff come in, turn off the light, and then leave. He will turn on his call light again and have to wait another hour for someone to come back. He was very frustrated with the lack of help. During an interview on 9/21/21 at 11:50 a.m., Staff Member 6 indicated there have been times when she was unable to complete her assigned tasks due to lack of staff showing up for work. During an interview on 9/22/21 at 11:45 a.m., Resident D indicated prior to this week, she had not had her hair washed in over 2 weeks. She told them they needed to wash her hair because she was not going out to her appointment with dirty hair. It took staff up to an hour to answer a call light. Some staff will come in, turn off the light, and then don't come back. She takes 40 mg (milligrams) of Lasix every morning and was	F 0725	**F 725 Sufficient Nursing Staff** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B was identified as being affected by the deficient practice. Resident D was identified as being affected by the deficient practice. Resident H was identified as being affected by the deficient practice. Resident R was identified as being affected by the deficient practice. Resident G was identified as being affected by the deficient practice. Resident K was identified as being affected by the deficient practice. Resident P was identified as being affected by the deficient practice. Resident Q was identified as being affected by the deficient practice. Resident S was identified as being affected by the deficient practice. Resident T was identified as being affected by the deficient practice. The deficient practice had the potential to affect 93 of 93 residents residing in the facility **Corrective action taken for those residents having the potential to be affected by the**	10/20/2021

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	told by the staff she could only get changed twice on day shift and twice on night shift. She told staff at 11:30 a.m. one day that she needed to be changed and was told she had to wait until after lunch. It's usually 1:00 p.m. or 2:00 p.m. before they get to her and by then has laid in a wet brief, with a bed sore, for 2 to 3 hours. During an interview on 9/22/21 at 11:18 a.m., Resident H indicated the facility was short staffed. When she turns on her call light it can take up to 2 hours for someone to answer her light. She knows when she has to go. She has had multiple accidents in her bed as she does not wear a brief because she knows when she has to go. One day, her family had to call the front desk to get them to have someone to come and clean her up. She did not get a bath last week and she was told by one of the staff members there was not enough staff for her to get a bath. When she had accidents on herself it makes her feel awful and she feels as though she was not getting the care she deserves. During an interview on 9/22/21 at 3:05 p.m., Resident R indicated there have been times she has turned her call light on to be suctioned and has had to wait anywhere from 20 minutes to an hour for her light to be answered. She knows when she needs to be suctioned and gets very anxious when she has to wait a long period for the staff to respond to her call light. During an interview on 9/23/21 at 1:03 p.m., Resident G indicated it takes the staff over an hour or two to answer her call light and she lays in a wet brief. They are very short staffed. During an interview on 9/23/21 at 1:41 p.m., Resident K indicated her treatments are not		**same deficient practice:** All residents have the potential to be affected by the deficient practice. The facility staffing pattern has been reviewed to ensure adequate staffing is in place to meet the needs of the residents. The facility has incentives in place to promote hiring of nurses and CNAs. Further, the facility has contracted with agency groups to assist in staffing the facility adequately. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide information as it relates to staffing of the facility, incentives offered, and agency use. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Schedule Coordinator/Designee will review the daily schedules Monday through Friday to include weekend schedules to ensure adequate staffing is in place as an ongoing practice. This will occur for no less than 3 months and compliance is maintained. The Administrator/DON/Schedule Coordinator/Designee will complete call light audits 3 days a week x 4 weeks, then 2 days a	

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	being completed as ordered twice daily. She does get bathed but it can be a fight at times. It can take over an hour for her call light to be answered due to not enough staff. During an interview on 9/23/21 at 3:45 p.m., Resident P indicated she has had bowel movements and had to wait over an hour to be changed. During an interview on 9/24/21 at 9:00 a.m., Resident Q indicated she had urinated all over her bed waiting for staff to answer her call light." It's an awful feeling when you have an accident in the bed and makes you feel dirty, and then to have to lay in it for over an hour." She typically uses the bed pan. Staff will come in, especially at night, turn off the light, say they will be back and then do not come back. During an interview and observation on 9/24/21 at 9:38 a.m. to 10:22 a.m., Resident S was observed with her call light on. The room was observed with a odor. The resident indicated she had a bowel movement and needed a bath. She had not had a bath for over 2 weeks as she had just returned from the hospital. The resident's call light was not answered until 10:22 a.m. During an interview on 9/24/21 at 9:40 a.m., Resident T indicated her roommates (Resident S's) call light had already been on at least 15 minutes. Sometimes it takes staff over an hour to answer her roommates call light. They come in, turn off her light, say they will be back, and then don't come back for over an hour. There is just not enough staff. On 9/24/21 at 9:53 a.m., CNA 9 was informed a resident at the end of the hallway was yelling for		week x 4 weeks, then 1 day a week x 4 weeks on rotating shifts rotating days and shifts to include weekends to ensure call lights are answered in a timely manner and to ensure adequate staff are available. This will occur for no less than 3 months and compliance is maintained. The Administrator/DON/SSD/Designee will resident interviews with 3 residents a week x 4 weeks, then 2 residents a week x 4 weeks, then 1 resident a week x 4 weeks to ensure staffing is sufficient to answer call lights and needs are met. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	help. CNA 6 indicated all the resident's will be yelling for help because it was just her and the nurse on the hall and they would get to them as soon as they could. This Federal tag relates to Complaints IN00361266, IN00362236, IN00362911, and IN00363091 3.1-17(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on interview and record review, the facility failed to ensure medications were administered, as ordered by the physician, for 1 of 3 residents reviewed for medication errors. Findings include: The clinical record for Resident C was reviewed on 9/21/21 at 1:11 p.m. Diagnoses included, but were not limited to, endocarditis, insomnia, and major depressive disorder. The care plan, dated 7/12/21, indicated the resident had an infection and to administer the medications per physician's order. The hospital discharge orders, dated 7/9/21, indicated the resident was to receive Gentamicin (antibiotic used to treat serious bacterial infections) 100 mg (milligrams) every 8 hours. The July 2021 medication administration record	F 0759	**F759 Free of Medication Error Rts 5 Prcnt or More** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents receiving medications have the potential to be affected by the deficient practice. An audit of medication administrations for the last 30 days has been completed. Any identified concerns were	10/20/2021

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	indicated the antibiotic was to be given at 5:00 a.m., 1:00 p.m., and 9:00 p.m. The clinical record indicated the resident did not receive the antibiotic on 7/14/21 at 5:00 a.m. The care plan, dated 7/12/21, indicated the resident used antipsychotic medications for anxiety/depression and to provide the medication as ordered by the physician. The admission orders indicated the resident was to receive Seroquel (medication used for anxiety and depression) 50 mg in the morning and afternoon and then receive Seroquel 200 mg in the evening. The clinical record indicated the resident did not receive the 50 mg doses in the morning/afternoon or the 200 mg dose in the evening on 7/10/21 or 7/11/21. The physician's order, dated 7/23/21, indicated the resident was to receive an additional 100 mg of Seroquel at bedtime for 5 days. The clinical record indicated the medication was not administered on 7/23/21, 7/24/21, and 7/25/21. During an interview on 9/23/21 at 12:30 p.m., The Director of Nursing indicated the majority of unsigned medication administrations was staff not documenting. On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Medication Administration" dated 8/3/2010. It included, but was not limited to, "Definitions: MAR: Medication Administration		immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Unit Manager/Designee held an in-service for all Licensed Nursing staff to provide education and expectations as it relates to the "Medication Administration Policy" and the timely administration of medications. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will complete a Medication Administration Observation for 2 residents 3 days a week x 4 weeks, then 2 residents 2 days a week x 4 weeks, then 1 resident a week for 4 weeks medications are being administered timely. This will occur for no less than 3 months and compliance is maintained. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	Record - the legal documentation for medication administration...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical...needs...of the resident...Medications will be charted when given...." This Federal tag relates to Complaint IN00362077 3.1-48(c)(1)			
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 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 a vancomycin trough was obtained, in a timely manner, for 1 of 3 residents reviewed for laboratory services. Findings include: The clinical record for Resident C was reviewed on 9/21/21 at 1:11 p.m. Diagnoses included, but	F 0776	**F 776 Radiology/Other Diagnostic Services** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice.	10/20/2021

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	were not limited to, endocarditis, chronic viral hepatitis, and sepsis. The care plan, dated 7/12/21, indicated the resident had an infection and to obtain labs as ordered. The physician's order, dated 7/28/21, indicated to obtain a vancomycin (antibiotic used to treat serious and life-threatening infections) trough (used to test the lowest concentration reached by a drug before the next dose was administered) on 7/29/21. The progress note, dated 7/30/21 at 3:41 a.m., indicated the vancomycin trough was missed on 7/29/21. The clinical record lacked documentation of the physician's notification or attempt to obtain the missed trough. During an interview on 9/23/21 at 10:01 a.m., LPN (Licensed Practical Nurse) 5 indicated when staff realized the lab was missed, they should have called the lab to have them draw it. On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Laboratory and Radiological Services and Results Reporting" dated 3/22/19. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care...The safety of residents...is of primary importance...The facility is responsible for the quality and timeliness of services...There are clinical...risks when laboratory...services are not performed in a timely manner...." This Federal tag relates to Complaint		**Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents requiring laboratory services have the potential to be affected by the deficient practice. A 30 day look back has been completed to ensure laboratory services have been obtained. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Laboratory and Radiological Services and Results Reporting" as it relates to obtaining ordered laboratory services to include understanding the process and use of a vancomycin trough. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks to ensure labs were obtained as ordered by the physician. This will occur for no less than 3 months and compliance is maintained. The DON/Unit Manager/Designee will present the results of these	

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	IN00362077 3.1-49(a)		audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
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:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be 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			

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	155659	A. BUILDING 00 B. WING	09/24/2021

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	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure staff donned appropriate personal protective equipment on the yellow zone and failed to ensure face masks were worn appropriately for 2 of 5 staff observed for infection control. (LPNs 3 and 6) Findings include: 1. On 9/21/21 at 11:25 a.m., while on the yellow zone (transmission base precautions), LPN (Licensed Practical Nurse) 3 was observed in a resident room administering medication without a gown on. During an interview on 9/22/21 at 3:18 p.m., RN 2 indicated full PPE (personal protective equipment), which would include an N95, face shield, gloves, and a gown) should be worn in resident rooms on the yellow zone. 2. During an observation with LPN 5, on 9/23/21 at 1:35 p.m., LPN 6 was observed entering and exiting resident rooms on the 200 hall with her face mask under her nose. An interview, on 9/23/21 at 1:40 p.m., LPN 5 indicated LPN 6 was educated to wear her mask correctly which was up over the nose. On 9/24/21 at 10:48 a.m., the Director of Nursing provided a current copy of the document titled "Infection Prevention Program" dated 3/9/2000. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident centered care that meets the...needs of the residents. Residents have a right to reside in a safe environment that promotes health and	F 0880	**F 880** **Corrective action for the residents found to have been affected by the deficient practice:** While on the yellow zone (transmission based precautions), LPN 3 was observed administering medications without a gown on. LPN #6 was observed wearing her mask under her nose when exiting resident rooms on 200 hall The deficient practice was identified to affect residents cared for by 2 of 5 staff observed for infection control. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Rounds were immediately completed by the Director of Nursing to ensure al staff were donning appropriate PPE (personal protective equipment) and face masks were being worn appropriately by all staff. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with the Director of Nursing to provide education and expectations regarding the	10/20/2021

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	reduces the risk of acquiring infections...Procedure...Education...Education to staff on donning and doffing of personal protective equipment is a focus of the infection prevention program...." 3.1-18(b)		"Infection Prevention" Program as it relates to donning appropriate PPE and wearing the mask appropriately **Corrective actions to be monitored to ensure the deficient practice will not recur:** 1.The Administrator/Director of Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure PPE is being donned appropriately for 6 weeks and until compliance is maintained. The Administrator/Director of Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure the appropriate mask is worn over the mouth and nose for 6 weeks and until compliance is maintained. 1.The Administrator/Director of Nursing/Designee will complete daily (7 days a week) visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with solutions in B1 as above. This will occur for 6 weeks and until compliance is maintained. Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any	

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			patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. **DPOC for F880** **Specific/Immediate:** ·The Administrator/Director of Nursing/Designee will provided education for all staff regarding how and when to don and doff PPE with return demonstration, including, but not limited to mask, respirator devices, gloves, gown, and eye protection will be completed following the CDC and facility policy. ·Facility Policy: Use of PPE While in the Facility, Covid 19 Isolation ·CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected Covid – 19 ·CDC Guidance: Sequence For Putting On Personal Protective Equipment (PPE) ·Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) ·The Administrator/Director of	

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			Nursing/designee will provide education for all staff regarding the need to maintain face covering over the mouth and nose, as well as, the appropriate covering to be used, at all times when in use. ·Facility Policy: Use of PPE While in the Facility, Covid 19 Isolation ·Stop Signs **1.Systemic :** 1.A Root Cause Analysis (RCA) has been completed with the visiting Consultant Infection Preventionist (IP)/Medical Director/Facility IP/DON. 1.The Root Cause of the identified areas within the F880 citing is as follows: (DPOC) A Root Cause Analysis (RCA) was conducted by the company Division (Consultant) Infection Preventionist (IP), with input and review from the Medical Director, Administrator, Regional Director of Clinical Operations, and Director of Nursing (DON) to determine the root cause resulting in the facilities Infection Control citation. Staffing numbers at the facility declined during the peak of the COVID 19 pandemic and continue through the most recent COVID 19 outbreak requiring the facility to obtain staff from outside	

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			resources such as agency. The facility has an opportunity to improve in their consistent infection control education for appropriate Infection control practices to include donning of PPE for Yellow zones, and appropriate wearing of mask over mouth and nose. 1.The facility with the Consultant IP have developed the following solutions and systemic changes to address the root cause findings: These documents have been included with submission of the DPOC. **DPOC:** ·The Administrator/Director of Nursing/Designee will complete return demonstration of donning and doffing competency with staff that will need to enter an isolation room. ·The Administrator/Director of Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure PPE is being donned appropriately for 6 weeks and until compliance is maintained. . ·The Administrator/Director of Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure the appropriate mask is worn over the mouth and nose for 6 weeks and until compliance is maintained. .	

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			1.The facility LTC Infection Control Self- Assessment has been reviewed and updated as appropriate to reflect an accurate reflection of the facility with the Consultant IP/Medical Director/Facility IP/DON. **1.Training:** 1.Training for staff has been implemented based on the Root Cause Analysis and LTC Infection Control Assessment findings. 1.The Consultant IP has provided training to the facility Administrator/DON/Unit Manager. 2.Training for staff has been targeted to staff members who will need to enter an isolation room and all staff who are required to wear a mask. 3.These training documents have been included with submission of the DPOC **1.Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** 1.The Administrator/Director of Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure PPE is being donned appropriately for 6 weeks and until compliance is maintained. The Administrator/Director of	

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			Nursing/Designee will observe 2 staff member daily (7 days a week) on rotating shifts to include weekends to ensure the appropriate mask is worn over the mouth and nose for 6 weeks and until compliance is maintained. 1.The Administrator/Director of Nursing/Designee will complete daily (7 days a week) visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with solutions in B1 as above. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance improvement (QAPI):** 1. The Director of Nursing will present the results of these audits monthly to the QAPI committee for review and to update or make changes to the DPOC as needed to maintain substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	