| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155771 | A. BUILDING 00<br>B. WING | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE | 1070 W JEFFERSON ST<br>FRANKLIN, IN 46131 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Residential Complaint IN00434298.<br><br>Complaint IN00434298 - No deficiencies related to the allegations are cited.<br><br>Survey dates: July 23, 24, 25, 26, 29, 30 and 31, 2024<br><br>Facility number: 001127<br>Provider number: 155771<br>AIM number: 200247220<br><br>Census Bed Type:<br>SNF/NF: 32<br>NF: 105<br>Residential: 155<br>Total: 292<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 100<br>Other: 27<br>Total: 137<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed August 6, 2024. | F 0000 | The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review. | |
| F 0695<br>SS=D<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Shannon Logan | Administrator | 08/22/2024 |

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.

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| | § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident received continuous oxygen treatment therapy for 1 of 3 residents reviewed for oxygen. (Resident 81)<br><br>Finding includes:<br><br>During an observation on 7/24/24 at 10:12 a.m., Resident 81 was observed lying in bed with her eyes closed and the head of the bed elevated. At the head of Resident 81's bed, next to the wall was an oxygen concentrator with oxygen tubing lying from the back side of concentrator over the top with the nasal cannula on the front side of concentrator. The tubing was observed to be out of Resident 81's reach.<br><br>During an observation on 7/24/24 at 1:08 p.m., Resident 81 was observed in bed with a food tray on the over bed table. The head of the bed was elevated. Resident 81's speech was slurred and she had difficulty keeping her eyes open. Resident 81's nasal cannula was observed to still be over the concentrator at the head of bed, out of reach of Resident 81.<br><br>During an observation on 7/24/24 at 1:14 p.m., RN 2 placed pulse oximeter, (a device which detects and displays a person's oxygen saturation level) | F 0695 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>There were no residents found to have been affected by the deficient practice. Resident 81 is known to be noncompliant with care needs. The hospice doctor and Resident 81 had a face-to-face medical visit on 7/16 and the Hospice MD noted that Resident 81 is noncompliant. Hospice MD has changed Oxygen order for Resident to have Oxygen administered as needed to maintain Oxygen levels greater than 90%. Resident 81 will have Oxygen levels checked every two hours.<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 on Oxygen have the potential to be affected. On 7/29/2024, all licensed nurses and QMAs received an in-service given | 08/16/2024 |

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| | observed the pulse oximeter result display indicated a reading of 75 percent. RN 2 then placed oxygen nasal cannula on Resident 81. Resident 81 was observed to become more alert with clear, audible speech.<br><br>During an observation 7/26/24 at 9:32 a.m., Resident 81 was observed up in a wheelchair propelling herself in the hallway with no oxygen. During an interview at that time, RN 10 indicated she was not familiar with Resident 81. RN 10 noted per order that Resident 81 had an order for continuous oxygen per nasal cannula.<br><br>On 7/24/24 at 12:50 p.m., Resident 81's clinical record was reviewed. Resident 81's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease and acute and chronic Respiratory failure with hypoxia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/10/24, indicated Resident 81 was severely cognitively impaired and utilized oxygen treatment therapy.<br><br>Physician Orders included, but were not limited to, oxygen per nasal cannula continuous inhalation to maintain oxygen saturation greater than 90 percent, every shift for respiratory failure, initiated 12/9/22.<br><br>The Care Plans included, but were not limited to: At risk for respiratory complications, initiated 2/25/22 The interventions included, but were not limited to, administer oxygen as ordered.<br><br>On 7/29/24 at 10:02 a.m., the Administrator provided a copy of the Oxygen Therapy Policy, reviewed 11/2014, and indicated it was the current policy in use by the facility. A review of the | | by the DON regarding the assessment and reporting out-of-range vital signs.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br>All residents receiving Oxygen Therapy had their orders audited and care plans reviewed for any non-compliant behaviors.<br>The Unit Manager and/or her designee on each unit will do random audits to check all residents receiving oxygen therapy have the correct order and are that they are not exhibiting any type of non-compliant behaviors. This audit will be completed daily for one week, then three times for one week, and then randomly once a week for two weeks.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits.<br>The DON and Unit Managers are | |

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| | policy indicated, "...It is the policy of the Nursing Department to administer oxygen in accordance with physician's order and on an emergency basis..."<br><br>3.1-47(a)(6) | | responsible for implementing and monitoring this plan.<br>**By what date the systemic changes for each deficiency will be completed?**<br>8/16/2024 | |
| F 0755 SS=D Bldg. 00 | 483.45(a)(b)(1)-(3)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records<br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records | | | |

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| | are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Based on record review and interview, the facility failed to document the drug dispositions for 2 of 3 closed records reviewed for drug dispositions. (Resident 139, Resident 44)<br><br>Findings include:<br><br>1. Resident 139's closed clinical record was reviewed on 7/29/24 at 9:17 a.m. Resident 139 was discharged home on 6/12/24. The diagnoses included, but were not limited to, multiple sclerosis; dementia; mood disturbance and anxiety; epilepsy; GERD (gastro-esophageal reflux disease); congestive heart failure (CHF); hyperlipidemia (HDL); depression; constipation, pain, and hypertension (HTN).<br><br>Physician's Orders, dated June 2024 and current at the time of Resident 139's discharge from the facility, included but were not limited to the following:<br><br>- Acetaminophen (over the counter pain medication) 1000 milligrams (mg) by mouth at bedtime for pain<br>- Albuterol Sulfate (a bronchodilator) inhalation nebulization solution 2.5 mg/3 ml (milliliters) .083% every 8 hours as needed for wheezing.<br>- Atorvastatin (a medication used to treat high cholesterol) 20 mg at bedtime.<br>- Cholecalciferol (Vitamin D) 50 micrograms (mcg) daily.<br>- Docusate sodium (stool softner) 100 mg twice a day.<br>- Escitalopram oxalate (antidepressant) 5 mg daily.<br>- Furosemide (a diuretic medication) 20 mg daily. | F 0755 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were affected by this alleged deficient practice. The facility has always followed the pharmacy's policies on drug-destruction. The only policy pharmacy had, stated that narcotics must have a destruction log. The facility keeps a destruction log for all narcotics.<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>No other residents were found to be affected by this alleged deficient practice. On 7/29/2024, the facility switched pharmacy providers. The new pharmacy provider has a policy in place that requires all medications, narcotics and non-narcotics to have a destruction log in place. Beginning 7/29/2024, all licensed staff received and signed acknowledgment of the new policy.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** | 08/16/2024 |

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| | - Levetiracetam (anticonvulsant medication) 500 mg twice a day.<br>- Metoprolol tartrate (a blood pressure medication) 12.5 mg twice a day.<br>- Pantoprazole sodium (a medication used to treat GERD) 20 mg daily.<br><br>The closed clinical record lacked a drug disposition document for Resident 139's non-narcotic medications.<br><br>2. Resident 44's closed clinical record was reviewed on 7/30/24 at 8:30 a.m. The diagnoses included, but were not limited to, HTN, type 2 diabetes, atrial fibrillation (a-fib), chronic kidney disease, HDL, restless leg syndrome (RLS), anemia, GERD, CHF, pain, and major depression.<br><br>Physician's Orders, dated July 2024 and current at the time of Resident 44's death, included but were not limited to the following:<br><br>- Acetaminophen extended release 650 mg every 6 hours as needed for pain.<br>- Aspirin (anti-inflammatory medication) 81 mg daily.<br>- Atorvastatin calcium 20 mg at bedtime.<br>- Empagliflozin (medication used to treat diabetes) 25 mg daily.<br>- Ferrous sulfate (iron supplement) 325 mg every other day.<br>- Gabapentin (nerve pain medication) 100 mg, 2 capsules daily at bedtime.<br>- Humalog kwik-pen insulin sliding scale for diabetes<br>- Isosorbide mononitrate (a medication for heart related chest pain) 20 mg daily.<br>- Pantoprazole sodium 40 mg daily.<br>- Rivaroxaban (blood thinner) 15 mg daily.<br>- Torsemide (diuretic medication) 60 mg twice a | | On 7/29/2024, the facility switched pharmacy providers. The new pharmacy provider has a policy in place that requires all medications, narcotics and non-narcotics to have a destruction log in place.<br>Beginning 7/29/2024, all licensed staff received and signed acknowledgment of the new policy.<br>The Unit Manager and/or her designee will complete audits on all discharged residents. This audit will be completed on all discharged residents four weeks.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The DON and Unit Managers are responsible for implementing and monitoring this plan.<br>**By what date the systemic changes for each deficiency will be completed?**<br>8/16/2024 | |

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| | day.<br><br>The closed clinical record lacked a drug disposition document for Resident 44's non-narcotic medications.<br><br>During an interview on 7/29/24 at 11:45 a.m., the Administrator indicated the closed clinical records for Resident 139 and Resident 44 lacked drug dispositions records for their non-narcotic medications. The facility disposed of the medications upon the resident's discharge from the facility; however, a non-narcotic drug disposition record was not completed for either resident.<br><br>During an interview on 7/31/24 at 8:45 a.m., Unit Manager 11 indicated resident medications were to be destroyed at the time of the resident's discharge from the facility. Non-narcotic drug disposition records were not completed when residents were discharged.<br><br>On 7/29/24 at 11:40 a.m., the Administrator provided a copy of the Medication Disposal and Returns policy, dated 6/21/17, and indicated it was the current policy in use by the facility. A review of the document indicated, "...facilities will dispose of...medications...in accordance with local, State, and Federal regulations..."<br><br>3.1-25(s) | | | |
| F 0812<br>SS=E<br>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 | | | |

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| | 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 serve food in accordance with professional standards for food service safety.<br><br>Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 6 of 6 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Assistant Dietary Manager, Chef 5, Dietary Aide 6, Dietary Aide 7, Kitchen Contractor 8, and Dietary Aide 9)<br><br>Findings include:<br><br>1. During the initial kitchen tour with the Dietary Manager (DM), on 7/23/24 from 10:10 a.m. to 10:20 a.m., the following was observed:<br>- Assistant DM was observed walking throughout the kitchen area where the noon meal was being prepared. Assistant DM's hair located in front of her ears was approximately 2 inches in length and the hair at the neckline was approximately 4 inches in length. The hair was observed to not be covered. | F 0812 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Culinary Supervisor was educated for not wearing proper hair coverage in the kitchen was educated on 7/26/2024. All culinary staff were educated beginning 8/13/2024 on the proper usage of hairnets when entering the kitchen.<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>No other residents were found to be affected by this alleged deficient practice. On 8/13/2024, all culinary staff were educated on | 08/16/2024 |

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| | - Chef 5 was observed walking throughout the kitchen area where the noon meal was being prepared. Chef 5's hair, approximately 2 inches in length, was observed to not be covered.<br><br>2. During a follow-up kitchen observation, on 7/23/24 from 11:30 a.m. to 12:05 p.m., the following as observed:<br>- Dietary Aide 6 was observed at the steamtable taking the noon starting food temperatures and plating the noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.<br>- Dietary Aide 7 was observed plating the noon meal at the steamtable. Dietary Aide 7 had multiple loose hairs in front of her ears and across the top of her head. The loose hairs were approximately 1 inch in length and were observed to not be covered.<br>- Chef 5 was observed walking throughout the kitchen area where the noon meal was being plated. Chef 5 was observed preparing food for the evening meal. Chef 5 had multiple loose hairs in front of his ears and at the neckline. The loose hairs were approximately 2 inches in length and were observed to not be covered.<br>- Kitchen Contractor 8 was observed walking throughout the kitchen area and near the steamtable where the noon meal foods were being plated. Kitchen Contractor 8's hair on his head was approximately 1 inch in length. He also had facial hair, approximately 2 inches in length, that covered his entire facial area. Kitchen Contractor 8's hair was observed to not be covered.<br><br>During an interview at that time, Kitchen Contractor 8 indicated all hair was to be kept covered when in the kitchen area. | | wearing hairnets in the kitchen.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br>New postings for use of hair restraints upon entry of kitchen have been posted at all kitchen entrances/exits. The Culinary Director and/or her designee will do random audits to ensure culinary staff are wearing hairnets and/or beard nets, and that all hair is fully covered. This audit will be completed once daily at random times for one week, then at random times, on three different days for one week, and then randomly once a week for two weeks.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The culinary manager will bring the results of these audits to the monthly Quality Assurance Meeting. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the Committee may decide to stop the written audits. The Culinary Manager is responsible for implementing and monitoring this plan. | |

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| | 3. During a dining observation on 7/23/24 at 12:10 p.m., Dietary Aide 9 was observed in the Rehabilitation Unit. Dietary Aide 9 was observed working at the steamtable unit and was plating the resident's noon meal. Dietary Aide 9 had multiple hair braids in front of the left ear. The braids were approximately 7 inches in length and were observed to not be covered.<br><br>4. During a follow-up kitchen observation, on 7/23/24 from 12:30 p.m. to 12:45 p.m., the following was observed:<br>- Chef 5 was observed walking throughout the kitchen area; near the steamtable where the noon meal was being plated; and working at the food preparation table preparing desserts for the evening meal. Chef 5 had multiple loose hairs in front of his ears and at the neckline. The loose hairs were approximately 2 inches in length and were observed to not be covered.<br>- Dietary Aide 6 was observed plating the noon meals at the steamtable and was taking the ending temperatures for the noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.<br><br>5. During a follow-up kitchen observation, on 7/30/24 from 11:10 a.m. to 11:20 a.m., the following was observed:<br>- Dietary Aide 6 was observed frying an egg on the grill and taking the noon meal food starting temperatures at the steamtable. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.<br>- Assistant DM was observed near the grill area | | **By what date the systemic changes for each deficiency will be completed?**<br>8/16/2024 | |

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|---|---|---|---|
| | 155771 | A. BUILDING 00<br>B. WING | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE | 1070 W JEFFERSON ST<br>FRANKLIN, IN 46131 |

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| | where noon foods were being prepared and was near the steamtable where the noon meal foods were being held. Assistant DM's hair located in front of her ears was approximately 2 inches in length and the hair at the neckline was approximately 4 inches in length. The hair was observed to not be covered.<br><br>6. During a follow-up kitchen observation, on 7/30/24 from 1:15 p.m. to 1:20 p.m., Dietary Aide 6 was observed at the steamtable plating the noon meal and began taking the ending temperatures for noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.<br><br>During an interview on 7/23/24 at 12:50 p.m.c, the DM indicated all staff's hair was to be covered while in the kitchen.<br><br>During an interview on 7/30/24 at 1:25 p.m., the Corporate Traveling Chef indicated staff were to keep their hair completely covered while in the kitchen.<br><br>On 7/25/24 at 9:00 a.m., the DM provided a copy of the Employee Sanitary Practices policy, dated 2013, and indicated it was the current policy in use by the facility. A review of the policy indicate, "...all kitchen employees will practice standard sanitary procedures...wear hair restraints when preparing food (hairnet, hat, and/or beard restraint) to prevent from contacting exposed food...follow all federal, state, and local requirements..."<br><br>On 7/25/24 at 4:05 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, | | | |

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| | "...food employees shall wear hair restraints, such as...beard restraints..."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | | | |

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| | (ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure the staff | F 0880 | **What corrective action(s) will be accomplished for those** | 08/16/2024 |

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| | were wearing PPE (personal protection equipment) for 1 of 3 residents who were observed for enhanced barrier precautions. (Resident 9)<br><br>Findings Include:<br><br>On 7/24/24 at 10:30 a.m., RN 2, CNA 4, LPN 3, entered Resident 9's room to provide wound care. RN 2 carried in supplies retrieved from treatment cart, LPN 3 assisted with turning and positioning Resident 9 while CNA 4 held clean linen. RN 2, LPN 3, and CNA 4 donned gloves. RN 2 and LPN 3 turned Resident 9 on his left side and RN 2 removed the old bandage and changed her gloves, no hand hygiene was observed. RN 2 cleaned the wound and a topical medication was applied to the wound. CNA 4 then provided incontinence care with only gloves. Only gloves were utilized during the observed treatment by all three staff providing care.<br><br>Resident 9's clinical record was reviewed on 7/24/24 at 11:00 a.m., The diagnosis included, but was not limited to, pressure ulcer of right buttock, stage 3.<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 6/14/24, indicated Resident 9 had moderate cognitive impairment and an open area to the right buttock.<br><br>The Physician Orders included, but were not limited to, "Enhanced Barrier Precautions- Gloves and Gown with treatment and or care every shift for wound" ordered 3/16/20..<br><br>During an interview on 7/26/9:28 a.m., Resident 9 indicated that "Nurses never wear a gown when providing wound care". | | **residents found to have been affected by the deficient practice?**<br>All staff were educated regarding using the proper PPE with enhanced barrier precautions on 7/29/2024 by the Unit Managers once the Administrator was notified of the alleged deficient practice.<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>No other residents were found to have been affected by the alleged deficient practice. On 7/29/2024, the Unit Managers checked all their residents who are on enhanced barrier precautions to ensure they had proper orders and signage to signify that EBPs were to be in place. Beginning 7/29/2024, all other staff were educated by the Unit Managers regarding proper usage of PPE for residents who are on enhanced barrier precautions.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br>The Unit Manager and/or her designee will do random audits to check that residents who are on enhanced barrier precautions are being cared for by staff wearing proper PPE. This audit will be | |

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| | During an interview on 7/26/24 at 11:00 a.m., Administrator indicated that staff should wear gloves and gown with Enhanced Barrier Precautions.<br><br>On 7/29/24 at 10:02 a.m., the Administrator provided a copy of policy titled, Otterbein Senior Life Procedure, Isolation Precautions, revised 8/1/22. The policy indicated Elements of Enhanced Barrier Precautions, gloves and gowns should be work during high-contact resident care, dressing, bathing/showering, changing linens, transferring (when in resident room), providing hygiene, toileting, device care (use in central line, urinary catheter, feeding tube, tracheostomy) and wound care (skin opening requiring a dressing).<br><br>3.1-18(b)(1) | | completed once daily for one week, then once daily three times for one week, and then randomly once a week for two weeks. | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Residential Complaint IN00434298. This visit included a Recertification and State Licensure Survey.<br><br>Complaint IN00434298 - No deficiencies related to the allegations are cited.<br><br>Survey dates: July 23, 24, 25, 26, 29, 30 and 31, 2024<br><br>Facility number: 001127<br><br>Residential Census: 155<br><br>Otterbein Franklin Senior Life Community was | R 0000 | The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review. | |

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| | found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Residential Complaint IN00434298. | | | |