STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00425228. Complaint IN00425228 - No deficiencies related to the allegations are cited. Survey dates: February 5, 6, 7, 8, 9, 12, 13, 2024 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census Bed Type: SNF/NF: 88 SNF: 9 Total: 97 Census Payor Type: Medicare: 10 Medicaid: 69 Other: 18 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 21, 2024.	F 0000	**Submission of this plan of correction does not constitute an admission by Brown County Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Smith	DON	03/02/2024

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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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity for 1 of 2 residents reviewed for dignity and 1 random	F 0550	**F 550 I. The corrective actions to be accomplished for**	03/01/2024

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	interview during the resident council meeting. A resident was not given oral care after vomiting and a resident's stained linens were not changed. (Resident 66, Resident 96) Findings include: 1. On 2/6/24 at 10:18 A.M., Resident 66 was observed laying in bed wearing a hospital gown that was falling off both shoulders and she was holding it up with her contracted hands. Her hair was greasy and disheveled and was not wearing non skid socks. On 2/9/24 at 1:23 P.M., Resident 66's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, dysphagia, aphasia The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 12/22/23, indicated her cognition was not able to be assessed, and was an extensive assist of 2 staff for bed mobility, transfers, and toileting. On 2/8/24 at 6:03 A.M., Resident 66 was observed laying in her bed with a dark brown substance smeared on mouth, sheets, right hand, and gown. At that time, NA 21 grabbed bed linens from the closet and notified the nurse for the 300 hall that Resident 66 had vomited again. After Certified Nurse Aide (CNA) 19 and Nurse Aide (NA) 21 wiped the resident off, changed her gown, and changed her linens, no water was given because the resident was NPO (nothing by mouth) due to being a tube feed and no oral care was offered or provided at that time. CNA 19 indicated immediately after care was finished that she needed to get back to her hall.		**those residents found to have been affected by the practice.Resident 66 received oral care and hygiene at the time of the concern.Resident 96 bed linens were changed at the time of the concern and will be changed routinely. II. The facility will identify other residents that may potentially be affected by the practice.Current residents receiving care have the potential to be affected. Current resident's have been observed for any dignity/resident rights concerns. Any concerns noted have been addressed as necessary. III. The facility policy on Resident Rights was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur.Facility staff will receive re-education regarding resident rights and dignity and the facility procedures for hygiene and changing bed linens by 2/28/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe 2 random resident's oral care/hygiene 5x a week for 8 weeks, then 2 random resident's oral care/hygiene 2x**	

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	During an interview on 2/13/24 at 10:10 A.M., CNA 19 indicated oral care should be done immediately after a resident had vomited. 2. On 2/07/24 at 2:17 P.M. during Resident Council, Resident 96 indicated he had been asking for clean sheets for his bed for a week and had been told they ran out and did not have any available. During an observation on 2/7/23 at 3:06 p.m., Resident 96's bottom sheet on his bed was covered with a pillow case. At that time, the resident indicated he took his pillow case off his pillow to cover the stains on his sheets because he had been trying to get his sheets changed for a week and was told they were out of clean sheets each time he asked. When the resident lifted the pillow case from his sheet, there were multiple dried stains on the sheet. He indicated the stains on the side were from his abdominal wound and wound vac leaking and the stain in the middle was from an accident he had in bed. On 2/08/24 at 08:59 A.M., Resident 96's clinical records were reviewed. The diagnosis included, but was not limited to, encounter for surgical aftercare following surgery on the digestive system, sepsis, and perforation of intestine (nontraumatic). The Admission MDS Assessment, dated 1/10/24, indicated Resident 96 was cognitively intact and required extensive assistance of two with bed mobility, transfer and toilet use and was getting surgical wound care. During an interview on 2/08/24 at 5:17 A.M., NA 21 indicated they were short on linens a lot. She was not sure if laundry was behind or if there weren't enough of them.		**a week for 8 weeks, and then 2 random resident's oral care/hygiene weekly for 36 weeks or as deemed by the Quality Assurance Committee. The DON/Designee will review all residents who were scheduled for a linen change 5x per week for 8 weeks, then will review all residents who are scheduled for a linen change 3x per week for 8 weeks, then all residents who are scheduled for a linen change weekly for 36 weeks or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	

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	A Resident Rights Policy provided on 2/9/24 at 2:20 P.M., dated 6/6/19, indicated the following: "A. Federal and state laws guarantee certain basic rights to all residents of our community. These rights include the resident's right to: 1. A dignified existence; 2. Be treated with respect, kindness and dignity;...20. Privacy and confidentiality;...37. Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality." 3.1-3(a)(1)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 4 residents observed during a medication pass. (Resident 58) Finding includes: On 2/8/24 at 7:11 A.M., Licensed Practical Nurse (LPN) 3 was observed during a medication pass to administer medications to Resident 58. The medications were obtained from the medication cart, placed in a medication cup, and taken into Resident 58's room. LPN 3 handed the medication cup to the resident, and the resident requested a pain medication. LPN 3 left the room prior to the resident taking the medications, closed the door,	F 0554	**F 554 I. The corrective actions to be accomplished for those residents found to have been affected by the practice.Resident 58's medications were taken by the resident without complications. His medications were no longer left at bedside for him to take without supervision.** **II. The facility will identify other residents that may potentially be affected by the practice.Current residents receiving care have the potential to be affected. Current resident's have been observed for any**	03/01/2024

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	and obtained a pain medication from the cart. LPN 3 took that medication to Resident 58, and left the room prior to the resident taking that medication. On 2/9/24 at 1:30 P.M., Resident 58's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and emphysema. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/28/24, indicated no cognitive impairment, and a requirement of supervision for transfers and bed mobility. Resident 58's clinical record lacked an order for self administration of medications. Resident 58's clinical record lacked a care plan for self administration of medications. Resident 58's clinical record lacked a self administration of medications assessment. On 2/9/24 at 1:43 P.M., Clinical Support 5 indicated Resident 58 did not have an assessment to self administer medications. On 2/12/24 at 10:04 A.M., LPN 3 indicated staff should stay with residents when passing medications until they take them. On 2/9/24 at 1:15 P.M., a current non-dated Medication Administration Skills Validation form was provided. At that time, Clinical Support 5 indicated the form served as a medication administration policy. The form indicated "Remain with the resident to ensure that the medication was swallowed" 3.1-11(a)		**self administration of medication concerns with no concerns noted. Residents were reviewed for any orders that are to be self administered to ensure appropriate self administration assessment was completed. III. The facility procedure on Medication Administration was reviewed with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur.Facility QMAs, and Nurses will receive re-education regarding Medication Administration by 2/28/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe 2 random resident's medication administration 5x a week for 8 weeks, then 2 random resident's medication administration 2x a week for 8 weeks, and then 2 random resident's medication administration weekly for 36 weeks or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date:**	

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			3/1/24	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document			

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	whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident in order to meet medical needs that were identified in the comprehensive assessment. Staff did not follow orders and implement care plan interventions for 6 of 8 residents reviewed for falls and nutrition. (Resident 38, Resident 53, Resident 68, Resident 2, Resident 64, Resident 80) Findings include: 1. On 2/5/24 at 10:00 A.M., Resident 38 was observed sitting in a wheelchair beside the bed. She was leaning over with her arms and head resting on the bed, her butt still in the wheelchair, and wearing socks that were not non-skid. On 2/7/24 at 1:57 P.M., Resident 38 was observed sitting in a wheelchair in her room with a bedside table in front of her. Resident 38 was wearing socks that were not non-skid. On 2/8/24 at 8:01 A.M., Resident 38's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and right femur fracture.	F 0656	=" b=""> =" b=""> **b="">** **b="">** =" p="">F656 =" p="">**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** =" p="">**Resident 38 was provided non skid socks and the resident's plan of care was reviewed** =" p="">**Resident 53 was provided non skid socks and the resident's plan of care was reviewed** =" p="">=" b="">Resident 68 had the padded mat opened and placed next to the bed and the plan of care was reviewed. Resident 2 has been followed routinely by the facility Dietician. The resident's weight is stable.	03/01/2024

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	The most recent Admission MDS (Minimum Data Set) Assessment, dated 1/17/24, indicated cognition status could not be determined. Resident 38 was dependent on staff with toileting and bathing, and had experienced a fall with fracture prior to admission. A current risk for falls care plan, dated 1/12/24, included, but was not limited to, the following intervention: Resident to have non skid socks while out of bed, dated 1/23/24. On 2/12/24 at 9:51 A.M., Licensed Practical Nurse (LPN) 7 indicated Resident 38 was supposed to have on non-skid socks at all times as a fall intervention. 2. During an observation on 2/8/24 at 5:21 A.M., Resident 53 was observed sitting in a wheelchair in the common area with plain white socks on both feet. During an observation on 2/8/24 at 7:24 A.M., Resident 53 was observed in a wheelchair in the common area with plain white socks on both feet. On 2/7/24 at 10:56 A.M., Resident 53's clinical record was reviewed. Resident 53's current diagnoses included, but was not limited to, Alzheimer's disease and anxiety disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/21/23, indicated Resident 23 required extensive assistance of 2 people for bed mobility and transfers. Resident 53's current Physician Orders included, but was not limited to, "Resident uses the following mobility devices: Wheelchair," dated		The facility will continue to weigh resident per the Physician orders and follow Dietician recommendations timely. The residents dietary recommendations were addressed. Resident 64 weights have been reviewed. Weights will be obtained and monitored for completion. The facility will follow any new recommendations as indicated by the Dietician timely. Resident 64s weight returned to stable weight when next weighed. Resident 80s weights have been reviewed. Weights will be obtained and monitored for completion. The facility will follow any new recommendations as indicated by the Dietician timely. The residents dietary recommendations were addressed. **II. The facility will identify other residents that may potentially be affected by the practice.Current residents receiving care have the potential to be affected. Current resident's have been observed for care plan interventions not in place, with no concerns noted. All resident's fall care plans were reviewed. Dietician recommendations for the previous 30 days were reviewed to ensure all Dietician recommendations have been addressed. All residents on weekly or daily**	

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	11/14/23. Resident 53's care plan included, but was not limited to, "...at risk for falling and fall related injuries due to cognitive deficits secondary to dementia, auditory hallucinations, and a history of falls before admission," last revised 12/13/23. Current interventions included, but was not limited to, "...Resident to wear non-skid socks at all times..." start date 11/14/23. 3. During an observation on 2/5/24 at 2:21 P.M., Resident 68 was observed sleeping in bed. A padded mat was folded up and placed underneath the bed. During an observation on 2/8/24 at 5:20 A.M., Resident 68 was observed sleeping in bed. A padded mat was leaning sideways on the air conditioner system. On 2/8/24 at 9:50 A.M., Resident 68's clinical record was reviewed. Current diagnoses included, but was not limited to, Parkinson's disease, anxiety disorder, and ataxic [without coordination] gait. The most recent Significant Change MDS, dated 2/2/24, indicated the resident had a fall in the last month prior to admission or reentry. Resident 68's current Physician's Orders included, but was not limited to, "...up as tolerated per plan of care," dated 1/25/24 Resident 68's care plan included, but was not limited to, "...Resident at risk for falling and fall related injuries related to Parkinsons," revised 2/2/24. Current interventions included, but was not limited to, "...padded mat at bedside..." start		**weights were reviewed. III. The facility will put into place the following systematic changes to ensure that the practice does not recur.The DON/ADON will receive re-education regarding Dietician recommendations by 2/28/24. The facility nursing staff will receive re-education regarding weighing residents per Physician orders and care plan interventions by 2/28/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe residents on rounds to ensure fall care plan interventions are in place 2x a day 5 days a week for 8 weeks, then 2x a day 3 days a week for 8 weeks, and then will observe residents for appropriate fall care plan interventions once weekly for 36 weeks or as deemed by the Quality Assurance Committee.** The DON/Designee will monitor using an audit tool daily/weekly weights 5x a week for 8 weeks, then 3x a week for 8 weeks, then weekly for 36 weeks or as deemed by the Quality Assurance Committee. DON/Designee will monitor timely completion of Dietician recommendations using an audit tool to track the date the Dietician Recommendations are	

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	date 7/13/23. During an interview on 2/12/24 at 10:06 A.M., Licensed Practical Nurse (LPN) 33 indicated Resident 53 should have non-skid socks on at all times and Resident 68 should have a fall mat placed on the floor beside his bed when he is in bed. 4. On 2/7/24 at 12:14 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain dysfunction, seizures, and persistent vegetative state. The most recent MDS Assessment, dated 12/5/23, indicated the resident's cognition was not able to be assessed, had weight loss, height was 6 foot, weight was 149 lbs (pounds), and he was totally dependent on 2 staff for bed mobility, transfers, and toileting. Physician's orders included, but were not limited to, the following: Obtain and record daily weight upon rising before am feeding, ordered 7/24/23 and discontinued 8/24/23 Jevity 1.5 per pump. Rate: 55 ml/hr continuous. 50 ml of flush three times a day, ordered 5/2/23 and discontinued 10/30/23 Jevity 1.5 per pump. Rate: 65 ml/hr continuous. 150 ml of flush every 6 hours, ordered 10/30/2023 The clinical record lacked a current order for weights to be completed on Resident 2. A current Feeding Care plan, revised 11/27/23, included, but was not limited to, the following intervention: Monitor and record weight per MD (Medical		received, and the date they are completed to ensure timely completion. This will be completed each day the Dietician recommendations are received each week for 36 weeks or as deemed by the Quality Assurance Committee. **The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	

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	Doctor) order, initiated 5/16/17 Progress Notes included, but were not limited to, the following: On 6/14/23-Resident weight: 157.7 lbs, Registered Dietician (RD) recommended weekly weights x 4 to be done On 6/19/23-Order for weekly weight from RD were put in (5 days later) On 7/18/23-Resident weight 145.4 lbs, RD recommended daily weights On 7/24/23-Order for daily weight was put in from RD (6 days later) On 8/15/23-Resident weight 141.2 lbs, RD recommended to increase Jevity tube feed from 55 to 65 ml/h (milliliter per hour) with 150 ml flush every 6 hours and continue with weight monitoring On 9/20/23-Resident weight on 9/4/23 was 146.7 lbs, RD recommended increase Jevity tube feed from 55 to 65 ml/h (milliliter per hour) with 150 ml flush every 6 hours On 10/23/23-Resident weight on 10/5/23 was 145.2 lbs, RD recommended increase Jevity tube feed from 55 to 65 ml/h and with 150 ml flush every 6 hours On 10/30/23-Order for Jevity tube feed from 55 to 65 ml/h was entered (2.5 months later) Review of resident weights from 6/1/23 to 8/24/23 when the daily weight order was discontinued were reviewed. The order for daily weights was entered on 7/24/23 but not started until 8/2/23 and the following days were missing: 8/8/23 8/10/23 8/11/23 8/17/23 8/20/23			

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	155333	A. BUILDING 00 B. WING	02/13/2024

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	5. On 2/9/24 at 2:46 P.M., Resident 64's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's, dementia, dysphagia. The most recent Quarterly MDS Assessment, dated 11/6/23, indicated Resident 64's cognition was severely impaired and he was an extensive assist of 2 staff for bed mobility, transfers, and toileting. Physician's Orders included, but were not limited to the following: Obtain and record weekly weigh, ordered 2/6/24 A current Nutrition/Weight Loss Care plan, revised 1/23/24, included, but was not limited to, the following interventions: Monitor/record weight routinely, notify MD/RD of significant weight changes, initiated 12/4/20 Progress notes included, but were not limited to the following: On 11/17/23 9:33 A.M.-"Wt [weight] record showing 13# [pound] loss in one month. Recommend to reweigh to verify accuracy. On 12/14/23 3:12 P.M.-"Resident has a noted significant weight loss of 6.1% in 30 days ... will be followed by IDT [interdisciplinary team and weight monitor weekly x 4 weeks. Plan of care in place and appropriate ... " On 1/23/24 11:29 A.M.-" ... nsg [nursing] noted prior edema which has resolved, and daily weights ordered to monitor changes ... " Resident 64's weights were reviewed from 9/4/23 to 2/5/24 and included, but were not limited to, the following weights:			

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	10/6/23 220.1 lbs 11/6/23 206.6 lbs 12/6/23 204 lbs 12/10/23 203 lbs 12/17/23 204.2 lbs 12/24/23 200.4 lbs 12/31/23 196.4 lbs 1/4/24 196.4 lbs 1/7/24 197.8 lbs 1/14/24 196.9 lbs 1/21/24 195.7 lbs 1/28/24 187 lbs 2/5/24 197 lbs The clinical record lacked a reweigh for 11/17/23 and 1/28/24. During an interview on 2/9/24 at 3:45 P.M., Clinical Support 5 indicated the weight for 1/28/24 must have been an error but there was not a reweigh. During an interview on 2/12/24 at 3:34 P.M., the DON indicated she was not sure why Resident 64 was not weighed as recommended by the dietician. 6. On 2/8/24 at 9:31 A.M., Resident 80's clinical record was reviewed. Diagnoses included, but was not limited to, pressure ulcer of sacral region, unstageable and seizures The most recent Quarterly MDS Assessment, dated 1/22/24, indicated Resident 80 was cognitively intact and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Physician's Orders included, but were not limited to, the following: Offer 240 ML Med-Pass Three Times A Day, ordered 12/4/23			

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	Offer 30 ml pro heal liquid protein Once A Day Upon Rising, ordered 9/5/23 Obtain and record daily weight upon rising before breakfast, ordered 11/08/2023 and discontinued 12/13/2023 Weekly weight Once A Day on Mon, ordered 12/18/23 A current Nutrition Care Plan, revised 1/29/24, included, but was not limited to, the following interventions: Monitor/record weight routinely, notify MD/RD of significant weight changes, initiated 8/29/23 Progress notes included, but were not limited to, the following: On 11/17/23 10:32 A.M.-"RD review ... She has orders for daily weights to monitor changes ... increase med pass from BID [twice daily] to TID [three times daily]. Continue with weight monitoring per order ... " On 12/4/23- Order from RD to increase Med pass to TID entered (17 days later) Resident 80's weights were reviewed from 11/6/23 to 1/15/24 and included, but were not limited to the following weights: 11/6/23 120 lbs 11/16/23 112.2 lbs 12/7/23 114.1 lbs During an interview on 2/12/24 at 1:59 P.M., the DON indicated she was responsible for getting the dietician's recommendations, asking the MD, and putting the orders into the resident's clinical record. She said the RD usually sends recommendations to her within 1 week of her			

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	visiting and she put orders in when she was able. During an interview on 2/12/24 at 3:34 P.M., Clinical Support 1 indicated the RD notes prior to October 2023 were before they started working at the facility and they weren't sure why the orders were missed. During an interview on 2/12/24 at 3:57 P.M., Clinical Support 1 indicated there was not a policy for the time frame orders should be put into the clinical record or for following MD orders but it was standard of Care to follow physician's orders. On 2/12/24 at 10:00 A.M., the Director of Nursing (DON) provided the Fall Prevention Policy and Procedure, dated May 2016, that indicated, "...Care plans are a vital part of the nursing process and serve as an individualized pathway used by all care givers...Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system..." 3.1-35(g)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record	F 0695	=”” b=””>	03/01/2024

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	review, the facility failed to ensure the residents received the necessary respiratory care and services in accordance with the professional standards of practice for 2 of 2 residents reviewed for respiratory care. The facility failed to have a physician's order for oxygen and follow physician's order for oxygen. (Resident 15, Resident 88) Findings include: 1. During an observation on 2/7/24 at 1:50 P.M., Resident 15 was sitting in a wheelchair in the common area with portable oxygen (O2) on at 2 liters per minute per nasal cannula with her eyes closed and her chin resting on her chest. During an observation on 2/8/24 at 10:01 A.M., Resident 15 was sitting in a wheelchair in the hallway outside of her room holding her oxygen tubing in her hand. The portable tank was hanging on the back of her wheelchair set at 2 liters. During an observation on 2/9/24 at 9:45 A.M., Resident 15 was sitting up in a wheelchair in the common area with oxygen on per nasal cannula at 2.5 liters per minute with her eyes closed and chin on chest. During an observation on 2/9/24 at 2:30 P.M., Resident 15 was sitting on the side of her bed with oxygen on at 2 liters per minute per nasal cannula. During an observation on 2/12/24 at 10:15 A.M., Resident 15 was sitting in a wheelchair in her room and the oxygen tubing was lying on the floor. The portable oxygen tank on the back of the wheelchair was set at 2 liters per minute.		=" b=""> =" span="">=" span="">F695 **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** =" b="">Resident 15's Physician orders were updated with Oxygen orders Resident 88's oxygen was placed on 2L per Physician order at the time of the concern. The residents care plan was updated with noncompliance due to her changing her settings herself. **II. The facility will identify other residents that may potentially be affected by the practice.Current residents receiving care have the potential to be affected. Current resident's have been observed for accurate liter flow of oxygen with no concerns noted. All resident's who utilize oxygen, their physician orders were reviewed with no concerns noted. III. The facility policy for oxygen administration was reviewed with no changes made. The facility will put into place the following systematic changes to ensure that the practice does not recur.The nursing staff will receive**	

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	On 2/7/24 at 10:54 A.M., Resident 15's clinical records were reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, chronic systolic (congestive) heart failure, and unspecified dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/27/23, indicated Resident 15 had severe cognitive impairment and needed extensive assistance of 2 for bed mobility, transfers, toilet use and had oxygen. Current physician orders included but were not limited to the following: Change and date oxygen tubing, humidifier bottle and nebulizer tubing Special Instructions: Change weekly and PRN (as needed) Once A Day on Sunday 10:00 P.M. - 6:00 A.M., dated 4/24/2020. The clinical record lacked an order for oxygen. A current care plan for "Resident is at risk for impaired gas exchange and requires oxygen therapy R/T (related to) COPD (chronic obstructive pulmonary disease)", initiated 11/01/23, included, but was not limited to the following intervention: Administer oxygen as ordered Start Date, 11/01/2023. During an interview on 2/12/24 at 10:02 A.M., LPN 37 indicated if a resident was wearing O2 (oxygen) they need an order, and if a resident needed O2 and didn't have an order they should call the MD (Medical Doctor) to get an order. 2. On 2/6/24 at 9:50 A.M., Resident 88 was observed lying in bed with oxygen via nasal cannula on. She indicated at that time that she wears it all the time. The oxygen concentrator was		**re-education regarding oxygen use and Physician orders for oxygen use by 2/28/24. IV. The facility will monitor the corrective action by implementing the following measures. DON/Designee will observe residents who wear oxygen 2x a day 5 days per week to ensure accurate liter flow and Physician order, then 2x a day 3 days per week, then weekly x 36 weeks or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	

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	observed to be at 3 lpm (liters per minute). On 2/7/24 at 12:16 P.M., Resident 88 was observed sitting in her room in a wheelchair with oxygen via nasal cannula on. The oxygen concentrator was observed to be at 3 lpm. On 2/9/24 at 9:45 A.M., Resident 88 was observed sitting in her room in a wheelchair with oxygen via nasal cannula on. The oxygen concentrator was observed to be at 3 lpm. On 2/12/24 at 9:53 A.M., Resident 88 was observed lying in bed with oxygen via nasal cannula on. The oxygen concentrator was observed to be at 3 lpm. On 2/8/24 at 9:46 A.M., Resident 88's clinical record was reviewed. Diagnosis included, but were not limited to, acute respiratory failure with hypoxia. The most recent Quarterly MDS Assessment, dated 12/7/23, indicated no cognitive impairment and no behaviors. Resident 88 required maximum assistance with toileting and bathing, and used oxygen therapy while a resident. Current physician orders included, but were not limited to, Oxygen (2 liter/min) continuous per nasal cannula, dated 10/4/23. A current potential for respiratory distress care plan, dated 11/14/23, included, but was not limited to, the following intervention: Administer oxygen per MD order, dated 11/14/23. On 2/12/24 at 10:02 A.M., LPN 3 indicated Resident 88's oxygen should be set at 2 lpm per the doctor's order, and was unaware that it was at			

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	3 lpm. An Oxygen Administration Skills Validation form provided on 2/12/24 at 10:30 A.M. by the Director of Nursing indicated to "Verify physician's order for the liter flow, method of delivery, length of administration prior to administering oxygen." 3.1-47(a)(6)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure services of an RN (Registered Nurse) were available at least 8 consecutive hours a day, 7 days a week for 1 of 27 days reviewed from the PBJ (Payroll Based Journal) Staffing Data Report during Quarter 4 of 2023 (weekends from July 1, 2023 through September 30, 2023). Finding includes: On 2/13/24 at 9:30 A.M., the Time Card Report from 7/1/23 through 9/30/23 was reviewed. Review	F 0727	F727 **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** ="" b="">
No residents were affected. **II. The facility will identify other residents that may potentially be affected by the practice.No residents were**	03/01/2024

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	of the Time Card Report indicated there was not any RN coverage on 9/29/23. During an interview on 2/7/24 at 1:46 P.M., the Administrator indicated the facility utilized Qualified Medication Aides (QMA) which may make their staffing ratio low. Corporate submits their staffing to the PBJ. On 2/14/24 at 12:33 P.M., a policy was requested, but not received during the survey period. 3.1-17(b)(3)		**affected.** **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.The DON/ADON were will receive re-education regarding RN coverage by 2/28/24 IV. The facility will monitor the corrective action by implementing the following measures. DON/designee will review 5 days per week that RN coverage requirement has been met for all 7 days of the week x 8 week, then will review RN coverage 3 days per week to ensure RN coverage has been met all 7 days x 8 weeks, then will review RN coverage weekly to ensure all 7 days of RN coverage has been met x 36 weeks or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	
F 0728 SS=E Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule.			

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	A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).			
	Based on interview and record review, the facility failed to ensure staff were completed with the CNA training program and evaluation within 4 months of their hire date for 4 of 4 staff that completed the CNA training program at the	F 0728	F728 **I. The corrective actions to be accomplished for those staff found to have been affected by the practice.**	03/01/2024

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	facility. Findings include: A list of staff that had completed the CNA training program at the facility was provided by the Assistant Director of Nursing (ADON) on 2/13/24 at 2:25 P.M., and indicated the following: On 2/12/24 at 9:47 A.M., employee records were reviewed. Hospitality Aide/Nurse Aide 25 had a start date of 8/25/23 and was not certified. Hospitality Aide/Nurse Aide 21 had a start date of 8/17/23 and was not certified. Hospitality Aide/Nurse Aide 29 had a start date of 6/29/23 and was not certified. Hospitality Aide/Nurse Aide 30 had a start date 6/30/23 and was not certified. During an interview on 2/13/24 at 11:10 A.M., Licensed Practical Nurse (LPN) 24 indicated as a Nurse Aide (NA) they have been checked off on everything but had not become certified. During an interview on 2/13/24 at 11:15 A.M., the ADON indicated they had completed the 120 hours but have not completed the certification test for various reasons. At that time, she indicated an unsupervised NA was allowed to do all care a CNA was responsible for, they just weren't certified. During an interview on 2/13/24 at 4:07 P.M., LPN 24 indicated they all took their first test and the ones who passed are certified. The ones who failed were responsible to reschedule the test and pay for it themselves. After delays with the electronic submission of applications to the State,		=" " b=" "> NA 25 is now certified and able to work as a CNA NA21 has been removed from doing direct patient care with residents until license is received. NA 29 has been removed from doing direct patient care with the residents until license is received. NA 30 is no longer an employee at the facility. **II. The facility will identify other staff that may potentially be affected by the practice.All NAs were reviewed and any NA that had exceeded the 4 months was removed from direct resident care as necessary** **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.The DON/ADON were will receive re-education regarding the 4 month time frame following the CNA training program by 2/28/24 IV. The facility will monitor the corrective action by implementing the following measures. DON/designee will review 5x a week the facility NA list to ensure no NA is exceeding the 4 months , then 3x a week the facility NA list will be reviewed to ensure no NA is exceeding the 4 months, then weekly x 36 weeks or as deemed by the Quality Assurance Committee. The**	

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	they were waiting for the State to send information to the Director of Nursing (DON), who is the director of the program, to approve the applications for the test. On 2/15/23 at 2:15 P.M., a CNA/staffing policy was requested and not received during the survey period. 3.1-14(b)		**results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on interview and record review, the facility failed to ensure complete and accurate documentation of resident records for 1 of 4 residents reviewed for hospitalizations. A resident's allergy list was not updated. (Resident 2) Finding includes: On 2/7/24 at 12:14 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain dysfunction, seizures, persistent vegetative state. The most current MDS (Minimum Data Set) Assessment, dated 12/5/23, indicated the resident's cognition was not able to be assessed and he was totally dependent on 2 staff for bed mobility, transfers, and toileting. The resident's clinical record did not list Bactrim (antibiotic) as an allergy. A current Allergy Care Plan, revised 11/27/23, included an allergy to Zosyn (antibiotic). Progress notes included, but were not limited to, the following: On 5/22/23 at 12:50 P.M., "This nurse reviewed systems and symptoms with [Nurse Practitioner's name]. New order received and noted for Bactrim DS BID [twice daily] x [for] 1 week. [mother's name] aware. ATB [antibiotic] started via Cubex [emergency] supply." On 5/24/23 at 1:47 P.M., "Resident has generalized rash to all extremities. suspected allergic reaction.	F 0842	F842 **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** ="" b="">
Resident 2s allergies were updated to Reflect the Bactrim DS **II. The facility will identify other residents that may potentially be affected by the practice.All residents were reviewed for the last 60 days to ensure any new allergy was added as necessary.** **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.The licensed nurses will receive re-education regarding adding allergies to the resident record by 2/28/24 IV. The facility will monitor the corrective action by implementing the following measures. DON/designee will review 5 days per week that there is no new allergies on any residents to ensure proper adding to the resident allergy list x 8 weeks, then will review 3 days per week x 8 weeks, then will review weekly x 36 weeks or as deemed by the Quality Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be**	03/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	contacted MD [medical doctor] who gave order to d/c [discontinue] Bactrim and start benadryl 25 mg [milligrams] q6h [every 6 hours] x [for] 3 days. order placed in matrix. family aware." On 5/26/23 at 12:22 P.M., "[Recorded as Late Entry on 05/27/2023 12:25 AM] Resident continues to receive Benadryl d/t possible allergic reaction to medication for treatment of cellulitis. Rash is resolving ... " On 7/29/23 at 2:33 P.M., " ... Generally very little change with patient from day to day. However, to [two] months ago he has had [sic] fever, redness around feeding tube site, and discharge from penis. Was given Rocephin IM [antibiotic] and started on Bactrim, but he had a reaction which was assumed to be due to the Bactrim, so it was stopped." During an interview on 2/12/24 at 1:59 P.M., the Director of Nursing (DON) indicated resident allergies are added to clinical record and any nurse would be able to update. During an interview on 2/12/24 at 3:34 P.M., Clinical Support 1 indicated the staff added the allergy to Resident 2's clinical record. During an interview on 2/13/24 at 9:41 A.M., Clinical Support 1 indicated there was not a current Accurate Documentation Policy but they follow regulations for accurate documentation. 3.1-50(a)(2)		**established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	155333	A. BUILDING 00 B. WING	02/13/2024

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (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			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure safe and sanitary infection control practices to help prevent the development and transmission of communicable diseases and infections for 4 of 5 residents observed for incontinence care, wound care, glucometer use. Gloves were not changed between dirty and clean tasks and the glucometer was cleaned with an alcohol wipe. (Resident 80, Resident 65, Resident 26, Resident 40) Findings include:	F 0880	F880 **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** ="" b="">
Resident 80 was assessed to ensure resident was cleaned properly , and no problems noted
Resident 65s wound was assessed with no complications noted to the wound.	03/01/2024

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	1. On 2/8/24 at 5:29 A.M., Nurse Aide (NA) 21 was observed performing incontinence care for Resident 80. NA washed her hands and put on gloves upon entering the room. She moved the bedside table, grabbed a clean brief, pulled down the sheets, removed the pillow between her legs and behind the resident, assisted resident onto her back, unfastened her brief, wiped creases of legs in front, grabbed a new wipe, and wiped the resident's peri area. Then she pulled out the wet brief. The resident indicated she had to urinate so NA placed the new brief under her and held it there. (A bedpan was not offered to the resident at the time.) After the resident was done, NA 21 grabbed another clean brief wiped the resident again, rolled the resident onto the right side to get the wet brief out, and put the new brief under the resident. NA 21 assisted the resident onto her back, pulled up and fastened the brief, pulled the draw sheet to roll the resident to her left side, adjusted the pillow under the resident's head, moved her call light, placed a pillow between her knees and one behind the resident, pulled her blanket up, took off her gloves, and sanitized hands. 2. During an observation on 2/8/24 at 12:09 P.M., LPN (Licensed Practical Nurse) 27 changed the sacral dressing on Resident 65. LPN 27 gathered supplies from the treatment cart, put Betadine gel in a medication cup, and put muscle rub in a medication cup. LPN 27 put gloves on, pulled the curtains around Resident 65, did not change gloves, put the head of the bed down, did not change gloves. LPN 27 rolled resident to the left side. Resident 65 had a bowel movement, LPN 27 was unable to find wipes in the resident's room, went into the bathroom to get a wash cloth, sprayed three in one cleaner on the resident's buttocks, used the dry wash cloth to clean the		Resident 26 was assessed to ensure resident was cleaned properly and skin was assessed. Resident 40 was assessed with no complications noted. **II. The facility will identify other residents that may potentially be affected by the practice.No other residents were affected upon observations, and there have been no resident concerns regarding handwashing/infection control.** **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.The facility nursing staff will receive re-education regarding Handwashing and Infection control with Peri care, hygiene, glucometer cleaning, and wound care by 2/28/24 IV. The facility will monitor the corrective action by implementing the following measures. DON/designee will do 3 handwashing observations , 2 peri care observations, one wound care observation, and 2 observations of glucometer machine cleaning 5 days per week x 8 weeks , then will go down to 3 days per week x 8 weeks, then weekly x 36 weeks as deemed by the Quality**	

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	resident, removed gloves without cleaning hands, put on clean gloves. LPN 27 cleaned 1 centimeter sized open area on sacrum with wound cleaner, applied skin prep around wound, put Betadine gel in opening, cut a piece off the Maxorb II dressing (with scissors), put Maxorb II dressing in wound and covered with Hydrocellular foam dressing, did not date dressing, removed gloves without cleaning hands and put on clean gloves. Resident 65 had another bowel movement. Certified Nurse Aide (CNA) 25 brought a package of wipes into room. LPN 27 cleaned buttocks with wipe, put clean brief under right side, turned resident to back, removed soiled brief and pulled clean brief through, cleaned front perineal area with a wipe, pulled brief between legs and fastened brief, removed gloves and put on clean gloves without cleaning hands. LPN 27 applied muscle rub to both legs, did not remove gloves. CNA 25 put on resident's socks and pants. LPN 27 helped pull pants up. CNA 25 assisted resident to sit on the side of the bed. LPN 27 and CNA 25 both lifted resident under the arms and assisted her to stand and pivot into wheelchair. LPN 27 brushed resident's hair, removed gloves, did not clean hands and wiped scissors with an alcohol wipe. 3. During an observation on 2/8/24 at 2:38 P.M., CNA 29 and CNA 31 were observed performing incontinence care on Resident 26. CNA 29 washed hands in bathroom and put on gloves, filled bath basin with warm water, took headphones off bed, put plastic bag on bed and put new bag in trash can, placed linens on wheelchair, uncovered resident and placed towel over perineal area without changing gloves. CNA 31 washed hands in bathroom and put on gloves, went back into bathroom and got soap, removed gloves and put		**Assurance Committee. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. V. Plan of Correction completion date: 3/1/24**	

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	clean gloves on. CNA 29 wet washcloth added soap, washed area under abd, wet washcloth and rinsed soap off, put wash cloth in plastic bag. Resident 26 complained of a sore area on right side under abdominal fold, 1/2 cm open area noted by CNA 29. CNA 29 wet wash cloth and put soap on it and washed groin area on left side, lifted scrotum and washed under scrotum, put wash cloth in plastic bag, wet washcloth and put soap on it and washed right groin area and under scrotum, put wash cloth in bag, wet wash cloth and put soap on it and washed penis, put wash cloth in bag. CNA 29 asked CNA 31 to go out to get more wash cloths. CNA 31 removed gloves, came back into room and went into bathroom, washed hands and put gloves on. CNA 29 wet wash cloth and rinsed penis and scrotum, put wash cloth in bag, dried resident, put towel in plastic bag. Resident 26 turned to left side, CNA 29 removed brief, pushed lift pad and lower sheet under resident. Resident 26's buttocks dark red but no open areas observed. CNA 29 wet wash cloth and put soap on it, washed buttocks, rinsed wash cloth and washed buttocks off again, put in trash bag, put bottom sheet on right side of bed and pushed under resident, folded top sheet twice to use as lift sheet, opened top drawer to get cream out with gloved hands, opened cream came out watery so removed gloves after throwing tube in trash, opened drawer again and removed another tube, put on his gloves and rubbed cream on buttocks, resident rolled to his back and turned to right side. CNA 31 removed sheets and handed to CNA 29 who put them in plastic bag, CNA 31 pulled sheets through and placed on mattress and pulled lift pad through, CNA 29 removed gloves,left room to go get top sheet returned to room and placed top sheet over resident. CNA 31 pushed sheet down behind mattress. CNA 29 put on gloves, carried basin into bathroom and			

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	155333	A. BUILDING 00 B. WING	02/13/2024

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	dumped out water. Resident 26 used remote to raise head of bed. CNA 29 removed trash bag from trash can and tied shut, put wash basin in plastic bag and put in bathroom, pushed curtains back and removed plastic bags from room. During an interview on 2/12/23 at 10:30 A.M., the Assistant Director of Nursing (ADON) indicated staff should wash or sanitize hands and should change gloves between dirty and clean tasks. 4. During an observation on 2/8/24 at 7:16 A.M., Qualified Medication Aide (QMA) 35 obtained a blood sugar on Resident 40. After the blood sugar was completed, QMA 35 used an alcohol swab to wipe the top of the glucometer where the strip is inserted. QMA 35 failed to use a proper sanitizing agent for the glucometer. During an interview on 2/8/24 at 7:42 A.M., LPN 27 indicated that bleach wipes should be used to clean the glucometer and then the glucometer should dry for 5 minutes. During an interview on 2/12/24 at 10:57 A.M., the Director of Nursing (DON) indicated alcohol should not be used to clean the glucometer. Germicidal wipes should be used to clean it. On 2/12/24 at 10:29 A.M., an undated Licensed Nurse Blood Glucose Testing Skill Validation form was provided by the DON and indicated, "...4. Prior to use the meter cleaned with bleach wipes or germicidal wipes...The meter should be vigorously rubbed over all surfaces and the meter should remain wet through the 2-3 minute "kill" time..." On 2/12/24 at 10:00 A.M., a Hand Washing/Hand Hygiene Policy, dated 3/24/16, was provided by the DON which indicated, "...5. Employees must			

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	wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);...h. Before and after assisting a resident with personal care;...k. Before and after changing a dressing...6. In most situation, the preferred method of hand hygiene is with an alcohol-based hand rub...If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents;...e. Before handling clean or soiled dressings, gauze pads, etc. [etcetera]; f. Before moving from a contaminated body site to a clean body site during resident care;...j. After removing gloves." 3.1-18(b) 3.1-18(l)			