STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155361	A. BUILDING 00 B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBER MANOR CARE CENTER	801 E ILLINOIS ST PETERSBURG, IN 47567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 8, 9 ,10, 11, and 12, 2024 Facility number: 000252 Provider number: 155361 AIM number: 100267780 Census Bed Type: SNF/NF: 35 SNF: 7 Residential: 16 Non-Certified Comprehensive: 4 Total: 62 Census Payor Type: Medicare: 7 Medicaid: 35 Other: 4 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 18, 2024.	F 0000	The submission of this plan Of correction does not indicate an admission by Amber Manor Care Center that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Amber Manor Care Center. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted July 9-12-2024. The facility respectfully requests from the department a desk review for substantial	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindi Lents	HFA Executive Director	08/01/2024

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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			compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically			

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	update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure physician notification prior to or after administration of an excessive dose of a medication as ordered for 1 of 2 residents reviewed for pain. (Resident 21) Finding includes: On 7/9/24 at 10:04 A.M., Resident 21's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy and arthritis. The most recent Annual MDS (Minimum Data Set) Assessment, dated 5/3/24, indicated a moderate cognitive impairment. Resident 21 had received scheduled pain medication. Current physician orders included, but were not limited to: acetaminophen capsule 650 mg (milligram) twice a day for mild pain (6:00 A.M. - 10:00 A.M., 6:00 P.M. - 10:00 P.M.), dated 7/27/23. acetaminophen capsule 650 mg oral every 4 hours as needed for fever, DO NOT exceed 3000mg acetaminophen in 24 hr period, dated 7/27/23.	F 0580	F 580 Notify of Changes Resident #21 suffered no ill effects from the alleged deficient practice. Resident was assessed with no concerns. MD contacted, and orders updated as indicated. All residents with medication that have “do not exceed” indications have the potential to be affected. Nursing staff educated on physician notification and documentation of “do not exceed” parameters. As a measure of on-going compliance, the DHS or designee will complete an	08/05/2024

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	acetaminophen tablet 650 mg every 4 hours as needed for pain, DO NOT exceed 3000mg acetaminophen in 24 hr period, dated 7/27/23. Resident 21's Medication Administration Record (MAR) for July 2024 indicated acetaminophen 650mg was administered on the following dates: 7/5/24 at 1:27 P.M. (as needed dose) 7/5/24 6-10 P.M. scheduled dose 7/6/24 at 12:21 A.M. (as needed dose) 7/6/24 at 5:13 A.M. (as needed dose) 7/6/24 6-10 A.M. scheduled dose 7/6/24 at 1:03 P.M. (as needed dose) Total amount of acetaminophen administered for the 24 hour period was 3900mg. On 7/10/24 at 9:55 A.M., Licensed Practical Nurse (LPN) 5 indicated staff was expected to add up all acetaminophen milligrams that had been given prior to giving an as needed dose to ensure they did not go over 3000mg in a 24 hour period. LPN 5 indicated if Resident 21 required a dose over the 3000mg limit, staff could either ask the resident if she would want to wait until it could be given, or staff could call the physician to request a different pain medication to give. LPN 5 indicated any communication with the physician would be placed in the progress notes. On 7/10/24 at 2:13 P.M., the Director of Nursing (DON) indicated staff was expected to monitor Resident 21's acetaminophen intake to make sure it did not go over 3000 mg in a 24 hour period. On 7/12/24 at 10:14 A.M., the DON provided a current Physician Notification policy, dated 9/17/17 that indicated "To ensure the resident's physician or practitioner ... is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need		audit of medication administration records for 3 residents with “do not exceed” medication parameters for appropriate identification and notification 3 x weekly for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks then monthly x 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and on-going in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	of provision of appropriate interventions for care ... Attempts to notify the physician/provider and their response should be documented in the resident electronic health record" 3.1-5(a)			
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 review, the facility failed to ensure respiratory care was provided consistent with the resident's orders and care plans for 1 of 2 residents observed and reviewed for respiratory care (Resident 5). Findings include: On 7/8/24 at 1:48 PM Resident 5 was observed resting in bed, oxygen concentrator was observed to be set to 1LPM(liter per minute). On 7/10/24 at 1:54 PM Resident 5's clinical record was reviewed. Diagnoses included but were not limited to pulmonary fibrosis and COPD (chronic obstructive pulmonary disease). The most recent Quarterly MDS (Minimum Data Set) Assessment dated 1/16/24 indicated Resident 5 is cognitively intact, had no behaviors, required substantial or maximum assistance from staff with bathing,	F 0695	F 695 Respiratory/Tracheostomy care and Suctioning Resident 5 suffered no ill effects from the alleged deficient practice. Resident was assessed and monitored With no adverse effects noted. Physician orders verified; oxygen Concentrator set to 2 lpm. Nursing department staff immediately Educated on Resident 5's oxygen Delivery, orders for head of bed to Be elevated and monitor for signs/symptoms of respiratory distress. All residents receiving oxygen	08/05/2024

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	transfers, and toileting, and used oxygen while a resident. Current physician orders included, but were not limited to: Continuous administration of oxygen at 2LPM per nasal cannula, dated 4/27/24. Assess/observe for signs and symptoms of shortness of breath while laying flat related to chronic lung disease, dated 4/27/24. Head of bed to be elevated to alleviate or reduce shortness of breath while laying flat related to chronic lung disease, dated 4/27/24. A current oxygen care plan related to COPD, dated 7/19/2018. Care plan had interventions as following but not limited to administer oxygen per orders, dated 7/19/2018. Observe and report signs of respiratory distress such as restlessness, wheezing, dyspnea (shortness of breath), difficulty with expectoration (coughing up phlem), diaphoresis (appearing pale and sweating), crackles, bubbling, tachycardia (elevated heart rated above 100 beats per minute), cyanosis (skin appearing blue) decreased breath sounds dated 7/19/2018. Resident requires elevation of head due to shortness of breath while lying flat as needed, dated 7/19/2018. Care plan dated 8/17/2018 related to COPD included intervention elevate head of bed or place in upright position. That intervention was dated 8/17/2018. On 7/10/24 at 9:55 AM Resident 5 was observed resting in bed, oxygen concentrator was observed to be set at 1LPM. On 7/10/24 observed CNA 2 and CNA 4 perform incontinence care on Resident 5 prior to getting		have the Potential to be affected. All nursing staff To be educated by the DHS/Designee Related to the oxygen delivery policy And resident physician's orders to Elevate the head of the bed. DHS/ADHS completed a visual Observation and audit of all residents receiving oxygen to ensure that the head of bed was elevated with no signs and symptoms of respiratory distress present and that liter flow matched current physician orders. A measure of on-going compliance, the DHS or designee, will complete audits of 3 residents receiving oxygen to ensure that oxygen liter flow matches current physicians' orders 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks. Then monthly for 3 months. As a quality measure, the DHS or designee will review any findings and corrective	

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	her out of bed. CNA 2 lowered the Resident's head of bed prior to performing incontinence care at 11:17 AM. Resident 5 then removed her nasal cannula, of which was administering her oxygen, and handed it to CNA 4. CNA 4 placed it in storage bag connected to the stationary oxygen concentrator in the resident's room. CNA 4 left room to get supplies for incontinence care at that time. Resident remained flat in bed without supplemental oxygen and nasal cannula in place. When CNA 4 returned, care was provided. CNA 2 and CNA 4 assisted resident to the side of the bed, preparing to transfer to wheelchair. Resident 5 was observed to be audibly wheezing. Resident 5 was observed for 20 minutes without supplemental oxygen or nasal cannula in place during care and was not offered oxygen during the process. On 7/10/24 at 2:18 PM DON (Director of Nursing) indicated that if a resident had a care plan for the head of the bed to be elevated due to chronic lung disease and staff observed signs of respiratory distress during care, staff would be expected to stop what they are doing and allow the resident to recover before finishing care. On 7/12/24 at 9:57 AM it was observed that Resident 5 was resting in bed without head of bed elevated. At that time resident indicated that it is common to have oxygen off and the head of her bed flattened when CNAs are caring for her. Indicated that if she were to tell staff she is short of breath, they would put her nasal cannula and oxygen back on her. Resident verbalized she feels like she is getting enough oxygen through her tank and nasal cannula. On 7/12 at 10:01 AM RN (Registered Nurse) 6 indicated Resident 5 has an order for 2L		action at least quarterly and on-going until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. -	

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	continuous oxygen via nasal cannula. Also indicated it is expected staff or CNAs caring for the residents to notify the nurse if oxygen was not administered correctly so that it may be corrected. Asked that RN 6 look at Resident 5's oxygen concentrator to ensure it is set correctly. RN 6 observed it to be set at 1L, increased it to 2L per what resident is ordered for. RN 6 also raised Resident 5's head of bed at that time, as it was not elevated. On 7/12/24 at 10:15 AM the ADON (Assistant Director of Nursing) indicated it is facility policy to follow a resident's orders and care plan. On 7/12/24 at 10:40 AM an Administration of Oxygen policy dated 5/2018 was reviewed. It indicated that "oxygen setting must be set and adjusted by a licensed nurse" and "adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered". 3.1-47(a)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following			

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	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 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			

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	followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 5 residents during observation of perineal care. Staff touched items with gloved hands, gloves were not changed between dirty and clean tasks during perineal care, and staff failed to wash hands or sanitize between dirty and clean tasks. During a random observation, staff failed to don gloves to empty a urinal (Resident 33, Resident 150, Resident 301) Findings include: 1. During an observation on 7/10/24 at 9:47 A.M., Certified Nurse Aide (CNA) 7 and CNA 9 performed incontinence care on Resident 33. CNA 9 used 1 wipe to clean Resident 33's vaginal area, then Resident 33 rolled to her right side and CNA 9 used 1 wipe to clean Resident 33's rectal area/buttocks. At that time, CNA 9 failed to removed gloves and perform hand hygiene before she obtained a clean brief.	F 0880	F 880 Infection Prevention & Control Completion Residents #33, #150, and #301 assessed with no findings and suffered no ill effects from the alleged deficient practice. All residents have the potential to be affected. DHS/ADHS educated nursing staff related to hand hygiene and standard precautions for glove use. As a measure of on-going compliance, DHS or designee will observe 5 staff providing resident care for hand hygiene 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then weekly for 4 weeks, then monthly x 3 months.	08/05/2024

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	2. During an observation on 7/10/24 at 11:10 A.M., CNA 7 and CNA 9 performed incontinence care on Resident 150. CNA 7 used her gloved hand to pull the curtain in the room and then used both gloved hands to use the remote to lower Resident 150's head of the bed. CNA 9 failed to change gloves before she cleaned Resident 150's perineal area and stool off of his rectal area/buttocks. 3. On 7/8/24 at 10:45 AM a random staff member in blue uniform was observed emptying a urinal in a resident's room without wearing gloves. During an interview on 7/10/24 at 1:32 P.M., the Infection Preventionist (IP) indicated gloves should be changed and hand hygiene should be performed between dirty and clean tasks, and staff should obtain new gloves prior to providing direct care to a resident if they touched items in the room. On 7/12/24 at 10:20 AM a Standard Precautions Guidelines policy provided by the facility was reviewed. The policy indicated "In addition to proper hand hygiene, it is important for staff to use appropriate protective equipment such as a barrier to exposure to any body fluids....gloves and other equipment such as gowns and masks are to be used as necessary to control the spread of infections". On 7/10/24 at 2:17 P.M., the IP provided a Guideline for Handwashing/ Hand Hygiene policy, revised 2/9/17, that indicated, "...Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub...1. All health care workers shall utilize hand hygiene frequently and appropriately...d. After removing gloves,		As a measure of on-going compliance, DHS or designee will observe 5 staff providing care for donning/doffing gloves per standard precautions 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then weekly for 4 weeks, then monthly x 3 months. As a quality measure, the ED/DHS or designee will review any findings and corrective action in QAPI meetings until 100% compliance achieved, then at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	worn per Standard Precautions for direct contact with excretions..." 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 8, 9 ,10, 11, and 12, 2024 Facility number: 000252 Residential Census: 16 Amber Manor Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The submission of this plan Of correction does not indicate an admission by Amber Manor Care Center that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Amber Manor Care Center. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBER MANOR CARE CENTER	801 E ILLINOIS ST PETERSBURG, IN 47567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Annual Survey conducted July 9-12-2024. The facility respectfully requests from the department a desk review for substantial compliance.	