DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 4 2022. This visit included a PSR to the Investigation of Complaint IN00375599 completed on April 4, 2022. Complaint IN00375599 - Corrected Survey dates: May 19, 20, 23 & 24, 2022 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 6 Medicaid: 71 Other: 10 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1) 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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	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 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.			
	Based on record review, and interview, the facility failed to develop a plan of care to meet the residents needs for 1 of 6 residents reviewed	F 0656	**What corrective action(s) will be accomplished for those residents found to have been**	06/16/2022

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	for care plans.(Resident 13) Finding includes: A clinical record review was completed on 5/24/2022 at 11:53 A.M. Resident 13's diagnoses included, but were not limited to: osteomylitis of the right ankle, amputation of right great toe, heart failure, diabetes, vascular dementia and end stage renal disease requiring dialysis. Current physician orders indicated Resident 13 was receiving Cefepime (antibiotic) intravenously daily until 6/2/2022. Physician orders to change the PICC (peripherally inserted central catheter) dressing using sterile technique and to change the wound vac dressing every Monday and Thursdays and PRN (as needed). During an interview, on 5/24/2022 at 3:57 P.M., LPN 8 indicated Resident 13 had care plans prior to going to the hospital on 4/20/2022. She indicated the resident returned to the facility on 4/28/2022, and was unsure why the care plans were closed out. LPN 8 printed Resident 13's current care plans. The care plans lacked a comprehensive care plan for the antibiotic use, the use of the PICC catheter, diabetes diagnoses, and the use of the wound vac. During an interview, on 5/24/2022 at 4:02 P.M., LPN 8 indicated the facility had issues with the computer company and there have been issues with the care plans and she would be putting in the care plans for the PICC line, antibiotic use, diabetes diagnoses and the wound vac.		**affected by the deficient practice?** • IDT team reviewed resident 56 and compressive care plan was reponed and reviewed including PICC line, antibiotic use, catheter use, wound vac and diabetes. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**? All residents at the facility have the potential to be affected. · Facility to complete audit of residents that were discharged to the hospital and returned in last 60 days completed to ensure that all care plans were open and active. · Facility to complete audit of all resident's care plans conducted to ensure accuracy, facility will audit 10 Resident Care plans weekly x 4 and 5 residents Care plans weekly until 100% of Resident care plans reviewed.	

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	On 5/24/2022 at 4:26 P.M., the Unit Manager provided the policy titled, "Care Plans, Comprehensive Person- Centered", dated December 2016, and indicated the policy was the one currently used by the facility. The policy indicated"...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. ...12. The comprehensive, person-centered care plan is developed within (7) days of the completion of the required comprehensive assessment (MDS)...14. The Interdisciplinary Team must review and update the care plan: c. When the resident had been readmitted to the facility from a hospital stay...." 3.1-35(a)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • IDT in-serviced on the MDS assessment process and their role including use of CARE PLAN Review sheet to ensure all areas are addressed • Audits Tool “Comprehensive Care Plan Audit Tool” will be completed for all new admissions to ensure completion within 21 days of the date of admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. • Audit Tool “Comprehensive Care Plan Audit Tool” will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD.	

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			How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • MDS/ Designee will complete Comprehensive Care Plan Audit Tool will be completed for all new admissions to ensure completion within 21 days of the date of admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. • Audit Tool "Comprehensive Care Plan Audit Tool" will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive	

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			quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to complete physician ordered dressing changes and treatment for non-pressure wounds for 1 of 3 residents reviewed for non-pressure wounds. (Resident 23) Finding includes: During an observation, on 5/19/2022 at 2:18	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · MD was made aware that residents dressing was dated 5/18/2022 during observation on 5/20/22. Resident 23 is followed by wound care team and was assessed by wound MD.	06/16/2022

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	P.M., Resident 23 was observed lying in bed with both lower extremities wrapped in kerlix (gauze wrapping) from the middle of her feet up to her knees. The wrappings on both legs were dated 5/18/2022. During an observation, on 5/20/2022 at 11:00 A.M., Resident 23 was observed lying in bed with the same wrappings dated 5/18/2022. A clinical record review was completed on 5/20/2022 at 11:06 A.M. Resident 23's diagnoses included, but were not limited to: diabetes, severe protein malnutrition, non-pressure chronic ulcer of the right an lower legs, and venous insufficiency. A Physician Order, dated 4/5/2022, indicated: left anterior/posterior lower leg: cleanse with normal saline, cover with xeroform (Vaseline gauze), gauze sponge, and wrap with kerlix every day shift for wound healing. A Physician Order, dated 5/16/2022, indicated: left dorsal foot wound clean with wound cleaner, apply xeroform and cover with ABD (gauze abdominal binder) and wrap with kerlix every day shift for wound healing. A Physician Order, dated 4/5/2022, indicated: right anterior/posterior lower leg cleanse with normal saline and apply xeroform, gauze sponge, and wrap with kerlix every day shift for wound healing. The TAR (Treatment Administration Record) for May 2022 indicated on 5/19/2022 the treatments to Resident 23's legs had been completed. On 5/20/2022 at 11:30 A.M., along with the Unit		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** · Full house sweep completed to ensure that all treatments were completed per MD order and dated appropriately. · RN # 6 educated on proper infection control practices related to dressing changes, hand hygiene and hand sanitizer. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All Licensed nursing staff in-serviced Quality of Care and treatment with emphasis on documentation of completed nursing services and following physicians' orders · All Licensed nursing staff in serviced on proper infection control practices related to dressing changes, hand hygiene and hand sanitizers **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DNS/ designee will complete	

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	Manager, Resident 23 was observed in bed with the wrappings dated 5/18/2022. The Unit Manager indicated the treatment was not completed on 5/19/2022 and should have been. On 5/20/2022 at 11:31 A.M., RN 6 entered Resident 23's room and place treatment supplies on a dresser. She washed her hands and then left the room. RN 6 returned a few minutes later with a bottle of hand sanitizer. She applied the hand sanitizer to her hands, placed it on the dresser and then "fanned" her hands in front of her and then applied gloves. RN 6 removed the foam booties from both feet and then put a towel on the bed under the residents lower legs and then she cut off the dressing to both legs. During an interview, on 5/20/2022 at 12:01 P.M., RN 6 indicated "the areas to the residents legs looked worse than the last time she had done the treatment" and indicated "they would look better if the treatment was done every day". RN 6 removed her gloves and applied new gloves and the removed the xeroform gauze off of the right and left leg. She then applied normal saline to gauze pad and cleansed the areas to the anterior and posterior right leg. She removed the gloves and applied new gloves. RN 6 applied normal saline to gauze pads and cleansed the left anterior and posterior leg. RN 6 removed the gloves and left the room. RN 6 returned a few minutes later with more saline syringes. She used the hand sanitizer and fanned her hands in front of her then applied new gloves. RN 6 applied the xeroform gauze to the right lower anterior and posterior leg. Wearing the same gloves, she opened a package of kerlix and wrapped it around the leg, and secured it with		"Quality of Care related to Treatment Audit" to include monitoring of dressing changes. · Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	tape. RN 6 removed her gloves and applied only 1 glove, then removed a gauze pad from the top of the left foot from an area that had been bleeding. RN 6 then applied another glove and applied xeroform to the anterior/posterior leg wounds. Wearing the same gloves, she then opened a package of kerlix and wrapped around the left leg and secured with tape. After completing the treatment to Resident 23's legs, wearing the same gloves, RN 6 picked up the treatment supplies off the bed, placed them on the dresser,and then picked up dirty linens. RN 6 then removed her gloves and did not wash her hands. During an interview,on 5/20/2022 at 12:35 P.M., RN 6 indicated she should have washed her hands after removing the gloves and should not have fanned her hands after using the hand gel. A policy was requested on 5/23/2022 for following physician orders but not provided. 3.1-37			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services 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.			

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	§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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation and interview, the facility failed to follow standards of care of visually observing a resident take their medications. Failed to ensure physician ordered medications were administered for 1 of 5 residents observed for medication administration and 1 of 3 residents reviewed for unnecessary medications. (Resident 17 and 32) Findings include: 1. On 5/20/2022 at 8:59 A.M., QMA 3 was observed to pull the following medications for Resident 17: oxycodone 10 mg (milligram),	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were affected by the alleged deficient practice. · Resident 17 had no negative effects related to QMA not visually observing resident take medication. · MD was notified that Resident 23's medication was	06/16/2022

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	folic acid 1 mg, docusate sodium 100 mg, aspirin 325 mg, Tylenol 500 mg, celebrex 200 mg, senna 8.6 mg, omeprazole 30 mg, and miralax 17 G (gram). QMA 3 went to Resident 17's room and placed the medications on the over the bedside table. QMA 3 then left the room with out visually observing the resident take the medications. During an interview, on 5/20/2022 at 9:00 A.M., QMA 3 indicated she should have watched the resident take the medications. 2. A clinical record review was completed on 5/23/2022 at 2:10 P.M. Resident 32's diagnoses included, but were not limited to: psychosis, depression, anxiety, and hypertension. Current physician orders for Resident 32 indicated she was to receive: Atorvastatin 10 mg (milligrams) at bed time; lidoderm patch 5% to the left shoulder every morning; nicotine patch 24 hour 14 MG/24 hr apply patch every morning; and oxycodone 10 mg two times a day. Resident 32's MAR (Medication Administration Record) dated May 2022, indicated the lidoderm pain patch was documented as (9) see progress notes on 5/13/2022 to 5/20/2022. The nicotine patch and the oxycodone were documented as (9) see progress notes on 5/20/2022, and the Atorvastatin was documented as (9) on 5/21/2022 see progress notes. Review of the progress notes, dated 5/13/2022 through 5/23/2022, indicated the medications were not administered on those dates due to medication not available.		unavailable. Resident 23's medications was received by pharmacy. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. QMA 3 was educated on medication administration with emphasis on visually observing residents take medications. · An in-service will be completed by DON/designee for all nursing staff related to Medication Administration and emphasis on visually observing residents take medication and medication availability and use of emergency kit. · EMAR audit completed and reviewed for last 60 days to identify other potential missing medications with any required follow up completed with MD and pharmacy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	During an interview, on 5/23/2022 at 10:52 A.M., the Director of Nursing indicated if a medication is not in the medication cart then they are to check the E-kit (emergency drug kit) and call the pharmacy. During an interview,on 5/24/2022 at 2:933 P.M., QMA 7 indicated if a medication was not in the medication cart she would get it put of the pixes (emergency drug kit) and if it was not there she would call the pharmacy and inform the Director of Nursing. On 5/24/2022 at 4:20 P.M., the Director of Nursing provided the policy titled, "Emergency Dispensing Kit-Non controlled Substances", dated May 2019, and indicated the policy was the one currently use by the facility. The policy indicated"... 3. If the medication is safe to give the resident and the item needed is in the kit, break seal on the kit and remove the prescribe medication...." 3.1-25(g)(2) 3.1-25(g)(3)		· An in-service will be completed by DON/designee for all nursing staff related to Medication Administration and emphasis on visually observing residents take medication and medication availability and use of emergency kit. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DNS/ designee will complete medication pass observations/ audits to ensure compliance. · DNS/Designee will complete EMAR compliance audit/review to identify any potential missing medications · Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-			

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	§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 4 of 5 residents observed during a medication pass. Six (6) medication errors were observed during 35 opportunities for error in medication administration. This resulted in a medication error rate of 17.14%. (Resident 16, 17, 18, and 19) Findings include: 1. On 5/20/2022 at 8:44 A.M., QMA 3 was observed to administer Klor-Con 20 meq (millequivlant), Acoyclovir 400 mg (milligrams), lactobacillus 10 mg, vitamin B-12, levetracetam 500 mg, magnesium oxide 400 mg, prednisone 10 mg, and ropinirole 0.5 mg to Resident 16. During an interview, on 5/20/2022 at 9:05 A.M., QMA 3 indicated the apixaban would be pulled from the EDK (emergency drug kit) and Resident 16 does her own nasal spray, she keeps it in her room. A clinical record review was completed on 5/20/2022 at 2:15 P.M., indicating Resident 16 was to receive apixaban (anti coagulant) 5 mg twice a day and flonase nasal spray daily. The clinical record lacked a physicians order for self administer medication or an order for may keep medication at bedside. The May MAR (Medication Administration Record) indicated the apixaban medication was documented as (9) other see progress note. The	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident 16 did not have a negative outcome related to the alleged deficient practice. Self-administration of nasal spray assessment completed, MD notified, and orders appropriate orders obtained. Resident 16's Care Plan was updated. • Resident 17 did not have a negative outcome related to the alleged deficient practice • Resident 18 did not have a negative outcome related to the alleged deficient practice. MD was notified of late administration. • Resident 19 did not have a negative outcome related to the alleged deficient practice. MD was notified of late administration. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents in the facility have the potential to be affected by alleged deficient practice	06/16/2022

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	clinical record lacked any documentation of why the medication was not given. During an interview, on 5/20/2022 ay 2:40 P.M., the Director of Nursing indicated Resident 16 should have had a self administration of medication assessment if she was doing her own medications and she should have had an order to self administer her medications and to keep at the bed side. 2. On 5/20/2022 at 8:59 A.M., QMA 3 was observed to pull the following medications for Resident 17: oxycodone 10 mg, folic acid 1 mg, docusate sodium 100 mg, aspirin 325 mg, Tylenol 500 mg, celebrex 200 mg, senna 8.6 mg, omeprazole 30 mg, and miralax 17 G. QMA 3 went to Resident 17's room and placed the medications on the over the bedside table. QMA 3 then left the room with out visually observing the resident take the medications. During an interview, on 5/20/2022 at 9:00 A.M., QMA 3 indicated she should have watched the resident take the medications. 3. On 5/20/2022 at 9:15 A.M., QMA 4 was observed to administer the following medications to Resident 18: senna 8.6 mg, famatidine 20 mg, metoprolol 50 mg, docusate sodium 100 mg and linzess 145 mcq. The label on the bottle of Linzess pills indicated to administer 30 minutes before breakfast. During an interview, on 5/20/2022 at 9:17 A.M., the Unit Manager indicated the medication was not given at the right time.		• QMA 3 was educated on Medication Administration with emphasis on visually observation residents take medications and medication availability and use of emergency kit. • QMA 4 was education on Medication administration with emphasis on Medication Administration Time. • RN #6 was education on Medication administration with emphasis on Medication Administration Time. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Licensed Nursing Staff were educated on Medication Administration with emphasis on visually observing residents taking medication, medication availability and use of Emergency Kit. Education includes return demonstration and Relias supporting online education by 6/16/2022 or before working in facility. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	A clinical record review was completed on 5/20/2022 at 9:25 A.M. A physician's order, dated 1/10/2022, indicated Linzess capsule give 1 capsule by mouth one time a day for constipation: Must be given at least 30 minutes before breakfast. 4. On 5/20/2022 at 9:55 A.M., RN 6 was observed to administer Resident 19 the following medications: gabapentin 100 mg, colace 100 mg, aspirin 81 mg, and hydrocodone 10/325 mg. During an interview, on 5/20/2022 at 9:57 A.M., RN 6 indicated the hydrocodone was given late and should not have been. A clinical record review was completed on 5/20/2022 at 10:10 A.M. and indicated the hydrocodone was to be given 2 times a day. The morning time was scheduled for 8:00 A.M. On 5/23/2022 at 8:53 A.M., the Director of Nursing provided the policy titled," Adverse Consequences and Medication Errors", dated April 2014, and indicated the policy was the one currently used by the facility. The policy indicated"... 6. Examples of medication errors include: a. Omission - a drug is ordered but not administered; ...g. Wrong time...." On 5/223/2022 at 1:45 P.M., the Director of Nursing provide the policy titles," Administering Medications", dated April 2019, and indicated the policy was the one currently used by the facility. The policy indicated"... 4. Medications are administered in accordance with prescriber orders, including any required time frame. ...7. Medications are administered within one (1) hour of their prescribed time, unless otherwise		• DON/ designee will complete medication pass observations/ audits to ensure compliance. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	specified (for example, before and after meals orders). ...10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication. ...27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision- making capacity to do so safely...." 3.1-48(c)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§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 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			

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	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, record review and interview, the facility failed to ensure staff practiced proper infection control practices when completing wound care for 1 of 1 residents reviewed for wound care. (RN 6) Finding includes: A clinical record review was completed on 5/20/2022 at 11:06 A.M. Resident 23's diagnoses included, but were not limited to: diabetes, severe protein malnutrition, non-pressure chronic ulcer of the right an lower legs, and venous insufficiency. A Physician Order, dated 4/5/2022, indicated: left anterior/posterior lower leg: cleanse with normal saline, cover with xeroform (Vaseline gauze), gauze sponge, and wrap with kerlix every day shift for wound healing. A Physician Order, dated 5/16/2022, indicated: left dorsal foot wound clean with wound cleaner, apply xeroform and cover with ABD (gauze abdominal binder) and wrap with kerlix every day shift for wound healing. A Physician Order, dated 4/5/2022, indicated: right anterior/posterior lower leg cleanse with normal saline and apply xeroform, gauze sponge, and wrap with kerlix every day shift for wound healing. The TAR (Treatment Administration Record) for	F 0880	A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective June 18, 2022. The DPOC and any supporting documentation should be submitted to ltcproviderservices@isdh.in.gov. Briarcliff Health & Rehabilitation Center must include the following as part of the submitted POC for the deficient practice cited at F880: **A. Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1). The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff on how to complete proper infection control practices when completing wound care. For this education and return demonstration, the following resources will be used: · Facility policy - Handwashing · Facility policy- Treatment	06/16/2022

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	May 2022 indicated on 5/19/2022 the treatments to Resident 23's legs had been completed. On 5/20/2022 at 11:30 A.M., along with the Unit Manager, Resident 23 was observed in bed with the wrappings dated 5/18/2022. The Unit Manager indicated the treatment was not completed on 5/19/2022 and should have been. On 5/20/2022 at 11:31 A.M., RN 6 entered Resident 23's room and place treatment supplies on a dresser. She washed her hands and then left the room. RN 6 returned a few minutes later with a bottle of hand sanitizer. She applied the hand sanitizer to her hands, placed it on the dresser and then "fanned" her hands in front of her and then applied gloves. RN 6 removed the foam booties from both feet and then put a towel on the bed under the residents lower legs and then she cut off the dressing to both legs. During an interview, on 5/20/2022 at 12:01 P.M., RN 6 indicated "the areas to the residents legs looked worse than the last time she had done the treatment" and indicated "they would look better if the treatment was done every day". RN 6 removed her gloves and applied new gloves and the removed the xeroform gauze off of the right and left leg. She then applied normal saline to gauze pad and cleansed the areas to the anterior and posterior right leg. She removed the gloves and applied new gloves. RN 6 applied normal saline to gauze pads and cleansed the left anterior and posterior leg. RN 6 removed the gloves and left the room. RN 6 returned a few minutes later with more saline syringes. She used the hand sanitizer and fanned her hands in front of her then applied new		Change · Facility Pre/Post Test related to Handwashing / Sanitizer · CDC Education- How to use Hand Sanitizer the Right Way 2).The DON, IP or Designee will ensure all staff involved are educated on infection control practices regarding wound care, including, but not limited to dressing changes. The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed during treatments, handwashing and sanitizer use,. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. **A. Systemic** 1). A root cause analysis (RCA) was conducted by the Infection Preventionist (IP), with input and review from the Medical Director, Executive Director, Director of Nursing, Unit Manager and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation. · Through staff interviews, it	

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	gloves. RN 6 applied the xeroform gauze to the right lower anterior and posterior leg. Wearing the same gloves, she opened a package of kerlix and wrapped it around the leg, and secured it with tape. RN 6 removed her gloves and applied only 1 glove, then removed a gauze pad from the top of the left foot from an area that had been bleeding. RN 6 then applied another glove and applied xeroform to the anterior/posterior leg wounds. Wearing the same gloves, she then opened a package of kerlix and wrapped around the left leg and secured with tape. After completing the treatment to Resident 23's legs, wearing the same gloves, RN 6 picked up the treatment supplies off the bed, placed them on the dresser,and then picked up dirty linens. RN 6 then removed her gloves and did not wash her hands. During an interview,on 5/20/2022 at 12:35 P.M., RN 6 indicated she should have washed her hands after removing the gloves and should not have fanned her hands after using the hand gel. On 5/23/2022 at 8:52 A.M., the Director of Nursing provided the policy titled," Handwashing/Hand Hygiene", dated August 2019, and indicated the policy was the one currently used by the facility. The policy indicated"... 8. hand hygiene is the final step after removing and disposing of personal protective equipment. Applying and Removing Gloves. 1. Perform hand hygiene before applying non sterile gloves...." 3.1-18(a)		was determined that staff was nervous completing dressing change being observed by state surveyor. Staff could use additional training related to infection control practices related to wound care, handwashing and use of sanitizer. · Lack of staff understanding of policy regarding handwashing and infection control practices during dressing change · Lack of adequate treatment supplies brought with RN to the room, causing her to leave room during treatment completion. · The facility leadership team failed to ensure that staff were educated regarding appropriate infection control practice related to wound care, handwashing and use of sanitizer b). The solutions and systemic changes developed by the Division (Consultant IP), DON, ADON and facility IP include: The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff facility staff related to handwashing and infection control practices during dressing change For this education and return demonstration, the following resources will be used: · Facility policy - Handwashing	

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			· Facility policy- Treatment Change · Facility Pre/Post Test related to Handwashing / Sanitizer · CDC Education- How to use Hand Sanitizer the Right Way The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed during treatments, handwashing and sanitizer use,. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. 2). The DON, IP Nurse and Division (Consultant) IP reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. Section F- Hand Hygiene and Use of Sanitizer Section G- Standard Precautions related to Glove Use / Hand Hygiene Section O- Wound Care **B. Training:**	

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			1).Per the LTC infection control assessment review and Root Cause Analysis ,VP of Clinical, ED, Medical Director , UM , facility IP and DON. The following training needs were identified and implemented by facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. Section F- Hand Hygiene and Use of Sanitizer Section G- Standard Precautions related to Glove Use / Hand Hygiene Section O- Wound Care The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff related to handwashing , sanitizer use and infection control practices during dressing change · Facility policy - Handwashing · Facility policy- Treatment Change · Facility Pre/Post Test related to Handwashing / Sanitizer · CDC Education- How to use Hand Sanitizer the Right Way	

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			B. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained. The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed during treatments, handwashing and sanitizer use,. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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