STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155715	A. BUILDING 00 B. WING	07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

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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 18, 19, 20, 21, 22, and 25, 2022 Facility number: 000347 Provider number: 155715 AIM number: 100275440 Census Bed Type: SNF/NF: 79 Residential: 22 Total: 101 Census Payor Type: Medicare: 8 Medicaid: 50 Other: 21 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 28, 2022.	F 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
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, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

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	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, record review, and interview, the facility failed to provide meals to residents needing assistance in a dignified manner for 2 of 5 residents dining observations. (Residents 36 and 34) Findings include:	F 0550	F 550 Resident Rights It is the policy of this facility that all residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.	08/31/2022

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	1. The dining room on the locked dementia unit was observed on 07/18/22 at 1:04 P.M. Resident 36 was sitting in a wheelchair at a table. Her meal was on the table on a plate with a plastic dome covering the plate. The resident's silverware was still wrapped in a napkin and laying on top of the cover over her plate. The resident's pop can was unopened. No staff were helping the resident to eat. Some of the residents in the locked unit's dining room were already finished with their meals. Two staff members were assisting other resident's with their meals. At 1:09 P.M., RN 7 asked the resident if she wanted to eat, took the cover off of her plate, and poured her pop into a cup of ice. The staff member stood on her feet and fed the resident her meal using a spoon. The staff member remained standing. There was a chair available for the staff member to sit down on. At 1:22 P.M., the two residents on either side of Resident 36 were finished with their meals and one had been taken to his room. RN 7 continued to stand over the resident and assist them with their meal until 1:37 P.M. The clinical record was reviewed on 07/20/22 at 10:08 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/08/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia and depression. The resident required extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. The resident required extensive assistance of one staff member for eating. 2. The dining room on the locked dementia unit was observed on 07/20/22 at 9:16 A.M. RN 8 was standing and assisting Resident 34 with their breakfast meal.		Corrective Action For Residents Affected: The two nurses referenced in the 2567 received individual education on resident rights and the need to treat all residents with respect and dignity including during meal service and assistance eating. RN 7 and 8 signed off on the policy and education and verbalized understanding of the importance of resident rights. (Attachment titled Resident Rights Education). Other Residents Having The Potential To Be Affected: All residents who require assistance eating have the potential to be affected. Dining observations will be completed three times per week to identify any additional issues during meal service and as staff are assisting residents. (Attachment titled Dining Observations). Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding resident rights and how to maintain dignity during meal service and while assisting residents to eat. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). The	

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	The dining room on the locked dementia unit was observed on 07/22/22 at 9:13 A.M. RN 7 was standing over the resident as she assisted her with her meal. At 9:16 A.M., RN 7 asked the resident if she wanted to eat, covered the resident's plate, and returned it to the kitchen cart. Little of the pureed meal had been eaten. During an interview at 9:18 A.M., RN 7 indicated she had offered the resident food and drinks a few times and the resident had shaken her head no and clenched her mouth shut. A second staff member attempted to assist the resident with her meal, sitting down to assist the resident in an available chair. At 9:26 A.M., the resident continued to eat while being assisted by the new staff member, CNA (Certified Nurse Aide) 9, who was speaking softly to the resident. The resident finished eating at 9:29 A.M., having consumed 25% of her meal. The clinical record was reviewed on 07/25/22 at 11:16 A.M. A Quarterly MDS assessment, dated 05/26/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertension, and depression. The resident required extensive assistance of one staff member for eating and was on a mechanically altered diet. During an interview on 07/22/22 at 2:33 P.M., CNA 9 indicated when assisting residents with their meals she talked to the resident as she was working with them. Sometimes she would set the residents' food to the side if they had refused to eat and came back a little later and tried again. She explained to the residents the importance of eating. She helped new hires in training to assist residents with their meals. Staff should sit down at eye level with a resident and ensure they are sitting up straight when assisting them with their		Director of Nursing or designee will perform Meal Rounds and complete Dining Observations for all three meals three times per week for 2 months, then 2 times per week for 2 months, and then weekly for 2 months to ensure that the deficient practice does not recur and that each resident's dignity is maintained. (Attachment titled Dining Observations). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly observations monthly for six months. If appropriate performance is observed 100% of the time, weekly observations will stop.	

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	meals. It was a choking hazard if they were laying back. The current Meal Supervision and Assistance Policy was provided by the DON (Director of Nursing) on 07/22/22 at 3:53 P.M. The policy indicated, "...The resident will be prepared for a well-balanced meal in a calm environment...with adequate supervision and assistance to...provide adequate nutrition, and ensure an enjoyable event...This includes...Monitoring for effectiveness and modifying interventions when necessary...Provide a relaxing, enjoyable environment during the mealtime..." 3.1-3(v)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to implement interventions to prevent pressure ulcers for 2 of 6 residents reviewed for pressure ulcers. (Residents 56 and 28)	F 0686	F 686 Treatment/Services To Prevent/Heal Pressure Ulcers It is the policy of this facility to implement interventions to prevent pressure ulcers.	08/31/2022

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	Findings include: 1. During an observation and interview on 07/22/22 at 10:30 A.M., Resident 58 was lying in bed on his left side. His left foot was lying on the bed and resting on the mattress. RN 11 had indicated the resident had a healed pressure ulcer to the left foot close to the pinky toe where the foot was currently pink/red in color. The clinical record for Resident 56 was reviewed on 07/20/22 at 2:00 P.M. An Annual MDS (Minimum Data Set) assessment, dated 02/07/22, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, traumatic brain dysfunction, neurogenic bladder, aphasia, quadriplegia, and seizure disorder. The resident was at risk for pressure ulcers and required two or more total staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The complete Care Plans was provided by the DON (Director of Nursing) on 07/22/22 at 3:17 P.M. The Care Plan included, but were not limited to, A Care Plan for skin related to the resident's high risk for pressure injury/ulcer with a start date of 06/23/20 that included the following interventions: - Apply pressure relieving mattress to the bed, check for bottoming out to ensure appropriateness of the mattress choice, - consult provider for appropriateness of using topical medication and gently apply to promote absorption, - encourage and assist with routine changes in		Corrective Action For Residents Affected: Resident 56 - The referenced deep tissue injury is healed. An order was entered to apply skin prep to the resident's left foot daily and the nurse will document that this was completed. An order was also entered for the nurse to check off that proper positioning interventions are in place every shift. (Attachment titled Resident 56 Orders). Resident 28 - The referenced deep tissue injury is healed. The orders that were missing are already in place and the nurse is required to ensure that the interventions are in place and check those orders off in the treatment record. (Attachment titled Resident 28 Orders). Corrective Action For Other Residents Having The Potential To Be Affected: All residents who are at high risk for pressure ulcers have the potential to be affected. The Wound Care Nurse completed an observation and review of all residents in the facility the week of August 1, 2022. (Attachment titled Resident Skin Observation). She performed an observation of the resident's skin, their interventions. orders, and care plans. No other issues were identified.	

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	position, - inspect skin over bony prominences and dependent areas with position changes, - keep linens free of wrinkles and foreign matter, - keep skin clean and dry. Use a skin lubricant/lotion on all areas, blot the skin dry, and never rub, - notify dietary of risks, - observe fluid intake daily, - protect skin from mechanical injury via slide board, turn sheet, trapeze, and/or lubricant use, - reposition at least every 2 hours or more frequently depending on resident's condition and tolerance of pressure. Reduce pressure over bony prominences and avoid positioning directly on the greater trochanter, and A Care Plan for skin related to the resident's risk for pressure ulcers and risk for development of non-pressure skin conditions due to intracranial injury, quadriplegia, contractures, benign prostatic hyperplasia, convulsions, chronic pain, dysphagia, aphasia, gastroesophageal reflux, anemia, and history of pressure ulcers with a start date of 04/05/16, included the following interventions: - geri sleeves to the bilateral upper extremities at all times, - use caution when removing/placing clothing to avoid skin tears, - assist resident to turn and reposition every two hours and as needed, - assure proper application of any splints/braces, - avoid friction of the skin with bed linens, bed, or chair, - keep bed linens as wrinkle free as possible and free of foreign matter, - leave carelift sling under resident. Limit creasing and tucking as much as possible,		Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding the prevention and treatment of pressure ulcers and the importance of the documentation of the interventions in place. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). The Wound Care Nurse will complete Wound Rounds on all high risk residents weekly and any resident identified as high risk on their quarterly Braden Scale Assessment to ensure that the appropriate orders and interventions are in place. Care plans will also be updated as these rounds occur. (Attachment titled Weekly Wound Rounds). The Director of Nursing will continue to audit all skin sweeps weekly. (Attachment titled Skin Sweep Audits). This audit in addition to the review of the Quarterly Braden Scale Assessments will help to identify residents to include in the weekly rounds to be proactive in preventative measures. Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review the results of the weekly wound rounds and	

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	- observe for and report any signs of skin breakdown to the MD, - pressure reducing cushion in the wheelchair, - pressure reducing mattress to the bed, - provide heel and elbow protectors if applicable. Keep padding under resident's elbow on wheelchair table. Pad foot pedal pegs on wheelchair if foot pedals are not attached, - provide incontinence care after each incontinent episode, - provide showering per schedule. Place bath blanket between resident and shower gurney for protection of skin, - refer to dietician as necessary to evaluate nutritional needs, - resident to wear socks at night, - siderails to aid in improved mobility and transfers, and - use lotion to maintain skin hydration. Thoroughly was and rinse resident's skin and blot dry rather than rubbing. The Point of Care bathing documentation indicated the resident had received either a bed bath or partial bed bath the following dates: - 02/05/22 a partial bed bath, - 02/07/22 a partial bed bath, - 02/08/22 a partial bed bath, - 02/09/22 a shower and partial bed bath, and - 02/12/22 a partial bed bath. A Wound Management Detail Report, dated 02/13/22 at 9:59 A.M., indicated there was a fluid filled purple blister to the left foot found during the A.M., care. There was redness surrounding the area that measured 5.7 cm (centimeters). There was 2+ edema on the whole top half of the foot and it was warm to touch.		audit results monthly for six months. The prevention of pressure ulcers is a high priority for the organization and is a standing agenda item for this committee and will be reviewed monthly on an ongoing basis.	

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	A Wound Management Detail Report, dated 02/13/22 at 7:18 P.M., indicated the resident had an unstageable- deep tissue injury (Persistent non-blanchable deep red, maroon or purple discoloration) to the left foot that measured 5.5 cm (centimeters) X (by) 3.5 cm. The wound was a dark, fluid filled blister and skin prep was applied. A Wound Management Detail Report, dated 02/23/22 at 1:10 P.M., indicated the resident had an unstageable wound with slough (yellow or white) /eschar (dry, adherent, intact without erythema or fluctuance) to the left foot. The blood filled blister had reabsorbed and was an intact area of eschar/scabbing. A Wound Management Detail report, dated 03/11/22 at 11:37 P.M., indicated the resident had gone to a wound care center and had the eschar removed from the left foot. The skin was pink/red and healed. A Weekly Skin Sweep, dated 02/05/22, indicated the resident had no new skin areas. The February 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the following: - An open ended physician order, dated 02/14/22, to keep the left foot propped up to keep pressure off of it as much as possible, every shift, - An open ended physician order, dated 02/14/22, for nursing to apply skin prep to the left foot pressure area by the 5th metatarsal, every shift - An open ended physician order, dated 05/29/20, to assure the resident's shoes were on in the A.M., once a day			

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	The EMAR/ETAR orders were signed out per the physician's orders. The clinical record lacked any indication the resident's feet had been elevated or that there was any redness or skin impairment to the left foot prior to the finding on 02/13/22 of a purple fluid filled blister. During an interview on 07/21/22 at 10:19 A.M., QMA (Qualified Medication Aide) 12 indicated she would alert the nurse of any new skin conditions. The residents were offered showers twice a week and the nurse assessed the skin once a week. During an interview on 07/21/22 at 2:21 P.M., RN 11 indicated the resident had a feeding tube and took nothing by mouth. The resident was unable to move around in the bed on his own, so the staff had to reposition him. He had pressure ulcer to his left foot that had since healed, and she was unsure how it developed. During an interview on 07/22/22 at 2:18 P.M., the DON indicated the resident had a blister that was a deep tissue pressure injury. The resident had contractures and with the resident having fragile skin the deep tissue injury could have developed quickly and the resident had some edema as well. The resident's left foot should be propped up to keep pressure off of it, and skin prep should continue to be applied to the left foot as a preventative. 2. The clinical record for Resident 28 was reviewed on 07/20/22 at 1:23 P.M. A Quarterly MDS assessment, dated 02/25/22, indicated the resident was cognitively intact. The diagnosis included, but was not limited to, Parkinson's Disease. The			

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	resident was at risk for pressure ulcers and required two or more staff assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing. The complete Care Plan was provided but the ADON on 07/22/22 at 3:20 P.M., the Care Plans included but were not limited to, A Care Plan for skin related to the resident's moderate risk for pressure injury/ulcer with a start date of 06/23/21, included the following interventions: - check bony prominences for redness, - encourage ambulation as much as the resident is able, - encourage changes in position at least every two hours and assist as required, - keep bed linens free of wrinkles and foreign matter, - keep skin clean and dry. Thoroughly wash and rinse all soap, blot dry and never rub, - report/record skin condition each week or more frequently if problem exists, - use skin lubricant/lotion during A.M. and evening care, - when lifting the resident, avoid friction the skin with linens, bed, or chair, and - when moisture is found, change the linens, gown, and pads, as soon as possible. If moisture is from urine or feces, the area should be washed and dried, and A Care Plan for skin related to the resident's risk for pressure ulcers and risk for development of non-pressure skin conditions due to decreased mobility related to Parkinson's, and personal history of pressure ulcers and incontinence with a start date of 05/27/21, included the following			

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	interventions: - air mattress, - apply skin prep to bilateral heels every three days for thirty days after admission/re-admission, then discontinue, - assist resident to turn and reposition every 2 hours, - avoid friction of the skin with bed linens, bed, or chair, - encourage adequate food and fluid intake to maintain optimal nutrition, - encourage resident to get out of bed daily as tolerated and encourage to ambulate if able, - encourage resident to turn and reposition every two hours and as needed, - keep linens as wrinkle free as possible and free of foreign matter, - monitor lab values as ordered, - observe for and report any signs of skin breakdown to MD, - pressure reducing cushion in wheelchair, - provide medications as ordered, - provide showering per schedule, - refer to dietician as necessary to evaluate nutritional needs, - siderails to aid in improved mobility and transfers, - use lotion to maintain skin hydration. Thoroughly wash and rinse resident's skin and blot dry rather than rubbing, and - weekly skin sweeps. A Weekly Skin Sweep, dated 03/30/22, indicated the resident had no new skin concerns. A Wound Management Detail Report, dated 04/01/22 at 2:45 P.M., indicated the resident had a darkened area to the tip on the right great toe that measured 0.9 cm X 0.7 cm.			

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A Wound Management Detail Report, dated 05/04/22 at 2:35 P.M. indicated the resident had an unstageable-deep tissue injury to the right great toe that measured 0.5 cm X 0.7 cm. The wound was closed. The treatment was for skin prep, three times a day and a bed cradle to the end of the bed to relieve pressure from the blankets, and offloading boots.

A Wound Management Detail Report, dated 06/01/22 at 6:49 A.M., indicated the resident had an unstageable-deep tissue injury to the right great toe that measured 0.8 cm X 0.7 cm. The wound was improving.

A Wound Management Detail Report, dated 07/20/22 at 7:46 A.M., indicated the wound to the right great toe had healed.

A Wound Management Detail Report, dated 05/04/22 at 2:32 P.M., indicated the resident had an unstageable-deep tissue injury to the left great toe that measured 0.1 cm X 0.2 cm.

A Wound Management Detail Report, dated 06/16/22 at 1:27 P.M., indicated the wound to the left great toe had healed.

The March, April, and May 2022 EMAR/ETAR included the following:

- an open ended physician's order, with a start date of 03/16/22, indicated the resident was to wear offloading boots when in bed, every shift,
- a physician order dated 05/05/22 through 07/20/22, for skin prep to the right and left big toe due to pressure area, every shift, and
- an open ended physician's order, with a start date of 05/06/22, indicated an air mattress due to

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	resident not getting up out of bed and refusing to turn and reposition, every shift. The EMAR/ETAR orders were signed out per the physician's orders. A Progress Note, dated 03/16/22 at 2:15 P.M., indicated the resident was refusing to use a pillow to keep her heels floated off the bed. A fax was sent to the NP (Nurse Practitioner) to ask for waffle boots to apply to the resident's feet to avoid pressure areas, with the resident choosing to stay in bed frequently. A Progress Note, dated 03/16/22 at 2:55 P.M., indicated waffle boots could be used. A Progress Note, dated 03/24/22 at 12:04 P.M., indicated the resident had been compliant with all orders including the recent order for offloading boots while in bed. A Progress Note, dated 03/30/22 at 12:57 P.M., indicated the resident had no behaviors that shift and had stayed in bed. A Progress Note, dated 04/01/22 at 2:43 P.M., indicated the resident had 2+ edema noted to her left calf. The NP was notified and ordered to prop the left leg up and change position. An area had been found on the resident's right great toe that measured 0.7 cm X 0.9 cm, blanchable and skin prep was applied. A Progress Note, dated 04/06/22 at 10:56 A.M., indicated the facility wound nurse was contacted to look at the resident's pressure areas and buttocks. She had stated she would come look at them that day and awaiting new orders from the facility wound nurse.			

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A Progress Note, dated 04/08/22 at 10:31 A.M., indicated the facility wound nurse was contacted to update regarding the redness on the resident's right great toe worsening. The wound nurse was to look at the area and would look for a bed cradle to help keep the blankets off the resident's toes.

A Progress Note, dated 05/04/22 at 3:04 P.M., indicated a new area was noted to the resident's left great toe.

There were no Progress Notes in the clinical record from 04/30/22 through 05/04/22.

The clinical record lacked a physician order for skin prep to the right great toe or a bed cradle until 05/04/22.

The clinical record lacked any indication the resident's toes had redness or impairment prior to the deep tissue injuries on 04/01/22 and 05/04/22.

During an interview on 07/21/22 at 2:18 P.M., RN 11 indicated the resident didn't get out of bed often. She had an air mattress, a bed cradle, and protective boots for her heels. They would turn and reposition the resident as she would allow. The resident had pressure injuries to the tops of her toes that she believed started from the blankets resting on her feet. The resident was tiny and fragile.

During an interview on 07/22/22 at 2:13 P.M., the DON indicated the resident had been refusing a lot of care and turning and repositioning. She believed the pressure wounds on her toes had started from the bed covers because she was refusing to wear her boots. They had started using a bed cradle since then, They had started

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	the skin prep on 04/01/22. The resident had no redness prior to the pinpoint areas starting on the top of her toes. During an observation on 07/21/22 at 10:49 A.M., the resident's toes were observed with no areas noted. Offloading boots and a bed cradle were in place. The current facility policy, titled "Pressure Injury Prevention and Management" updated January 2021 was provided by the DON on 07/22/22 at 3:17 P.M. The policy indicated, "...This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries...The facility shall established and utilize a systemic approach for pressure injury prevention and management, including assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate..." 3.1-40(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without			

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	an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to provide consistent urinary catheter care for 1 of 4 residents reviewed for UTIs (Urinary Tract Infections). (Resident 14) Findings include: During an interview on 07/18/22 at 2:14 P.M., RN 7 indicated Resident 14 had a urinalysis completed and had ESBL (Extended Spectrum Beta-Lactamase, an enzyme found in some strains of bacteria) in her urine. The resident had completed a series of antibiotics. The staff wore a gown and gloves when in contact with the resident's urine. The resident had an indwelling urinary catheter. During a family interview on 07/18/22 at 2:29 P.M.,	F 0690	F 690 Bowel/Bladder Incontinence, Catheter, UTI It is the policy of this facility to provide consistent urinary catheter care for our residents. Corrective Action For Resident Affected: Resident 14 - An order was entered for catheter care the day that it was noted during survey. (Attachment titled Resident 14 Orders). Corrective Action For Other Residents Having The Potential To Be Affected: All residents with catheters have	08/31/2022

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	the family indicated the resident had a UTI that was resistant to antibiotics. The resident had no signs or symptoms currently and had recently been on antibiotics for seven days. The clinical record was reviewed on 07/20/22 at 3:02 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 05/05/22, indicated the resident was rarely understood. The diagnoses included, but were not limited to, Alzheimer's disease, arthritis, and hypertension. The resident was totally dependent on two or more staff members for bed mobility, dressing, toilet use, and personal hygiene. The urinalysis culture results record was provided by the ADON (Assistant Director of Nursing) on 07/25/22 at 3:12 P.M. The results, dated 07/03/22, indicated the resident had ESBL in her urine and the antibiotic Bactrim was order for seven days. The June 2022 EMAR/ETAR (Electronic Medication Administration Record / Electronic Treatment Administration Record) was provided by the ADON on 07/25/22 at 10:00 A.M. The record contained the following orders: - An open ended order, with a start date of 04/18/22, to anchor an indwelling urinary catheter for a diagnoses of a stage 3 (full-thickness skin loss potentially extending into the subcutaneous tissue layer) pressure area on the coccyx. - An open ended order, with a start date of 04/19/22, to empty the urinary catheter bag and record the amount every shift, three times a day, - An open ended order, with a start date of 04/19/22, to keep the catheter and tubing as free of kinks as possible, maintain the catheter bag below		the potential to be affected. All orders of residents with catheters were audited to ensure that the appropriate order for catheter care was in place. (Attachment titled Catheter Care Orders Audit). All other residents had the appropriate orders in place. Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding consistent urinary catheter care and the facility policy as well as the appropriate documentation of that care. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). A catheter care competency will be completed with all nursing staff who provide catheter care. (Attachment titled Catheter Care Competency). The Director of Nursing or designee will audit the records of residents with catheters as well as any new admissions with foley catheters weekly to ensure that the appropriate orders and documentation of the care provided are in place. (Attachment titled Foley Catheter Order and Documentation Audit). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results	

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	the level of the bladder, but do not allow to rest on the floor, every shift, days, evenings, and nights, and - An open ended order, with start date of 05/11/22, to irrigate the urinary catheter with normal saline as needed for sediment / blockage. The record lacked an order for catheter care to be completed. The progress notes for June 2022 were provided by the ADON on 07/25/22 at 10:00 A.M., and contained the following: - A note, dated 06/04/22 at 10:12 P.M., indicated good peri care had been provided by the staff. - A note, dated 06/29/22 at 3:36 P.M., indicated a CNA (Certified Nurse Aide) had reported to LPN (Licensed Practical Nurse) 5 the resident's urinary catheter was not intact and urine had leaked out all over the bed. The LPN replaced the catheter and the urine was thick, yellow, mucousy, and had a strong odor. No other notes indicated urinary catheter care had been provided. The July EMAR/ETAR was provided by the ADON on 07/22/22 at 10:25 A.M. The record contained the following orders: - An order, with a start date of 07/03/22 and an end date of 07/10/22, for Bactrim (antibiotic) twice a day for a diagnosis of a UTI with ESBL, - An open ended order, with a start date of 04/19/22, to empty the urinary catheter bag and record the amount every shift, three times a day,		of the weekly audits monthly for three months. If the appropriate orders are in place and the documentation of the care provided is in place 100% of the time, weekly monitoring will stop and monthly audits will occur for the next three months. If after six months of of audits, 100% compliance continues, auditing will stop.	

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	- An open ended order, with a start date of 04/19/22, to keep the catheter and tubing as free of kinks as possible, maintain the catheter bag below the level of the bladder, but do not allow to rest on the floor, every shift, days, evenings, and nights, and - An open ended order, with start date of 05/11/22, to irrigate the urinary catheter with normal saline as needed for sediment / blockage. The record lacked an order for catheter care to be completed. The July 2022 progress notes were provided by the Admissions Nurse on 07/22/22 at 12:05 P.M. and contained the following: - A note, dated 07/01/22 at 11:00 A.M., indicated the hospice CNA (Certified Nurse Aide) had provided "am" care and shampooed the resident's hair. The hospice nurse had obtained urine from the catheter for a urinalysis, culture, and sensitivity, - A note, dated 07/03/22 at 2:51 P.M., indicated the resident's urine culture results confirmed ESBL in the resident's urine, the resident was placed in contact isolation, staff were to wear PPE (Personal Protective Equipment) when in direct contact with the resident's urine, and there was a new order for the antibiotic Bactrim, twice a day, for seven days, - A note, dated 07/08/22 at 11:27 A.M., indicated a hospice CNA had been in to complete ADLs (Activities of Daily Living) for the resident, and - A note, dated 07/18/22 at 2:10 P.M., indicated a CNA alerted RN 7 to the residents pad on her bed			

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	being wet with urine. The RN changed the resident's indwelling urinary catheter and had thick, amber urine with sediment returned. The CNA indicated the resident had vomited during her afternoon meal. No other notes indicated urinary catheter care had been provided. The Care Plan was provided by the ADON on 0725/22 at 10:00 A.M. A bowel and bladder care plan, with a start date of 04/20/22, indicated the resident had an indwelling urinary catheter to promote healing of a sacral ulcer. An approach, with a start date of 04/20/22, indicated to provide catheter care daily. During an interview on 07/21/22 at 2:07 P.M., on the 400 Hall, LPN 3 and QMA (Qualified Medication Aide) 2 indicated the CNAs completed catheter care for the residents. They checked it through out the shift and emptied the drainage bag once a shift. The staff on the 400 hall worked eight hour shifts. The CNAs documented the output in the EHR (Electronic Health Record). The QMA offered to demonstrate urinary catheter care. Urinary catheter care was observed on 07/21/22 at 2:25 P.M. QMA 2 used hand sanitizer and donned a gown and face shield. She was already wearing a surgical mask. She entered the resident's room, washed her hands with soap and water, donned gloves, got paper towels, placed the paper towels on the floor next to the resident's urinary catheter bag, placed a graduated cylinder on the paper towels, then placed a package of aloe wipes directly on the floor next to the paper towels, not on the paper towels. She removed her gloves, washed her hands, donned clean gloves, took the			

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	spout out of the receptacle on the catheter bag, unclamped the spout, drained the urine into the graduated cylinder, reclamped the spout, cleaned the end of the spout with an aloe wipe, and replaced it in the receptacle on the urinary catheter bag. She put the package of aloe wipes back on the lid of the soiled linen receptacle, picked up the cylinder of urine and paper towels, and emptied the cylinder in the toilet. She threw the paper towels away and rinsed out the cylinder and placed it back in a plastic bag. She removed her gloves and gown and exited the resident's room. She used hand sanitizer and cleaned her face shield. She charted the amount emptied on the catheter order that indicated to empty and document the amount. The results of her documentation of the amount was visible under the vitals records. The QMA failed to clean around the insertion site of the catheter and she did not document that she had provided that type of care. During an interview on 07/22/22 at 11:43 A.M., CNA 6 indicated the CNAs emptied the catheters and cleaned around the insertion site, one time per shift, three times a day, and documented on the resident's record. During an interview on 07/22/22 at 11:47 A.M., the ADON indicated each resident had an order for the staff to complete catheter care daily. The order for catheter care daily was under the nursing orders. The nurses should have been signing off on it on the EMAR/ETAR. It was a nursing order to provide catheter care daily. Catheter care consists of washing around the catheter insertion site. The nurses did not have to be the ones to complete the care. They put catheter care in the residents' orders to ensure it was completed daily. The nurse would have to observe the catheter			

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	care being done by another staff member or complete the care themselves in order to sign off that it had been completed. All residents who had an indwelling catheter should have a physician's order for catheter care daily. The resident should have had an order for catheter care daily to ensure it was getting completed. The staff should have clicked on the order when they were putting in the other catheter orders for monitoring. They had urinary catheter orders that included several different orders. There was a list of orders that the staff clicked on to include them in the EMAR/ETAR and the nurses signed off on them indicating the care was provided. The current Catheters - Catheter Care policy, with an updated date of January 2021, was provided by the Administrator on 07/22/22 at 10:51 A.M. The policy indicated, "...Catheter care is to be performed every shift and as needed...Provide privacy...Assist resident to a lying position...Drape resident to expose only the perineal area. Expose insertion site...starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place as to not pull on the catheter..." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable			

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	parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to accurately monitor a resident's meal intake for 1 of 3 residents reviewed for nutrition. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 07/20/22 at 10:29 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 04/29/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart failure, hypertension, and non- Alzheimer's dementia. The current Care Plan titled, "Nutritional Status", with a start date of 07/19/19, included, but was not limited to, an intervention with a start date of 07/19/19 that indicated staff were to observe and record the resident's intake of food. The July 2022 Vitals Report for breakfast, lunch, dinner, and supplements was provided by the DON (Director of Nursing) on 07/22/22 at 1:37 P.M. The report lacked documentation of the dinner meal for the following dates:	F 0692	F 692 Nutrition/Hydration Status Maintenance It is the policy of this facility to accurately monitor resident's meal intake. Corrective Action For Resident Affected: Resident 10 was a Hospice resident and was very near end of life. She passed away during the survey on 7-24-2022. Other Residents Having The Potential To Be Affected: All residents at risk for altered nutrition and hydration have the potential to be affected. An audit will be completed on all residents at risk for altered nutrition and hydration to identify any further issues. (Attachment titled Meal Consumption Documentation Audit). Systemic Changes And Steps To Assure Deficient Practice Does	08/31/2022

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	- 07/01/22, - 07/02/22, - 07/03/22, - 07/08/22, - 07/13/22, - 07/15/22, - 07/16/22, - 07/17/22, and - 07/21/22. During an interview on 07/21/22 at 10:19 A.M., QMA (Qualified Medication Aide) 12 indicated staff were to monitor resident's fluid and food intake and document in the resident's clinical record. During an interview on 07/22/22 at 11:43 A.M., CNA (Certified Nurse Aide) 6 indicated the resident's meal consumption was documented in the resident's clinical record. The current facility policy titled, "Assist Nutrition and Hydration", updated January 2021 was provided by the DON (Director of Nursing) on 07/22/22 at 3:54 P.M. The policy indicated, "...Residents within the facility will maintain adequate parameters of nutritional and hydration status, to the extent possible, to ensure each resident is able to maintain the highest practicable level of well-being..." 3.1-46(a)(1)		not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding the need to monitor the meal intake of all residents. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). The Director of Nursing or designee will complete a weekly audit of Meal Consumption Documentation to ensure the deficient practice does not recur. The sample size will be 5 residents on each nursing unit for all three meals for a total of 25 residents. (Attachment titled Meal Consumption Documentation Audit). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the weekly audit results for three months. If appropriate documentation is occurring 100% of the time, weekly monitoring will stop and monthly audits will occur for another three months. If after six months of audits, 100% compliance continues, auditing will stop.	
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			

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	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. §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 record review and interview, the facility failed to ensure wound healing medications/supplements were available for 1 of 6 residents reviewed for pharmacy services. (Resident 56) Findings include: The clinical record for Resident 56 was reviewed on 07/20/22 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/22/22,	F 0755	F 755 Pharmacy Services/Procedures It is the policy of this facility to ensure supplements are available. Corrective Action For Resident Affected: Resident 56 did have a time that his supplement was not available due to supply chain issues. His record lacked documentation of	08/31/2022

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	indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, traumatic brain dysfunction, neurogenic bladder, aphasia, quadriplegia, and seizure disorder. The resident had an unhealed pressure ulcer. A current physician's order, with a start date of 07/01/22, indicated Pro-Stat Sugar Free, 30 ml (milliliters) twice a day, for wound healing. The July 2022 EMAR (Electronic Medication Administration Record) indicated the resident had not received the Pro-Stat for the following dates and times due to the medication being unavailable: - 07/06/22 7:00 A.M. to 10:00 A.M., and 7:00 P.M. to 10:00 P.M., - 07/07/22 7:00 A.M. to 10:00 A.M., and 7:00 P.M. to 10:00 P.M., - 07/08/22 7:00 A.M. to 10:00 A.M., and 7:00 P.M. to 10:00 P.M., - 07/09/22 7:00 P.M. to 10:00 P.M., - 07/10/22 7:00 P.M. to 10:00 P.M., and - 07/11/22 7:00 A.M. to 10:00 A.M., and 7:00 P.M. to 10:00 P.M. The clinical record lacked documentation the pharmacy or physician had been notified of the medication/supplement not being available. During an interview on 07/22/22 at 3:04 P.M., LPN 10 indicated the Pro-Stat for residents was supplied by the dietary department. If it was unavailable from dietary and there was a physician's order the pharmacy would be contacted, and it would be ordered through them. If the medication/supplement was unavailable to administer the pharmacy should have been		physician notification and this could not be added after the fact. Other Residents Having The Potential To Be Affected: All residents who receive supplements have the potential to be affected. An audit was performed on all residents who receive supplements for the past month to ensure that the supplements were available and if not that the physician was notified. (Attachment titled Supplement Availability and Physician Notification Audit). Systemic Changes And Steps To Ensure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding the need to notify the physician if a supplement is not available for further orders and direction and/or for an acceptable alternative. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). The Director of Nursing or designee will perform a weekly audit on all residents who receive supplements to ensure that the supplement is available and if the supplement was not available that the physician was notified. (Attachment titled Supplement Availability and Physician Notification Audit).	

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	contacted and a progress note documented in the clinical record. During an interview on 07/22/22 at 3:08 P.M., the ADON (Assistant Director of Nursing) indicated the Pro-Stat was provided by dietary and if they could not get it in a timely manner then it would be ordered from the pharmacy. The current facility policy titled, "Medication Reordering" updated January 2021, was provided by the DON (Director of Nursing) on 07/25/22 at 11:53 A.M. The policy indicated, "...It is the policy of the facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident..." 3.1-25(a)		Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly audits monthly for three months. If the appropriate supplements are available and physician notification occurs if not 100% of the time, weekly monitoring will stop and monthly audits will occur for another three months. if after six months of audits, 100% compliance continues, auditing will stop.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related to labeling medications and having unsecured, loose capsules and tablets in the medication carts for 2 of 4 medication carts reviewed. (200 Hall Medication Cart and 100 Hall Medication Cart) Findings include: 1. A medication cart on the 200 hall was observed on 07/18/22 at 11:03 A.M., with QMA (Qualified Medication Aide) 4, and contained the following medications: - Debrox ear drops with no open date for Resident 54, the bottle was not transparent, - Erythromycin eye drops with no open date for Resident 70, - Symbicort inhaler with no open date for Resident 48, and - Diclofenac tube of ointment, 1/4 full, with no open date for Resident 44. The cart contained the following loose pills laying in the bottom of the drawers: - four pills in small single bubble packs, the QMA indicated they were Zofran tablets, - eight whole white tablets of various shapes and	F 0761	F 761 Label/Store Drugs and Biologicals It is the policy of this facility to store medications appropriately. Corrective Action For Residents Affected: The items that had no open dates were discarded and reordered. The loose pills were also discarded. Other Residents Having The Potential To Be Affected: All residents who receive medications have the potential to be affected. A med cart audit was completed the week of August 8, 2022. Every medication cart in the facility was audited for open dates and loose pills or capsules. (Attachment titled Medication Storage Audit). Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding the	08/31/2022

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	sizes, - one oval lavender tablet, - one oval green tablet, - one round red tablet, and - one red capsule. The QMA indicated the medication carts were to be cleaned daily on night shift. She disposed of the loose pills in the sharps container. 2. A medication cart on the 100 hall was observed on 07/18/22 at 11:23 A.M., with LPN (Licensed Practical Nurse) 5, and contained the following medications: - Sustane eye drops with no open date for Resident 25, - Fluticasone propionate nasal spray, 3/4 full, with no open date, for Resident 73, - Albuterol inhaler with no open date for Resident 73, - A bottle of chewable Ocuvite vitamins, less than half full, with no open date for Resident 67, and - A Victoza insulin pen, over 3/4 full, with no open date, resident name, or pharmacy label. The cart contained the following loose pills laying in the bottom of the drawers: - three small round white tablets, - one large round white tablet, - one small oval white tablet, - one small peach 1/2 tablet, and - an open roll of Rolaids, 3/4 full, with no resident name or label. The LPN indicated the staff generally dated all items when they were opened. She did not know how long insulin pens were good for once they were removed from the refrigerator.		need to put open dates on all medications and to discard any loose pills or capsules. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). The Director of Nursing or designee will complete a medication cart audit weekly of all medication carts to ensure that the deficient practice does not recur. (Attachment titled Medication Storage Audit). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly audits monthly for three months. If appropriate practice is found 100% of the time, weekly monitoring will stop and monthly audits will occur for another three months. If after six months of audits, 100% compliance continues, auditing will stop although monthly pharmacy audits will continue.	

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	The Victoza insulin pen package insert was provided by the DON (Director of Nursing) on 07/22/22 at 3:17 P.M. The insert indicated, "...Recommended Storage...After initial use of the Victoza pen, the pen can be stored for 30 days at controlled room temperature...This will reduce the potential for contamination, infection and leakage while also ensuring dosing accuracy..." The current Medication Storage Policy, updated in January of 2021, was provided by the DON on 07/22/22 at 3:53 P.M. The policy indicated, "...It is the policy of this facility to ensure all medications housed on our premises will be stored...according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security..." 3.1-25j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)			
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			

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	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 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			

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	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, interview, and record review, the facility failed to ensure appropriate infection control guidelines were followed related to TBP (Transmission Based Precautions) for 1 of 3 residents reviewed for isolation precautions. (Resident 48) Findings include: Resident 48 was observed and interviewed in her room on 07/18/22 at 1:25 P.M. The resident indicated she was resting because she had not been feeling well. She was currently receiving an antibiotic for a UTI (Urinary Tract Infection). The antibiotic had recently been changed from an oral medication to an injectable medication. She was glad she did not need to be in isolation because of the infection. There was no PPE (Personal Protective Equipment), isolation cart, or signage	F 0880	F 880 Infection Prevention and Control It is the policy of this facility to 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. Corrective Action For Resident Affected: Resident 48 was placed in contact precautions on 7/20/2022. Other Residents Having The Potential To Be Affected:	08/31/2022

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	outside the resident's room that indicated the resident was in isolation or on TBP. On 07/20/22 at 2:33 P.M., the resident was observed in her room in bed. The resident was not on TBP or in any type of isolation. The resident's clinical record was reviewed on 07/20/22 at 2:45 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/10/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), hypertension, heart failure, diabetes, and bipolar disorder. The resident was always incontinent of bowel and bladder and required extensive staff assistance with toileting and personal hygiene. An Established Patient Acute Visit Nurse Practitioner note, dated 07/18/22, regarding the resident's UTI indicated the urine sample was growing Klebsiella Pneumoniae ESBL (Extended Spectrum Beta Lactamase) and Escherichia Coli ESBL. The plan was to discontinue the current antibiotic (Bactrim), and begin Invanz antibiotic, 1 gram, as an IM (Intramuscular) injection for 5 days. On 07/20/22 at 2:32 P.M., the DON (Director of Nursing) provided the culture and sensitivity report for the urinalysis obtained on 07/14/22. The final culture indicated Klebsiella Pneumoniae ESBL and E. Coli ESBL were present in the resident's urine. During an interview on 07/20/22 at 3:33 P.M., the DON indicated the resident should have been placed in EBP (Enhanced Barrier Precautions) if she had ESBL in her urine. EBP meant that staff should wear a gown and gloves if they were going		All residents who have a multi-drug resistant organism have the potential to be affected. An Audit was performed on all residents with a multi-drug resistant organism the week of August 8, 2022 and all were in the appropriate isolation. (Attachment titled Isolation Precautions for Residents With MDROs Audit). A root cause analysis using the 5 Why's format was completed to determine the root cause of the resident with ESBL not being in Contact Precautions. (Attachment titled Root Cause Analysis). After completion of the root cause analysis it was determined that the agency nurse who received the results was not properly trained during the onboarding process resulting in lack of knowledge of facility policy and procedure as she started prior to improvements to the onboarding process. This nurse went through the onboarding process and education with the Director of Nursing on August 12, 2022. (Attachment titled Lutheran Community Home Agency Staff Attestation Statement). All nurses and QMAs received education on August 12, 2022 regarding ESBL and the need to place the resident in contact precautions when a positive culture is received. (Attachment titled ESBL/Contact Precautions). The Director of Nursing or	

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	to come into contact with the bacteria. They had another resident in the facility with ESBL in their urine and that resident was in isolation. During an interview on 07/21/22 at 9:40 A.M., the DON indicated she checked with the facility Infection Preventionist, and the resident did not need to be in EBP due to the ESBL in her urine because she had a private room with a private bathroom. The current facility policy related to infection control had not yet been updated to reflect current practices and procedures for EBP. On 07/21/22 at 10:26 A.M., the outside of Resident 48's room was observed. The resident's door was closed. An isolation cart with PPE was outside the resident's room and a sign on the door indicated the resident was in "Contact Precautions". The sign indicated staff were to wear gloves whenever touching the resident's skin or surfaces and items near the resident, and a gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment near the resident. During an interview on 07/21/22 at 10:48 A.M., the ADON (Assistant Director of Nursing) indicated the resident was in EBP for ESBL in her urine. Their facility policy had not yet been updated to reflect EBP, the sign on the resident's door indicated she was in "Contact Precautions". With Contact Precautions, staff would need to wear a gown and gloves any time they entered the resident's room. With Enhanced Barrier Precautions, staff would only need to wear a gown and gloves if they were likely to come into contact with the bacteria. This resident had ESBL in her urine. The resident was incontinent and wore briefs. Staff were to wear a gown and gloves		designee will complete daily visual rounds for at least six weeks to ensure that the appropriate isolation precautions are in place for residents with MRDOs. (Attachment titled Isolation Precautions for Residents With MDROs Audit). Systemic Changes and Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff on August 29, 30, and 31, 2022 regarding the appropriate isolation precautions for residents with multi drug resistant organisms. (Attachment titled Mandatory Staff Education - Plan of Correction 2022). Staff will also be educated on the CDC recommended but not yet CMS mandated Enhanced Barrier Precautions. The Director of Nursing or designee will complete a weekly audit of all residents who receive culture and sensitivity results to ensure that the appropriate isolation precautions are implemented if indicated. (Attachment titled C&S Results and Isolation Precautions Audit). The Infection Preventionist at Schneck Medical Center, continues to provide consultative services to Lutheran Community Home. She reviewed the root case analysis, the LTC Infection Control Assessment, and the facility policies on August 12,	

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	when providing incontinence care. The current facility policy, titled "Infection Control Policies, Isolation Precautions", dated March 2020, was provided by the DON on 07/21/22 at 9:40 A.M. The policy indicated, "...It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents..." 3.1-18(b)		2022. She approved all and agreed all are accurate. Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly C&S/Isolation Precautions audits monthly for three months. If the appropriate practice is occurring 100% of the time, audits will decrease to monthly for the next three months although the Infection Preventionist will continue to monitor and update the committee on residents with MDROs in the building on an ongoing basis. If after six months of audits, 100% compliance continues, auditing will stop. The Quality Assurance Performance Improvement Committee will review, update, and make changes to the DPOC as needed for sustaining substantial compliance monthly for the next six months. The committee will monitor the results of observations and audits as presented by the Infection Preventionist monthly for six months.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000	Submission of this plan of correction does not constitute an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155715	A. BUILDING 00 B. WING	07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

(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
	State Licensure Survey. Survey dates: July 18, 19, 20, 21, 22, and 25, 2022 Facility number: 000347 Residential Census: 22 Lutheran Community Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on July 28, 2022.		admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	