STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155546	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL POINTE HEALTH AND REHAB	3400 W COMMUNITY DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00407948. Complaint IN00407948- No deficiencies related to the allegations are cited. Survey dates: May 3, 4, 5, 8 and 9, 2023 Facility number: 000565 Provider number: 1555546 AIM number: 100267630 Census Bed Type: SNF/NF: 96 SNF: 11 Total: 107 Census Payor Type: Medicare: 26 Medicaid: 60 Other: 21 Total:107 These deficiency/ies reflect/s State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 15, 2023.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

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

Derek Gibson | Administrator | 05/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	or other residents. Based on observation, record review, and interview, the facility failed to ensure a call light was placed within reach of a dependent resident for 1 of 3 residents reviewed for activities of daily living. (Resident 159) Findings include: During a random observation on 5/8/23 at 10:44 a.m., Resident 159 was observed seated in his wheelchair, to the right of the lower end of his bed. His call light button was clipped to his bedsheet, to the left of his wheelchair. He indicated he had urinated on himself and his left arm was sore and in the wrong position, but he had been unable to get the staff's attention. The resident indicated he was unable to reach the call light due to his inability to move his left arm and inability to reach the call light button with his right arm. During an interview on 5/08/23 at 10:48 a.m., CNA 7 indicated the call light button was attached to the resident's bed in a place the resident was unable to reach. The clinical record for Resident 159 was reviewed on 5/5/23 at 9:42 a.m. Diagnoses included stroke, hemiplegia to his left side, and depression. An admission Minimum Data Set (MDS) assessment, dated 4/20/23, indicated the resident was cognitively intact, required extensive assistance for bed mobility, transfer, dressing, toileting, and bathing. During an interview on 5/9/2 at 10:18 a.m., the DON indicated the resident's call light button should be placed so the resident can use it to call	F 0558	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Resident 159"s call light was placed within reach as soon as it was brought to staff's attention. 2. All residents have the potential to be affected. Rounds were completed throughout the facility immediately to ensure call lights were within reach. 3. The Call Light System policy was reviewed and no changes were necessary. Staff will be re-educated on this policy. The DON or her designee will make rounds daily, 7 days a week, at random times, to ensure call lights are within reach for 4 weeks and until 100% compliance is achieved, then twice weekly for five months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/02/2023

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	staff for assistance. A current facility policy, last revised 10/2022, titled, "Resident Call System," provided by the DON on 5/9/23 at 10:41 a.m., indicated the following: "...Guidance:...The call light should be within reach of the resident whether in bed, sitting in a chair in their room, in the toilet and bathing areas. The intent of this requirement is that residents, when in their rooms, toilet and bathing areas, have a means of directly contacting caregivers...." 3.1-3(v)(1)			
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to complete a significant change assessment after hospice admission for 1 of 1 residents reviewed for hospice. (Resident 44) Findings include: The clinical record for Resident 44 was reviewed	F 0637	The facility will ensure this requirement is met through the following corrective measures: 1. No resident was harmed. A significant change assessment was completed for resident 44 and the current assessment is accurate.	06/02/2023

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	on 5/5/23 at 11:04 a.m. The resident's diagnosis included senile degeneration of the brain. He had a physician order to admit to hospice on 12/12/22. The resident had a Quarterly Minimum Data Set (MDS) assessment, dated 12/15/22, which lacked indication of hospice services. During an interview on 5/8/23 at 11:29 a.m., the MDS coordinator indicated the assessment done on 12/15/22 should have been a (comprehensive) significant change assessment related to the resident's new hospice admission. During an interview on 5/9/23 at 11:13 a.m., the MDS coordinator indicated she used the RAI (Resident Assessment Instrument) manual as the policy and procedure for completing MDS assessments. She had access to the online manual. Review of the current online RAI manual (April 25, 2023) retrieved from www.cms.gov on 5/9/23, indicated the following: "...significant change in status assessment (SCSI) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home...." 3.1-31(d)(1)		2. All residents receiving hospice services have the potential to be affected. A audit was completed of all residents receiving hospice services to ensure a significant change MDS completed and no others were found missing. 3. The facility will continue to utilize the RAI Manual as it's guide/policy. The Case Manager and MDS coordinator were educated on the need to complete a significant change MDS with a resident newly on hospice caseload. The Case Manager or her designee will review all resident with a new payor change to hospice twice weekly for 4 weeks and until 100% compliance is achieved, then every other week for 5 months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each			

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	resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			

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	Based on record review and interview, the facility failed to include activities of daily living needs in a baseline care plan for 1 of 3 residents reviewed for activities of daily living. (Resident 159) Findings include: The clinical record for Resident 159 was reviewed on 5/5/23 at 9:42 a.m. Diagnoses included stroke, hemiplegia of the left side, and depression. The resident admitted on 4/20/23 from an acute care hospital following a stroke. An admission Minimum Data Set (MDS) assessment, dated 4/20/23, indicated the resident was cognitively intact and required extensive assistance of two staff for bed mobility, transfer, dressing, toileting, and bathing. The clinical record lacked a baseline health care plan regarding the resident's needs for staff assistance for his activities of daily living (ADLs). The comprehensive care plan for ADLs was developed/revised on 4/26/23, six days after admission. During an interview on 5/9/23 at 10:14 a.m., the DON indicated the resident's baseline care plan had not included his specific needs regarding safe ADL care. This should have been included in the baseline care plan. A current facility policy, revised 10/2022, titled, "Care Planning," provided by the DON on 5/9/23 at 10:41 a.m., indicated the following: "...Procedure:...Baseline Plan of Care: 4. A Baseline plan of care will include at a minimum and will be completed within 48 hours of admission... 5...c. Any services and treatments to be administered by the facility and personnel acting	F 0655	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 159 was not harmed. His current care plan is up to date. 2. All residents newly admitted to the facility have the potential to be affected. An audit of all admissions in the past 14 days will be completed to ensure a baseline care plan has been completed that includes ADL's. 3. The Care Planning policy was reviewed and no changes were indicated. Licensed nursing staff will be re-educated on this policy. The DON or her designee will review baseline care plans on newly admitted residents within 48 hours to ensure ADL's is addressed appropriately 7 days a week for 4 weeks and until 100% compliance, then weekly for 5 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/02/2023

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	on behalf of the facility...." 3.1-30(a)			
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, interview, and record review, the facility failed to ensure medications were administered according to physician orders for 1 of 1 resident reviewed for diarrhea/constipation. (Resident 18) Finding includes: During an interview on 5/3/23 at 10:15 a.m., Resident 18 indicated he was staying in bed in his room because he had a terrible time with diarrhea. Staff were aware because he was unable to get up to the restroom, so they had to clean him up multiple times throughout the day. Due to an intolerance of dairy products, he had an order for Lactaid to be given before each of his meals. Nursing staff had been administering it at various times. Often, it was not administered before his meals and many times as late as two hours after he had eaten. He was getting frustrated because the diarrhea was not controlled. During an interview on 5/4/23 at 11:08 a.m., the resident was in his room in bed when his meal tray	F 0684	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 18 was not harmed. His BIMs score is a 15. He will be assessed for self-administration of lactaid and an order obtained to self administer his lactaid. 2. No other residents were harmed. An audit was completed to ensure no other residents are affected. 3. The policy entitled Following Medication-Physician Orders/Parameters was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The DON or her designee will audit each unit's Medication Administration records weekly to ensure medications are administered when ordered/timely for 4 weeks and until 100% compliance is achieved, then	06/02/2023

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	was delivered. His meal included chocolate milk. He indicated he had not received his Lactaid yet. He also received prune juice, though his lunch ticket indicated cranberry juice. Resident 18's clinical record was reviewed on 5/4/23 at 4:33 p.m. Diagnoses included atrial fibrillation, chronic combined systolic and diastolic heart failure, unspecified severe protein calorie malnutrition, unspecified hemorrhoids, unspecified constipation, and major depressive disorder. He had a current medication order, dated 4/17/23, for Lactaid (lactose intolerance) 3000 units, one tablet before meals for digestion. A quarterly Minimum Data Set assessment, dated 4/5/23, indicated the resident was cognitively intact. The resident required extensive assistance for toileting. He was always incontinent of bowel. A current malnourishment care plan , revised on 1/8/23, indicated the resident was at risk for malnourishment related to stress. Interventions included, I will receive my medications as ordered. Review of the Medication Administration Audit Report from 4/20/23 to 5/4/23 indicated Lactaid was scheduled to be administered to the resident each day at 7:00 a.m., 11:00 a.m., and 4:00 p.m. The medication was administered after meals on the following dates: a. 4/20/23 - breakfast dose at 8:54 a.m. and lunch dose at 12:59 p.m. b. 4/21/23 - lunch dose at 3:10 p.m. and dinner dose at 5:19 p.m. c. 4/23/23 - dinner dose at 5:10 p.m. d. 4/24/23 - breakfast dose at 9:44 a.m. and lunch		twice monthly for 5 months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	dose at 12:24 p.m. e. 4/25/23 - breakfast dose at 7:52 a.m., lunch dose at 12:29 p.m., and dinner dose at 7:29 p.m. f. 4/26/23 - lunch dose at 11:49 a.m. g. 4/27/23 - breakfast dose at 1:18 p.m. and lunch dose at 1:18 p.m. h. 4/28/23 - breakfast dose at 1:28 p.m., lunch dose at 1:28 p.m., and dinner dose at 7:24 p.m. i. 4/29/23 - breakfast dose at 8:24 a.m. and dinner dose at 5:11 p.m. j. 4/30/23 - breakfast dose at 8:36 a.m. k. 5/1/23 - breakfast dose at 8:10 a.m., lunch dose at 2:29 p.m., and dinner dose at 5:19 p.m. l. 5/2/23 - breakfast dose at 3:04 p.m., lunch dose at 3:04 p.m., and dinner dose at 6:56 p.m. m. 5/3/23 - breakfast dose at 8:16 a.m. n. 5/4/23 - breakfast dose at 8:20 a.m., lunch dose at 12:03 p.m., and dinner dose at 5:24 p.m. Review of the resident's bowel documentation, from 4/10/23 to 5/8/23, included 18 episodes of diarrhea/loose stools. During an observation on 5/5/23 at 11:10 a.m., the resident was delivered his meal tray in his room for lunch. During an interview on 5/5/23 at 12:26 p.m., the resident was in his bed in his room. He indicated he did not receive his Lactaid before his meal at lunch on this date. He had sour cream with his taco. During an interview on 5/8/23 at 2:48 p.m., the resident indicated he was aware what the Lactaid pill looked like and provided a description of the pill. He had spoken to nearly every nurse that brought him his medication about the delay in getting his Lactaid before meals, but nothing had changed. Some of the staff told him he was			

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	administered his medication as it was ordered. He also spoke with the CNAs about it because he felt bad when they had to clean him up so often. He had never refused to take his Lactaid, even when it was administered at the wrong time. Often, he did not get out of bed to do activities because he was hesitant to get far from his bed with the loose bowel movements. During an interview on 5/8/23 at 4:18 p.m., LPN 5 indicated Resident 18's unit received their meals each day on a regular basis at the following times: breakfast 7:00 a.m., lunch 11:00 a.m., and dinner from 4:00 to 4:30. During an interview on 5/8/23 at 5:17 p.m., CNA 4 indicated she was familiar with the resident. He had problems with frequent bowel incontinence. During an interview on 5/8/23 at 5:27 p.m., LPN 5 indicated the resident had mentioned a delay in receiving his Lactaid before meals on a couple of different occasions. The Lactaid was ordered to be administered before meals and was not effective if it was not administered before meals. The medication should have been administered according to the provider's order. During an interview on 5/9/23 at 10:16 a.m., the DON indicated the resident's Lactaid had not been administered according to the physician order on many different occasions. Medications should have been administered as ordered. A current policy, last revised 3/2020, titled "FOLLOWING MEDICATION-PHYSICIAN ORDERS/PARAMETERS," provided by the DON on 5/9/23 at 9:09 a.m., indicated the following: "...Purpose: To administer medication in a safe and effective manner and following physician			

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	ordered parameters. Procedures: ... C. Review 6 Rights (3) times: 1) Right Resident; 2) Right Medication; 3) Right Dose; 4) Right Time; 5) Right Route; 6) Right Documentation...." 3.1-37(a)			
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- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician. There were 25 opportunities with 3 errors, resulting in a 12% medication administration error rate. These errors involved 1 of 7 residents observed for medication administration. (Resident 211) Findings include: During observation of medication administration for Resident 211, on 5/4/23 at 10:15 a.m., LPN 8 prepared the following medications to administer: a. Potassium chloride extended release (supplement) 10 meq (milliequivalent) b. Senna (stool softener) 8.6 mg (milligram) c. Vitamin D3 (supplement) 125 mcg (microgram) d. Oyster shell 500 mg with vitamin D 200 mg (supplement) e. Anastrozole (breast cancer preventive) 1 mg f. Atorvastatin calcium (to treat high cholesterol) 10 mg g. Citalopram (to treat depression) 40 mg h. DOK (laxative) 100 mg i. Ferrous Sulfate (supplement) 325 mg	F 0759	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 211 was not harmed. She has discharged home. 2. All residents have the potential to be harmed. LPN 8 was re-educated. 3. The policy entitled Medication Administration was reviewed and no changes were indicated. Licensed staff and QMA's will be re-educated on this policy. The DON or her designee will complete med pass observations 3 times weekly for 4 weeks and until 100% compliance is achieved, then weekly for 5 months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/02/2023

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	j. Omeprazole delayed release (to treat acid reflux) 40 mg k. Fluticasone propionate (to treat seasonal allergies) nasal spray 50 mcg l. Aspirin (blood thinner) enteric coated 81 mg m. Metformin (to treat diabetes) 500 mg n. Trelegy Ellipta (to treat COPD) 100/62.5 mcg per inhalation During administration of fluticasone propionate nasal suspension 50 mcg, LPN 8 inserted tip of bottle into the residents left nostril and provided two quick squirts. She repeated this into the resident's right nostril. At no time did the LPN instruct the resident to sniff. She provided the resident with a tissue and the resident wiped liquid away from her nose. A clinical record review for Resident 211 was completed on 5/4/23 at 10:29 a.m. Current, signed, physician's orders for the resident included: a. Fluticasone propionate nasal suspension 50 mcg/action, one spray in each nostril, dated 4/26/23. b. Atorvastatin calcium 10 mg, one tablet at bedtime, dated 4/26/23. c. Vitamin D3 25 mcg, one tablet daily (in addition to 125 mcg), dated 4/29/23. During a reconciliation of the resident medication administration observation, the vitamin D3 25 mg was not listed as administered. During an interview on 5/4/23 at 10:26 a.m., LPN 8 indicated she administered two sprays of the fluticasone propionate nasal suspension because she wanted to be sure the first spray came out.			

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	She indicated she should have administered one spray in each nostril and instructed the resident to sniff. During an interview on 5/4/23 at 10:43 a.m., LPN 8 indicated she should not have administered the resident's atorvastatin calcium and that it should be administered at bedtime. She indicated she saw the vitamin D3 25 mcg packet, but felt it may have been an old order since the resident was administered another dosage of vitamin D3. A current facility policy, effective 2/1/18, "Medication Administration," provided by the DON on 5/9/23 at 1:28 p.m., indicated the following: "...Procedure: 1) Preparation/Administration...d. Follow the six (6) rights of medication administration i. Right medication...v. right time...." An undated patient information document for Flonase (fluticasone propionate) nasal spray, provided by the DON on 5/9/23 at 1:28 p.m., indicated the following: "...Using your FLONASE nasal spray: Step 1. Blow your nose to clear your nostrils. Step 2. Close 1 nostril. Tilt your head forward slightly and , keeping the bottle upright, carefully insert the nasal applicator into the other nostril. Step 3. Start to breathe in through your nose, and while breathing in press firmly and quickly down 1 time on the applicator to release the spray....Step 6. Repeat steps...in the other nostril...." 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			

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

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection prevention and control strategies were utilized during wound care for 1 of 3 residents reviewed for pressure ulcers. (Resident 90) Finding includes: Resident 90's clinical record was reviewed on 5/4/23 at 4:30 p.m. Diagnoses included contusion of the lower back and pelvis, unspecified injury to an unspecified level of the lumbar spinal cord,	F 0880	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 90 was not harmed. His wound care was re-done once the facility administration was notified. 2. All residents with wound care have the potential to be affected. The wound care nurse has been re-educated on proper clean technique.	06/02/2023

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	incomplete paraplegia, and acute ischemic heart disease. A current, 3/28/23 physician order indicated the following: every day shift, after cleansing with soap and water, pat dry, apply hydrogel (wound treatment) soaked gauze, and wrap the wound with roll gauze. Change daily and as needed. A current, 3/28/23 physician order indicated the following: every day shift, after cleansing the right heel with normal saline, pat dry, apply Medihoney Gel (wound treatment) to the wound bed, cover with gauze, and wrap the wound with roll gauze. Change daily and as needed. A current, 3/29/23 physician order indicated the following: after cleansing the sacral wound with Dakins wound solution (wound cleanser), pat dry, apply foam to the wound bed, and the wound vacuum at 150 mmHg. Plastic drape (wound vacuum dressing) may be utilized for skin protection. Change every Monday, Wednesday, Friday, and as needed. A quarterly Minimum Data Set, dated 4/8/23, indicated the resident had severe cognitive impairment. He required extensive to total dependence for bed mobility, transfers, and toileting. The resident was always incontinent of bowel. He had one unhealed Stage 3 pressure ulcer (wound with significant skin damage that may expose muscle, bone, or tendon) and two unstageable (wound with full thickness tissue loss but is covered by dead or blackened tissue) pressure ulcers. A current care plan for risk of pressure ulcers, dated 1/4/23, indicated the resident was at risk related to weakness and immobility.		3. The policy on Skin Integrity and Pressure Injury was reviewed and no changes indicated at that time. Licensed staff were re-educated on this policy. The DON or her designee will complete 3 wound treatment observations weekly for 4 weeks and until 100% compliance is achieved, then weekly for 5 months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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A current care plan for a Stage IV sacrum pressure ulcer, dated 4/12/23, indicated the wound was related to a multiple system failure.

A current care plan for bilateral heels unstageable pressure ulcers, dated 4/12/23, indicated the wounds were related to a multiple system failure.

A sacral wound culture report, collected on 2/22/23, indicated the resident had a history of a wound infection, with growth of multiple organisms.

A skin and wound evaluation, dated 4/28/23, indicated the Stage 3 sacrum pressure ulcer measured 4.5 centimeters (cm) length (L) x 2.6 cm width (W). Depth was not determined. Slough (dead tissue) covered 30 % of the wound bed. A faint odor was present.

A skin and wound evaluation, dated 4/28/23, indicated the left heel deep tissue pressure injury (non-blanchable deep red, maroon, or purple tissue) measured 2.7 cm L by 4.1 cm W. Depth was not determined. Eschar (black tissue) filled the wound bed.

The resident's skin and wound evaluation, dated 4/28/23, indicated the right heel deep tissue pressure injury measured 1.3 cm L x 1.7 cm W. Depth was not determined.

During a wound care observation from 5/5/23 at 2:17 p.m. to 2:49 p.m., upon entry to the resident's room, a foul odor was observed. LPN 3 carried multiple packages of gauze, gauze wrap, wound wash, Medihoney, and Negative Pressure Wound Therapy drape into the resident's room. The wound treatment supplies were in her arms and up

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	against her clothing. She placed the wound supply items directly on the resident's overbed table without a barrier. The resident's personal items were on the overbed table as well. A moderate amount of serous (clear colored) drainage was observed on the resident's bilateral heel dressings, as well as on the draw sheet. After hand hygiene, LPN 3 donned gloves, turned off the wound vacuum canister, and then removed the dressing from the resident's sacrum. LPN 3 doffed her soiled gloves and did not perform hand hygiene. She opened a package of gauze and placed it directly on the overbed table. She cleaned a pair of scissors, and placed them partially on the gauze. The handle and part of the blade hung over each side of the gauze, against the overbed table. She donned gloves and obtained a sacrum wound measurement, then doffed her gloves. She did not complete hand hygiene when donning or doffing. She opened the resident's door with the doorknob and closed it behind her. She returned to the room with a cotton swab. LPN 3 placed her bare right hand on the doorknob and closed the door. She donned clean gloves and opened the cotton swab and measured the depth of the sacrum wound. With the same gloves on, she picked up the wound wash bottle from the overbed table surface, opened a package of gauze, opened the bottle, poured the wound wash on the gauze and cleansed the sacral wound. A dry gauze was used to pat the wound dry. LPN 3 doffed her gloves, and without hand hygiene, donned a new pair of gloves. She applied skin protectant to the surrounding skin. She doffed her gloves and donned a new pair. She did not perform hand hygiene. She opened the drape, and placed it against the same bed pad and draw sheet which had been previously soiled with drainage from the heel wound. She picked up the scissors from			

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	against the overbed table and used them to cut the drape into pieces. The drape pieces were then placed around the wound with the same gloves. She doffed her gloves. Hand hygiene was not performed. LPN 3 used the door knob to open the door with her bare hand, left the room, and obtained more supplies. She returned to the room and closed the resident's door with the doorknob. Hand hygiene was not performed. She donned another set of gloves and picked up the scissors from against the overbed table and cut foam to fit the wound bed. The scissors were placed directly on the resident's bed pad. She placed the foam in the wound bed and attached the drape over the wound bed that was against the soiled pull sheet from the heel dressings. She picked the scissors up from the bed, without cleaning them, and cut a hole in the drape directly over the residents wound. A long piece of foam, which was used to form a bridge, was cut with the contaminated scissors. It was secured with the pieces of drape that were against the bed linens. The contaminated scissors were used to cut another hole in the drape. The wound vacuum tube was secured and negative pressure was turned back on. She doffed her gloves. LPN 3 washed her hands with soap and water. She opened the resident's door with the doorknob to go get a device to measure the resident's heel wounds. She re-entered the resident's room and shut the door with her hands. Hand hygiene was not performed. She donned gloves. The same contaminated scissors against the linens on the bed were used to removed the right heel dressing. The dressing had moderate drainage present. The scissors were placed back against the linens. Gloves were doffed and new gloves donned without hand hygiene. LPN 3 cleaned, dried, and measured the right heel wound. She picked up			

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	and opened a gauze pad and the Medihoney tube from against the overbed table and squeezed it onto the gauze. The gauze was placed directly on the wound bed of the right heel. Roll gauze was obtained from the overbed table and the right heel was wrapped and taped. Her gloves were doffed and new gloves donned, without hand hygiene. The left heel dressing, with moderate serous drainage, was removed with the contaminated scissors. Her gloves were changed, without hand hygiene. A gauze pad was picked up off of the overbed table and opened with her gloved hands. The hydrogel container was picked up from of the overbed table and opened with her gloved hands. Hydrogel was placed on the gauze pad. The gauze pad was placed on the wound bed. Roll gauze was retrieved from the overbed table, opened, and wrapped around the left heel wound. Her gloves were doffed without hand hygiene. The dressing was secured with tape. The nurse replaced the lid onto the Hydrogel, reapplied the resident's pressure relief boots, and the resident was repositioned in bed. LPN 3 collected and tied shut the trash bag. She did not perform hand hygiene prior to exiting the resident's room, or before touching other surfaces. She walked down the hallway and used her hands to open the soiled utility room. During an interview on 5/5/23 at 3:07 p.m., LPN 3 indicated she should have used a barrier on the overbed table before she set wound supplies down in the resident's room. She should not have placed the wound drape pieces against the bed linens without a barrier in place. Hand hygiene should have been used in addition to changing gloves throughout the wound care observation. These practices placed the resident at risk for infection. The resident was not currently being treated for infection but had been approximately			

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	two months ago. During an interview on 5/9/23 at 10:44 a.m., the DON indicated staff were required to use barriers on surfaces prior to the placement of wound supplies and hand hygiene between glove changes during wound care. A current facility policy, revised 6/2021, titled "Skin Integrity and Pressure Injury," provided by the DON on 5/5/23 at 4:20 p.m., indicated the following: " ...Policy: It is the policy of this facility to provide care that is consistent with professional standards of practice to prevent pressure injuries and does not develop pressure injuries unless the individual's condition demonstrates that they were unavoidable; and A resident with pressure injuries and any break in the integrity of the skin receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure injury from developing.... 3.1-18(l)			