STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

(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 State Residential Licensure Survey and the Investigation of Complaint IN00295667. This visit resulted in an Immediate Jeopardy. Complaint number IN00295667- Substantiated. Federal/State Deficiency related to the allegations is cited at F677. Survey Dates: May 29, 30, 31, June 3, 4, and 5, 2019. Facility Number: 001145 Provider Number: 155616 AIM number: 200120200 Census Bed type: SNF/NF: 87 Residential: 7 Total: 94 Census payor type: Medicare: 6 Medicaid: 79 Private: 2 Total: 87 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed June 12, 2019.	F 0000	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. However to remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain. New Albany Nursing and Rehab respectfully request a paper compliance plan of correction.	
F 0568 SS=A Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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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	(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on record review and interview, the facility failed to ensure resident account statements were provided on a quarterly basis for 1 of 22 residents reviewed for resident rights. (Resident C). Findings include: During an interview, on 5/31/19 at 8:25 a.m., Resident C indicated he was his own Power of Attorney and he had an account with the facility. He had "not ever" received a quarterly statement of the account from the facility. The clinical record for Resident C was reviewed on 6/3/19 at 11:21 a.m. The resident was his own representative. The annual MDS (Minimum Data Set) assessment, dated 01/29/19, indicated the resident was cognitively intact. The clinical record lacked documentation of the resident receiving any quarterly statements. During an interview, on 6/4/19 at 2:33 p.m., the Business Office Manager indicated the resident did have an account, but she did not have any	F 0568	· Resident C was given a copy of his latest quarterly statement with a signed verification it was hand delivered to him by the Business office manager. · The quarterly statements for all Residents that are their own representative were hand delivered their quarterly statements by the Business office manager or her designee. · The office manager was in-serviced on 06/21/2019 regarding resident funds policies and procedures. A spread sheet has been created to track the receipt of the statements with a signature for confirmation the resident received the statement. Statements that are mailed out to responsible party will have a self-addressed stamped envelope for signature proving receipt of statement to be returned to facility. If receipt of statement not returned within 5 business days a	07/14/2019

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	way to show proof that he had received his quarterly statements. "When they [the statements] come in the mail, I fold them up, put them in an envelope, and give them to activities to hand out. The next one should be coming out soon. They do them [the statements] quarterly ... I don't specifically remember seeing his name. I cannot guarantee he has gotten them, because I do not hand deliver them. I will have to change that and have them sign for them, when they come here." The most recent "Resident Facility Trust Fund" Policy and Procedure, was provided on 06/04/19 at 2:50 p.m., by the Business Office Manage. The policy indicated "... The accounting department will issue a statement, on a quarterly basis, of all transactions to each resident or his/her Responsible Party Designee or Legal Guardian ... The facility will prepare Quarterly Statements once they are received from...and the AR Specialist has informed them that the account is reconciled. The signed copy of the statement will be kept in the resident's file ..." 3.1-6(e)		follow up phone call will be made by Business office manager or her designee to verify receipt. All copies will be retained in the Business office. · Audits of the quarterly statements will be completed by Business office manager or her designee on a quarterly review for 6 months. Audits will be reviewed in Quality Assurance meeting monthly. If 100% compliance is not achieved, an action plan will be developed to ensure compliance. · Facility alleges compliance by July 1, 2019 · Please see Exhibit A	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to develop a care plan for a resident's noncompliance with medical care. This deficient practice affected 1 of 25 residents reviewed for care plans. (Resident 26). Findings include: During an observation of Resident 26, on 5/31/19 at 9:36 a.m., the resident was sitting in her wheelchair in the activities room. Her bilateral lower extremities were swollen, but were not elevated. The left lower extremity was wrapped in an elastic bandage. An interview with Resident 26, on 5/31/19 at 9:37 a.m., she indicated her legs had been swollen for a "couple of weeks ..." The clinical record was reviewed, on 6/3/19 at 8:40 a.m., the resident's diagnoses included, but were not limited to, heart failure and cellulitis.	F 0657	· Resident 26 care plan was immediately corrected to reflect non-compliance of elevating her lower extremities. · An audit of all resident care plans were completed by MDS and her designees to validate all care plans were current and updated. · The MDS person was in-serviced on 06/21/2019 regarding care plan revisions and timeliness. A copy of the 24-hour nursing report sheet will be given to MDS so all care plans can have additional information added. Daily morning meetings any and new information will be discussed, and care plans updated then. · The director of nursing and IDT will audit five care plans per week for three months, and all	07/14/2019

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	The current Physician's order for Resident 26 indicated, the resident was to receive bumex 2 mg (milligrams) twice daily. The open areas were to be cleansed with normal saline, pat dry, apply calcium alginate, and wrap left calf with two layers of compression wrap every day. The nurse's note, dated 3/22/19, indicated the resident had pitting edema to the left lower leg and was noncompliant with elevating the lower extremities. The nurse's note, dated 4/4/19, indicated the resident's family member had taken her to a doctors appointment and reported to the facility the cardiologist had sent her to the hospital related to her legs. A nurse's note, dated 4/11/19, indicated the resident was educated to elevate her legs, however she refused. The nurse's note, dated 4/18/19, indicated the physician was notified of the resident's pitting edema, redness, and swelling to the bilateral lower extremities. A new order was received for clindamycin 300 mg by mouth 3 times daily for 10 days related to cellulitis. The nurse's note, dated 4/19/19, indicated the resident was encouraged to elevate her legs, however she would only elevate her legs for short periods of time. The nurses note, dated 4/30/19, indicated the resident was noncompliant with elevating her legs. The nurses note, dated 5/24/19, indicated the		care plans as they come due quarterly for six months and ongoing. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility alleges compliance by July 14, 2019 · Please see Exhibit D	

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	resident refused her bilateral leg wraps. The resident's complete care plans were reviewed on 06/03/19 at 10:38 a.m. The clinical record lacked a care plan for the resident's non-compliance with the elevation of her legs or treatments. During an interview, on 6/4/19 at 11:10 a.m., the DON (Director of Nursing) indicated "She [Resident 26] does go see a cardiologist. Usually when she goes for an appointment they send her to the hospital for fluid volume overload. We try to monitor her fluid intake, but she's noncompliant. We try to get her to elevate her feet, she won't though ... She should have a care plan for noncompliance." An interview with the MDS (Minimum Data Set) Coordinator,on 6/5/19 at 8:00 a.m., she indicated "care plans are updated with each assessment and as needed." On 6/3/19 at 11:35 a.m., the DON presented a copy of the facility's current policy titled "Care Planning - Interdisciplinary Team." Review of this policy at this time included, but were not limited to, "Policy Interpretation and Implementation:...The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status...The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of the care plans: When there has been a significant change in the resident's condition..." 3.1-35(d)(2)(B)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the			

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	necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure residents were provided with supplies necessary to maintain personal hygiene for 5 of 5 residents reviewed for ADL care. (Residents B, C, E, F, and G). Findings include: 1. During an interview, on 05/31/19 at 8:37 a.m., Resident C indicated "... I need briefs because I do have accidents. It's been at least a month since they've had my briefs. We were out completely for like two weeks, then they got some in, I got one or two packs out of it and that was it... They don't have any that are big enough for me. I pee on myself, even just adjusting myself sometimes I leak. I don't have that many clothes to come in here and keep changing all the time." The facility did away with wipes. The staff were using washcloths. The washcloths were very rough, "it's like... sandpaper". The annual MDS (Minimum Data Set) assessment, dated 01/29/19, for Resident C indicated the resident was cognitively intact. 2. During an interview on 05/31/19 at 9:09 a.m., Resident B indicated, "They [the facility] run out of gloves. They don't carry my briefs. I missed resident council, because they didn't have my briefs. They say they can put me in a smaller size, but that's uncomfortable. I need a bariatric. They should have what I need... It's very embarrassing. I don't want to get up often, but when I do and I can't, that aggravates me...When I came here, I was on the wipes list. All they say is they're on	F 0677	· Residents B, C, E, F and G, supplies were immediately obtained for them. · The supply needs for all residents were reviewed and inventory adjustments made as needed. · The director of nursing was in-serviced on 06/21/2019 regarding maintaining medical supply par levels sufficient in number to meet the needs of the residents. Supply orders have been placed on a PAR level by medical records. Supply budget has been increased. Immediate audit was completed of all supplies that were in the building and what had previously ordered to reflect the amount of supplies that are needed. Weekly inventory will be completed of all supplies and what will be ordered. Purchase orders will be turned in to Administrator and DON. · Director of nursing or designee will inventory medical supply closets weekly for six months and ongoing. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility date certain will be July 14, 2019 · Please see Exhibit E	07/14/2019

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	backorder. I haven't seen any wipes in a few weeks. Right now they're using rough wash rags..." The annual MDS assessment, dated 05/7/19, for Resident B indicated the resident was cognitively intact. 3. During a resident council meeting, on 05/30/19 at 10:46 a.m., Resident F stated "Anything we need for daily supplies we are always out". 4. During a resident council meeting, on 05/30/19 at 10:46 a.m., Resident E indicated "We have no briefs and supplies like wipes". 5. During a resident council meeting, on 5/30/19 at 10:46 a.m., Resident G indicated, "We run out of supplies all the time". An observation, on 05/29/19 at 9:00 a.m., of the 400 Hall supply closet indicated the closet did not contain any packages of bariatric briefs. An observation, on 06/3/19 at 1:52 p.m., of the 400 Hall supply closet indicated the closet only contained 2 packages of medium briefs, 11 packages of large briefs, 5 packages of extra large briefs, 9 packages of double-extra large briefs, 3 boxes of large gloves, one box of extra large gloves, toothbrushes, 2 bottles of peri wash, 3 deodorants, and combs. There was no shaving cream, shampoo, toothpaste, lotion, razors, or bariatric briefs. An observation, on 06/4/19 at 1:28 p.m., of the 400 Hall supply closet indicated the closet only contained, 2 packages of medium briefs, 3 packages of large briefs, 9 packages of extra large briefs, 6 packages of double-extra large briefs. There was no shaving cream, shampoo,			

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	toothpaste, lotion, razors, wipes, or bariatric briefs. An observation, on 06/3/19 at 1:52 p.m., of the 1, 2, 3, Hall supply closet indicated there were no wipes located. An observation, on 06/4/19 at 1:32 p.m., of the 1, 2, 3 Hall supply closet indicated the closet only contained 15 new admission packages, 2 packages of extra large briefs, 1 package of large briefs, deodorant, toothpaste, lotion, one shaving cream, and 3 small/medium packages of briefs. There were no bariatric briefs or wipes. During an interview on 06/3/19 at 1:55 p.m., CNA (Certified Nursing Aide) 15 indicated, "Actually I don't even think they order them [bariatric briefs] like that... We run out of briefs quite often, they said they cut the budget or something..." During an interview, on 06/3/19 at 1:56 p.m., CNA 13 indicated Residents B and C were supposed to get wipes, however right now the facility was using wash rags. The residents had complained prior to her about the texture of the wash rags hurting them. During an interview, on 06/4/19 at 8:23 a.m., LPN (Licensed Practical Nurse) 12 indicated, "We do run short on the briefs. I'm not sure what the problem is. I don't think it's with medical records because she does the ordering...but we do run short at times... I do know the...residents down stairs wanted the wipes instead of wash cloths." During an interview on 06/4/19 at 11:00 a.m., with Medical Records, she indicated "I order the supplies every Monday and they arrive on Wednesday. I am aware they are running out of			

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	briefs. We have a new budget and I'm trying to stay within the budget." This Federal tag relates to Complaint IN00295667. 3.1-38(a)(3)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure the monitoring of residents during the duration of the nebulizer treatments for 2 of 2 residents observed for respiratory care. (Residents 185, and 76). Findings include: 1. During an observation of the 1, 2, 3 Hall, on 5/29/19 at 11:39 a.m., Resident 185 had received a nebulizer breathing treatment. The nurse was not in the resident's room or visible near the room during the duration of the nebulizer treatment. The clinical record was reviewed on 6/3/19 at 8:15 a.m. The resident's diagnoses included, but were not limited to, schizoaffective disorder, hypertension, and hyperlipidemia. The resident's cognition was moderately impaired.	F 0695	· Residents 185 and 76 had self-administration assessment completed immediately by nursing personnel. Resident 76 is now on Hospice and can no longer hold nebulizer. Resident 185 will be supervised by nursing or respiratory when receiving mini nebulizer treatments. · Self-administration of nebulizer treatment assessments were completed on all residents currently self-administering to determine appropriateness. · In service for all licensed staff, RN, LPN, QMA on Nebulizer treatments will be completed by July 4, 2019. · The director of nursing or designee will observe five nebulizer	07/14/2019

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	The Physician's Order, dated 5/22/19, indicated the resident received "DuoNeb Solution 0.5-2.5 (3) MG [milligrams]/3ML [milliliter] [Ipratropium-Albuterol] 1 vial inhale orally via nebulizer four times a day for SOA [shortness of air]." The Nurse's Note, dated 5/26/19 at 10:00 p.m., indicated "Res [resident] abed resting comfortably. Confused @ [at] x's [times], v/s [vital signs] WNL [within normal limits]...Needs assist x 1 with ADL's [activities of daily living]..." A SELF ADMINISTRATION OF MEDICATION ASSESSMENT form, dated 5/22/19, indicated "The resident IS NOT able to safely self-administer medications." 2. On 5/29/19 at 8:05 a.m., Resident 76 was observed with his nebulizer mask on and the machine running while he was laying in his bed. The nurse was administering medications on another hall during the duration of the resident's nebulizer treatment. At 8:26 a.m., the resident turned off his nebulizer machine himself without the nurse present. On 5/29/19 at 1:30 p.m., Resident 76 was observed with his nebulizer mask on and the machine running while he was laying in his bed. The nurse was not in the resident's room or in the hallway. On 5/31/19 at 8:50 a.m., Resident 76 was observed with his nebulizer mask on and the machine running while he was laying in his bed. The nurse was not observed in or near the resident's room. On 5/31/19 at 12:45 p.m., Resident 76 was observed with his nebulizer mask on and the machine running. The nurse was not in the		treatments weekly for one month and bi-monthly for six months. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility alleges to be in compliance by 7/14/19 · Please see Exhibit F	

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	resident's room or visible in the hallway. The clinical record was reviewed for Resident 76 on 6/03/19 at 8:17 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder, insomnia, and vitamin deficiency. The Quarterly MDS (Minimum Data Set) assessment, dated 5/26/19, indicated the resident was alert and oriented. The Care Plan, dated 2/25/19 and revised on 3/18/19, indicated "The resident has Shortness of Breath while lying flat r/t Decreased lung expansion/COPD." The interventions included, but were not limited to, "Assist resident/family/caregiver in learning signs of respiratory compromise... Monitor/document breathing patterns. Report abnormalities to MD: Nasal flaring, Respiratory depth changes, Altered chest excursion, Use of accessory muscles, Pursed-lip breathing or prolonged expiratory phase, Increased anteroposterior chest diameter. Monitor/document/Report breathing abnormalities to MD... Breathing treatments per MD Order..." The Care Plan, dated 2/20/19 and revised on 2/25/19, indicated "The resident has Oxygen Therapy r/t Ineffective gas exchange." The interventions included, but were not limited to, "Mini neb treatment per MD order...Give medications as ordered by physician. Monitor/document side effects and effectiveness. If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal."			

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	155616	A. BUILDING 00 B. WING	06/05/2019

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	The Physician's Orders, dated 5/13/19, indicated the resident received the following: -"Albuterol Sulfate Nebulization Solution (5 MG/ML) 0.5% 1 application inhale orally via nebulizer every 2 hours as needed for COPD [and] SOA" - "Brovana Nebulization Solution 15 MCG/2ML. [Arformoterol Tartrate] 1 application inhale orally via nebulizer two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION...ACUTE RESPIRATORY FAILURE WITH HYPERCAPNIA" - "DuoNeb Solution 0.5-2.5 (3) MG-ML [Ipratropium-Albuterol] 1 application inhale orally four times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION." On 6/3/19 at 10:30 a.m., the review of the current SELF ADMINISTRATION OF MEDICATION ASSESSMENT form for Resident 76 indicated "N/A [Not Applicable]" During an interview, on 6/04/19 at 8:15 a.m., LPN (Licensed Practical Nurse) 18 indicated when administering nebulizer treatments she would listen to the resident's lungs and set up the nebulizer machine. It takes 10 to 15 minutes for the duration of the treatment. After the treatment she would check the resident's lungs sounds again. "We are in and out during treatment, it depends on how 'with it' the residents' are." During an interview, on 6/4/19 at 8:29 a.m., the DON (Director of Nursing) indicated the nurse should perform a pre assessment and post			

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	assessment on the resident receiving a nebulizer treatment. "They should probably stay with the resident during the treatment." The review of the current Nebulizer Therapy...policy, on 6/3/19 at 11:34 a.m., indicated the "...PROCEDURE FOR AEROSOL THERAPY...Have the patient seated or semi-fowlers position, place medication cup, turn on the compressor, have the patient breath 'slow and deep' for the duration of therapy, occasionally [sic] taking an 'extra deep' breath with a slight hold, have the patient take a deep breath and cough after therapy..." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure the monitoring of residents dialysis cite after dialysis and have a signed dialysis contract for 2 of 2 residents reviewed. (Resident 79 and 48). Findings include: 1. The clinical record for Resident 79 was reviewed on 05/31/19 at 1:24 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, bipolar disorder, and end stage renal dialysis. The resident went to dialysis on Monday, Wednesday, and Friday.	F 0698	· Resident 79 and 48 both remain at facility and continue with hemodialysis 3 times a week. Contract with Fresenius Dialysis Center is in place and in Administrators office. · All nursing staff to be in serviced on dialysis fistulas and what to monitor for. In servicing will be completed by 7/14/19. Orders obtained to monitor fistula site for 24 hours after dialysis on Monday, Wednesday, Friday every 6 hours. These orders have	07/14/2019

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	The Care Plan, dated 03/7/18, indicated "The resident needs dialysis [hemodialysis] r/t [related to] renal failure." The interventions included, but were not limited to, "... Monitor/document/report to MD PRN [as needed] any s/sx [signs/symptoms] of infection to access site: Redness, Swelling, warmth or drainage...Monitor/document/report to MD PRN for s/sx of following: Bleeding, Hemorrhage, Bacteremia, septic shock. Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP [blood pressure] immediately." The "Dialysis Communication Sheets" or clinical record lacked documentation of the shunt site monitoring for 24 hours after dialysis days. 2. The clinical record for Resident 48 was reviewed on 06/4/19 at 2:29 p.m. The resident's diagnoses included, but were not limited to, hypertensive chronic kidney disease stage 5 and acute kidney failure. The resident went to dialysis on Monday, Wednesday, and Friday. The Care Plan, dated 01/16/19, indicated "The resident needs dialysis...r/t renal failure." The interventions included, but were not limited to, "Check and change dressing daily at access site. Document...Monitor/document/report to MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report to MD PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock."		been placed on the TAR. If any abnormal are noted MD will be notified immediately and will be documented in resident chart. · DON or designee will monitor TAR 3 times a week for 1 month, and bi-monthly for six months. PRN monitoring will be on going. The audits will be reviewed monthly by the QAPI Committee. If a threshold of 100% is not met and action plan will be developed to ensure compliance. · Facility alleges to be in 100% compliance by July 14, 2019 · Please see Exhibit G	

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	The "Dialysis Communication Sheets" or clinical record lacked documentation of the site monitoring for a 24 hour period after the dialysis days. During an interview, on 6/4/19 at 1:38 p.m., the DON (Director of Nursing) indicated the nursing staff should monitor and document the bruit/thrill and shunt site post dialysis for 24 hours. She provided 5 of the Dialysis Communication Sheets for Resident 79, which were left blank of the residents names and assessments post dialysis between 3/1/19 and 6/9/19. Resident 48 had 16 Dialysis Communication Sheets, with only vitals listed and no assessments of the dialysis site. During an interview on 6/4/19 at 2:11 p.m., RN 3 indicated the resident's site and vitals should be monitored every 4 hours upon return from dialysis. "We don't do it often enough." On 06/03/19 at 10:15 a.m., the Administrator was unable to provide a copy of the dialysis contract for the dialysis residents. During an interview, on 06/03/19 at 10:15 a.m., the Administrator indicated he had been unable to locate a contract for dialysis. .He had spoken to the Dialysis Company Manager who told him they had one with the facility when it was owned by a different corporation, but neither of them had been able to locate the old contract and a new one would have to be made. During an interview, on 06/03/19 at 10:28 a.m., the Dialysis Company Manager indicated she was unable to locate a contract for dialysis with the facility. The facility had not provided the information needed for a new contract when the new corporation had taken over, and she was			

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	unable to locate the old contract. A new contract would have to be made. The "Hemodialysis, Care of Residents" policy dated April 2005, revised June 2008, provided on 06/03/19 at 11:36 a.m. by the DON included, but was not limited to, "... Post Hemodialysis/Ongoing Care... Upon return from dialysis, the nurse will check for thrill* and bruit* twice during the shift for which the resident returned. The nurse will assess the condition of the access site for bleeding, redness, tenderness or swelling. If any of these conditions are noted, contact physician and document findings..." 3.1-71(a)			
F 0812 SS=L Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

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	serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the meatloaf temperatures were obtained and meat was fully cooked prior to serving to residents for the afternoon meal. This deficient practice had the potential to effect 86 of 87 residents. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 05/29/19 at 11:55 a.m., when staff served undercooked (raw) meatloaf to residents for lunch. The Administrator and Director of Nursing, were notified of the Immediate Jeopardy on 5/29/19 at 3:44 p.m. The Immediate Jeopardy was removed on 05/31/19 at 2:20 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an observation, on 5/29/19 at 11:55 a.m., staff members served meatloaf to residents in the Hall 4 dining room. The meatloaf portions were red and pink in the center, several residents had already started to consume the meatloaf prior to staff noticing. During an interview, on 5/29/19 at 11:58 a.m., RN 3 indicated the meatloaf needed to be pulled, because it was raw in the center and the residents would need something else to eat for lunch. During an observation of the Hall 1, 2, 3 dining room on 5/29/19 at 12:00 p.m., CNA (Certified Nursing Aide) 4 was feeding meatloaf to Resident 19. The meatloaf was red throughout the center.	F 0812	· Eighty six of the eighty-seven residents were monitored for 3 days after meatloaf was served, no resident had any s/s of n/v, temp or adverse effect from eating any of the meatloaf. · The cook that had prepared that meal no longer works at New Albany Nursing and Rehab. · Thermometers immediately provided for dietary staff · Dietitian notified of state concerns. · Medical Director notified of event with new orders received to monitor all effected residents temp every shift times three days. Zofran 4 mg by mouth every eight hours as needed for any signs and symptoms of nausea or diarrhea. · All residents' responsible parties notified by staff. · Dietary cook educated on food prep, time and temp abuse, proper serving temp, and when to notify dietary manager or administrator of supplies needed. Cook is being re-trained by dietary manager · In-service is ongoing for all dietary staff on proper food temperatures and usage of thermometer. Recipes were checked to make sure proper temperature and time was listed. If thermometer is unavailable for any reason, dietary manager / administrator must be notified	06/06/2019

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	Upon interview, on 5/29/19 at 12:01 p.m., CNA 4 indicated the resident had consumed approximately 25% (percent) of the meatloaf. She had not noticed the meatloaf was red in the center during feeding, but upon interview could see that it was red. During an interview, on 5/29/19 at 12:02 p.m., Resident C indicated he had eaten about 25% of his meatloaf, but could not eat anymore because it was raw. This was the second piece he had ordered due to sending the first piece back for being undercooked. He did not want anything else to eat as his appetite was ruined. Upon interview, on 5/29/19 at 12:20 p.m., the Dietary Assistant indicated, " ... The kitchen told me when I got here about the meatloaf. It looks raw to me, she said it was the BBQ [barbeque] sauce but that isn't from the BBQ sauce, that's raw. This [the meatloaf] shouldn't have been served like that [raw/undercooked]." During an interview, on 5/29/19 at 12:30 p.m., Dietary Cook 6 indicated she had not checked the temperature of the meatloaf prior to serving. She did not have a thermometer available to take temperatures until after 11:00 a.m., when the food had already been served. She had not had a thermometer off and on because people kept stealing them. The Dietary Cook had seen the pink meat, but thought it was due to BBQ sauce being an ingredient in the meatloaf. On 5/29/19 at 1:02 p.m., the Dietary Assistant, was observed serving the last of the fish sticks to residents, who had their meatloaf removed during the lunch meal service.		immediately. No food leaving out from the kitchen until temperature is obtained and documented. · Also an ongoing in-service for all staff if they find the meat or any other food is not properly cooked, stop serving and immediately notify the dietary manager, assistant dietary manager, and don or administrator. Ongoing floor in-service is already completed. · Dietary Manager or her designee will monitor temp logs daily for six months and ongoing. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Please see Exhibit H	

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	On 5/29/19 at 1:03 p.m., Resident 70 came out to the hallway in his wheelchair and told the Dietary Assistant his fish sticks were cold inside. She offered him another plate, but he refused and indicated he was done. He stated, "The meatloaf was raw and the fish was cold, so I'm done." Upon interview, on 5/29/19 at 1:04 p.m., The Dietary Assistant indicated she had a lot to do and she did not have enough time to ensure the fish was heated through. Upon interview, on 5/29/19 at 1:12 p.m., the Dietary Assistant indicated all staff members were supposed to have a thermometer. She was aware the Dietary Manager had to bring a thermometer down because the Dietary Cook 6 had not had one. Food should always be checked for temperature prior to being served. During an interview on 5/29/19 at 1:14 p.m., Dietary Cook 7 indicated food temperatures should always be checked prior to serving. The review of the "Weekly Temperature Record" sheet on 5/29/19 at 2:10 p.m., indicated no temperatures had been obtained and documented for breakfast or lunch on 5/29/19 or 5/18/19. The "Food Temperatures on Service Line" Policy, dated 6/2018, provided on 5/30/19 at 10:30 a.m., by the Dietary Manager, included, but was not limited to, "Policy: Foods will be served at proper temperature to ensure food safety ... Record reading on 'Food Temperature Record' form at beginning of tray line and end of tray line. If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature. Take the temperature of each pan of product before serving			

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	..." The Immediate Jeopardy began on 05/29/19 was removed on 05/31/19 when the facility in-serviced dietary staff related to the food preparation time, safe food temperatures, serving temperatures, not to serve uncooked food, and in-serviced all staff when to notify the Dietary Manager or supervisor of food concerns. Thermometers were immediately provided for dietary staff, but the noncompliance remained at the lower scope and severity level of widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been in-serviced. 3.1-21(l)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement			

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	based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be 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.			

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	§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, record review, and interview, the facility failed to follow appropriate infection control guidelines related to perineal care for 2 of 2 residents observed for infection prevention. (Resident 71 and 69). Findings include: 1. During the observation of perineal care (washing of genitals and anal area), on 5/31/19 at 10:58 a.m., for Resident 71 with CNA (Certified Nurse Aide) 9 and CNA 8, the CNAs entered the resident's room and after performing handwashing and applying gloves. CNA 9 started the perineal care and the labia was cleaned with a soapy washcloth using 4 swipes of the same area of the cloth, she folded, then wiped the area with 8 swipes with the same area, folded, then 6 swipes with the same area of the cloth in a front to back motion. The washcloth was discarded. The labial area was dried with a washcloth without folding at each swipe. The resident was rolled onto her right side. CNA 8 obtained a soapy washcloth and the anal area was washed using 2 swipes with the same area of the washcloth, she folded, then 3 swipes with the same area of the cloth, folded, then 3 swipes with the same area of the wash cloth, in a front to back motion. A dry washcloth was obtained and using 2 swipes with the same area of the washcloth, folded, then 3 swipes with the same area of the cloth.	F 0880	· Resident 71 and 69 did not have any adverse effects or infections from peri care that was performed. · All C.N.A.s were in serviced on proper peri care of females, males, and residents with Foley catheter. A return demonstration completed by every C.N.A. and a skills checklist completed. · Yearly skills check offs will be completed going forward. · DON or her designee will audit peri care performed on 10 residents a week times 1 month, then 5 residents weekly for 1 month, then 3 residents weekly for 4 months. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility alleges compliance by 7/14/19 · Please see Exhibit I.	07/14/2019

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	During an interview, on 05/31/19 at 10:58 a.m., CNA 8 indicated during perineal care she would use a stack of clean washcloths with warm soapy water and one stack with just wet washcloths. The soiled linens were put into a bag. We clean from front to back. Using a washcloth to clean the front first, then the back. We fold to not use the same area of the washcloth twice." The Care Plan, dated 3/9/18, indicated "The resident has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to]Alzheimer's." Interventions included, "...TOILET USE... clean self, transfer onto toilet, transfer off toilet) and to use toilet. Frequent incontinence of B/B [bowel/bladder]. Require physical assist with incontinence care..." The Care Plan, dated 3/9/18, indicated "The resident has potential for urinary tract infection related to incontinence." The interventions included, but were not limited to, "...Clean peri-area from front to back.." 2. During an observation, on 6/4/19 at 11:28 a.m., of perineal care on Resident 69 with CNA 10 and CNA 11, the CNAs performed hand washing and applied gloves. CNA 10 obtained a soapy wash cloth and cleaned the creases to each side of the labia. She folded the washcloth and cleaned down the labial folds, then pulled back up, from back to front. The resident was rolled onto their right side. The resident was in the middle of a bowel movement and the soiled dressing and alginate calcium was removed. She swiped the stool from the anal area. She discarded the stool filled wash cloth into the trash bag. She obtained another washcloth and using 3 swipes with the same area of the cloth, swiped additional stool from the anal			

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	155616	A. BUILDING 00 B. WING	06/05/2019

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	area. She folded the wash cloth and swiped the remaining stool from the anus, across the wound. The Care Plan, dated 1/16/19, indicated "Resident is incontinent of Bowel and Bladder r/t [related to] dementia and unaware of toileting needs." The interventions included, but were not limited to, "...Encourage proper incontinence protection..." During an , on 6/5/19 at 8:26 a.m., the DON (Director of Nursing) indicated the CNAs should wash the resident from front to back and not use the same area of the wash cloth. The stool should be put into the toilet and not left on the wash cloth. The CNA should not drag the soiled wash cloth across the wound. The review, on 5/30/19 at 10:05 a.m., of the current Catheter Care, Urinary policy, included, but was not limited to, "...Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique. 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00295667. This visit resulted in an Immediate Jeopardy. Complaint number IN00295667- Substantiated.	R 0000	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. However to remain in compliance with all federal and state regulations the facility has taken and will take actions set	

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	Federal/State Deficiency related to the allegations is cited at F677. Survey dates: May 29, 30, and 31, June 3, 4, and 5, 2019. Facility number: 001145 Residential Census: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain. New Albany Nursing and Rehab respectfully request a paper compliance plan of correction.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	Based on record review and interview, the facility failed to maintain a minimum of one staff member on duty with current CPR and First Aid training for 24 hours a day. This deficient practice had the potential to affect 7 of 7 residents residing in the facility. Findings include: The review of the staff schedule for 05/31/19, 06/1/19, 06/2/19, 06/3/19, and 06/4/19 indicated, there was no staff member working at any time during the two twelve hours shifts that were CPR (Cardio Pulmonary Resuscitation) and First Aid certified. During an interview, on 06/5/19 at 1:35 p.m., with the DON (Director of Nursing), she indicated "I don't have CPR and First Aid cards for the employees. The company won't pay for the cards. Our employees can't afford to pay for them and they are expensive..." On 06/5/19 at 2:45 p.m., the DON indicated, "We don't have a policy for the CPR and First Aid. I didn't realize I had to have certifications for CPR and First Aid for the Assisted Living." During an interview, on 06/5/29 at 3:40 p.m., the Administrator indicated, they had not been able to find proof of First Aide or CPR certification for the staff.	R 0117	· Residents R1 through R9 were affected as staff first aid certifications had expired on 6/1/19. · All AL residents are potentially affected and First aid/CPR training will be provided by 6/29/19 for all staff that work in the Assisted living area. · The human resources manager was in-serviced on 06/24/2019 regarding the requirements for CPR training and record keeping. Human Resources will keep a binder with all employees' certifications, CPR, and any other licensure required. A copy of said binder will also be giving to the DON office. All nursing staff will be provided with CPR/First Aid training within 30 days. Binder will be audited on the first of each month by Human Resources for any certifications that are expiring. Don will be notified to schedule classes. DON or her designee will also monitor binder to verify that all certifications are current. · DON and Human Resources will monitor binders monthly for 6 months. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility alleges compliance by July 14, 2019 · Please see Exhibit B	07/14/2019

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R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.			
	Based on interview and record review, the facility failed to ensure residents' medications regimes were reviewed by a licensed pharmacist. This deficient practice effected 7 of 7 residents living in the Assisted Living Hall. (Residents 1, 2, 3, 4, 5, 8, and 9). Findings include: 1. The clinical record for Resident 1 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, anxiety, recurrent depressive disorders, chronic pain, and low back pain. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. The resident received antianxiety and antidepressant medications and antipsychotics were received routinely and as needed. 2. The clinical record for Resident 2 was reviewed	R 0298	· Pharmacy consultants were notified immediately of the affected residents in Assisted living that had not had a medication review. Pharmacy consultant was scheduled to come in immediately and conduct the review. · All AL resident medication reviews were audited for timeliness and the pharmacy consultant made reviews as needed. · The director of nursing was in-serviced on 06/21/2019 regarding timely pharmacist medication regimen reviews for AL residents. Pharmacy has been made aware that Assisted Living residents are not on our PCC program and are on paper and must come in building monthly to review their medications. A pharmacy review sheet has been	07/14/2019

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	on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, neuropathy, bronchitis, fatty liver, osteoarthritis, spine fracture, and dyslipidemia. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. 3. The clinical record for Resident 3 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, schizophrenia paranoid, tardive dyskinesia, anxiety, esophageal disorder, and insomnia. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. 4. The clinical record for Resident 4 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, delusional, and hypertension. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. 5. The clinical record for Resident 5 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, and thyroid disorder. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. The resident received antidepressants and opioids weekly. Antipsychotics were received routinely and as needed. 6. The clinical record for Resident 8 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, atherosclerosis, depression, hypertension, neuropathy, coronary		placed in each resident chart to show when each resident has been reviewed. Pharmacist will sign sheet when review is completed. Pharmacist will also send email notifications that this has been done and the review is available on their web portal for MD and DON. · Don or her designee will audit charts monthly for six months to check for compliance. The audits will be reviewed monthly by the QAPI committee. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. · Facility alleges compliance by July 14, 2019 · Please see Exhibit C	

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	artery disease, chronic pain, hardware of the thoracolumbar spine, osteomyelitis, anemia, acute renal failure, urinary obstruction, and chronic kidney disease stage 4. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. 7. The clinical record for Resident 9 was reviewed on 06/5/19 at 2:25 p.m. The resident's diagnoses included, but were not limited to, anemia, stroke, right sided weakness, and history of headaches. There was no documentation in the clinical record that indicated a licensed pharmacist had regularly reviewed the resident's medications since 1/11/19. During an interview, on 06/5/19 at 2:24 p.m., the DON (Director of Nursing) indicated the pharmacy contacted her and had not been doing the Assisted Living pharmacy reviews. They did not know the Assisted Living residents were not on the facility's computer system. The review, on 06/6/6/19 at 8:02 a.m., of the Medication Regimen Review Monthly Report, dated 5/21/18, included, but was not limited to, " ...The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimized adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator ...The facility assures that the consultant pharmacist has access to residents and the residents' medication records ..."			

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