STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 31, June 1, 2, 3, and 6, 2022. Facility number: 000081 Provider number: 1551162 AIM number: 100289570 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 1 Medicaid: 37 Other: 9 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 13, 2022.	F 0000	Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure incontinent products were stored in a manner to maintain a resident's dignity, for 1 of 2 residents reviewed for dignity (Resident 10). Findings include: During an observation on 5/31/22 at 2:09 p.m., Resident 10 was lying in bed, two bags of	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 10 incontinent products were relocated out of visible sight. **How other residents having the**	06/29/2022

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	incontinent products at the foot of the bed were visible from the hallway. During an observation on 6/1/22 at 10:41 a.m., a bag of incontinent products was at the foot of his bed and visible from the hallway. During an observation, on 6/2/22 at 9:22 a.m., a bag of incontinent products was at the foot of his bed and visible from the hallway. The resident's clinical record was reviewed on 6/1/22 at 8:59 a.m. Diagnoses included, but were not limited to, anxiety disorder and major depressive disorder. A 3/8/22 quarterly MDS (Minimum Data Set) assessment indicated he was cognitively intact. He required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. He had an indwelling urinary catheter and was always incontinent of bowel. A current care plan, dated 9/13/21, indicated he was incontinent of bowel movements due to no apparent awareness of being soiled. The interventions included, but was not limited to, assist with incontinent care as needed. During an interview, on 6/2/22 at 10:43 a.m., the resident did not know why the incontinent products were at the foot of bed. During an interview, on 6/6/22 at 9:29 a.m., LPN 7 indicated the incontinent products should not be stored at the foot of the bed. Review of a current facility policy, titled "Resident Rights," with a revised date of 11/16 and provided by the Nurse Consultant on 6/6/22 at 11:41 a.m.,		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who use incontinent products have the potential to be affected. Audit completed by IDT on 6/21/22 to identify residents who utilize incontinent supplies completed and ensure proper of incontinent supply storage. Daily room rounds to be completed by customer care companions to address any improperly stored incontinent supplies. In-service all staff by 6/29/22 per DNS/Designee on Resident Rights Policy, Storage of personal care items, specific to incontinent supplies. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Daily room rounds to be completed by customer care companions to address any improperly stored incontinent supplies. In-service all staff by 6/29/22 per DNS/Designee on Resident Rights Policy, Storage of personal care items, specific to incontinent supplies. IDT will complete room rounds daily during GEMBA to observe any incontinent supplies within	

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	indicated "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...." 3.1-3(a)		visible sight. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. CQI tool titled F550 will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent abuse by a resident (Resident 28) toward other residents for 2 of 4 residents reviewed for abuse (Resident 38 and Resident 36). Findings include: 1. On 6/1/22 at 2:12 p.m. Resident 38 sat in a facility chair in dining room with activities and eating snacks. On 6/2/22 at 9:24 a.m., she was walking to activities to the dining room from her room. On 6/2/22 at 1:01 p.m., she was ambulating to room. On 6/3/22 at 9:00 a.m. she sat on the sofa in the dining room.	F 0600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 38 and 36 were followed by MCSS for psychosocial distress with none noted and participating in activities per residents' baseline. Residents 38 and 36 have not been involved in no other incidents. Resident 28 currently out of facility at neuro psych for evaluation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents in this facility have the potential to be affected.	06/29/2022

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	On 6/6/22 at 9:22 a.m., she was in bed in her room. Resident 38's clinical record was reviewed on 6/1/22 at 2:01 p.m. Diagnoses included, but was not limited to, Alzheimer's disease, cognitive communication deficit, other recurrent depressive disorders and other specified anxiety disorders. An 4/6/22 annual MDS indicated she was severely cognitively impaired. She required limited assistance of one staff member for transfers, walking in her room and corridor, locomotion on and the off unit. She had a 5/12/22 revised behavioral symptoms care plan that indicated she had a history of being verbally aggressive with staff and wandered into others residents rooms. Interventions included, but were not limited to, keep resident separated from Resident 28 (4/5/22) and encourage and assist to utilize the cordless phone and a private area to utilize the cordless phone (4/6/22). A nurses note, dated 4/4/22 at 2:24 p.m., indicated she stood at the nurses station talking on the phone when Resident 28 came up to her and grabbed hold of her sweater sleeve and was shook it. The CNA and QMA intervened and separated the residents. Skin assessment done and no injuries were noted. 2. On 6/1/22 at 1:39 p.m. Resident 36 sat in a facility chair just outside the dining room, an activity aide asked if he would like to participate in an activity. On 6/2/22 at 8:45 a.m. he was working with therapy in the dining room.		All staff to be in serviced by DNS/ED/Designee by 6/29/22 on Abuse policy. All cottage staff to be in serviced by ED/MCSS by 6/29/22 on How to Respond to Behavioral Expressions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff to be in serviced by DNS/ED/Designee by 6/29/22 on Abuse policy. All cottage staff to be in serviced by ED/MCSS quarterly on How to Respond to Behavioral Expressions. MCSS to identify planed programing and activities for the day daily in Morning Meeting. Assign Rounding Manger to ensure activities are occurring as scheduled on 1st and 2nd shift, noting resident engagement. Activities are provided per resident preference, including individual activities. IDT to review any behaviors daily in clinical meeting to identify root cause to ensure interventions implemented to prevent recurrence. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	On 6/2/22 at 1:05 p.m. he was working with therapy in the dining room. On 6/3/22 at 8:56 a.m. he was ambulating independently in the hallway. On 6/6/22 at 9:21 a.m. he was working with therapy in the sun room. Resident 36's clinical record was reviewed on 6/1/22 at 1:35 p.m. Diagnoses included, but was not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere with behavioral disturbance and disorientation. An 4/12/22 admission MDS indicated he was severely cognitively impaired. He required limited assistance of one staff member for transfers. He required supervision to walk in his room and corridor and locomotion on and off the unit. He had a 5/5/22 revised communication care plan that indicated he was to be separated from Resident 28 and to redirect to a separate activities of choice. A nurse note dated 5/5/22 at 10:05 a.m. indicated he was seated at table in dining area of the secured unit. He reported to staff that Resident 28 made contact with his left ear. It was not witnessed by staff. Residents were immediately separated, assessment completed with no injuries. He was assisted to a different area of unit and began conversing with other resident with no signs or symptoms of psychosocial distress. 15 minute monitoring was initiated. Review of the investigation provided by the Administrator, on 6/2/22 at 2:25 p.m., indicated an		**assurance program will be put into place;and** The Executive Director and/or Designee will complete F600 QAPI tool weekly x4 weeks and monthly for 6 months then quarterly thereafter. If 100% compliance is not achieved an action plan will be implemented. The Administrator is responsible for the implementation and monitoring of this process. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	

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	interview with CNA dated 5/5/22, she heard Resident 38 call out "ouch" and reported Resident 28 made contact with his left ear. 3. On 6/1/22 at 8:35 a.m., Resident 28 was observed in the dining room at a table with a male resident sitting to his right and a female resident sat across from him. On 6/2/22 at 10:08 a.m., he sat at a table in the dining room eating breakfast. On 6/2/22 at 1:27 p.m., staff assisted him to his room from the table in the dining room. On 6/3/22 at 9:01 a.m., he sat in dining room eating breakfast. On 6/6/22 at 9:28 a.m., he was ambulating independently in hall with napkin in his left hand and mumbling to himself. Resident 28's clinical record was reviewed on 6/1/22 at 8:23 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, Alzheimer's disease, cognitive communication deficit, delusional disorders and mood disorder due to known physiological condition. His medications included, but were not limited to, thioridazine (antipsychotic) tablet 25 mg (milligram) twice daily. A quarterly, MDS (Minimum Data Set) dated 3/28/22, indicated he was severely cognitively impaired, He had delusions and hallucinations. He wandered daily. He required extensive assistance with two staff members for bed mobility. He required supervision with transfers, walking in his			

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	room and the corridor, locomotion on and off the unit. He used a wander/elopement alarm daily. He had a 5/26/22, revised behavioral symptoms care plan that indicated he had a diagnosis of dementia with behavioral disturbances as example by removing trim off of the walls, turning tables over, and hallucinations/delusions, hearing voices at times, and verbal and physical aggression towards staff etc. and he utilized an antipsychotic medication (5/26/22). Interventions included,1. Ensure resident sees and hears staff prior to approach and provide care so as not to startle. 2. Redirect to activity of interest, listening to music, sports, etc... 3. Validate residents feelings when appropriate. 4. Redirect resident to a safe, calming environment to complete activity of choice to deter overstimulation. 5. 15 minute safety checks or one on one staff supervision as needed. 6: Allow resident to throw his trash away, put his dirty dishes in proper spot so that they can be washed with staff assistance as resident accepts (2/18/22). 7. Resident to have two staff members present while completing all personal cares, assuring staff members safety as well as resident's (5/9/22). He had a 5/25/22, revised behavioral symptoms care plan that indicated he had a potential for contact with another resident due to diagnosis of unspecified dementia with behavioral disturbance. Interventions included 1. Offer him a snack and fluids upon arising and wandering throughout the secured unit (9/30/21). 2. He was to receive toileting assist when awake at night. 3. Increase supervision as appropriate (9/30/21). 4. Separate residents immediately and notify supervisor (9/30/21). 5. Offer an activity of his choice prior/during to shift change. Offer a cup of coffee and quiet area. He had labs and urinalysis to rule			

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out a current medical issue. Provide him with a busy box to carry around and collect items of his choice (4/6/22). 6. Keep resident separated from Resident 38 (4/5/22). 7. Keep him separated from [another resident name] (5/2/22). 8. Keep him separated from Resident 36 (5/5/22). 9. Offer an a.m. snack between breakfast and lunch meals. Offer and encourage resident to use bathroom prior too and following meals as resident accepted (5/6/22).

His nurses notes and IDT notes indicated, but was not limited to the following:

On 4/4/22 at 2:21 p.m., he was by the nurses station while Resident 38 was on the phone, he went up to Resident 38 and grabbed hold of her sweater sleeve. CNA and QMA intervened and separated the residents. No injuries were noted. He was given a snack and sat down at table in the dining room.

An IDT (Interdisplinary Team) note, dated 4/5/22 at 10:28 a.m., indicated he stood at the nurses station while Resident 38 used the phone and he grabbed hold of her arm. They were immediately separated and a head to toe assessment was completed and they were offered a separate activity of their choice. The root cause of his behavior was psychosocial factors, he was completing an activity as he only participated in activities of his choice, he was attempting to collect items for his personal collections in which he enjoys and attempted to get the phone from Resident 38 for his personal collection of items. The preventative intervention related to the root cause was he was to be offered a activity of his choice prior/during to shift change and to be offered a cup of coffee and quiet area. He was to have labs and urinalysis to rule out a current

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medical issue and provide him with busy box for him to carry around and collect items of his choice.

On 4/5/22 at 2:47 p.m., the psychiatric nurse practitioner evaluated Resident 28 due to the resident to resident event. She awaited lab results and discontinued the 15 minute checks.

On 5/5/22 at 10:05 a.m., Resident 28 was ambulating in the unit, Resident 38 reported that Resident 28 made contact with his ear. They were immediately separated. The contact was not witnessed by staff. Assessment of resident revealed no injury. Resident 28 was assisted with toileting then seated at table with snack. 15 minute monitoring was initiated.

An IDT note, dated 5/6/22 at 1:02 p.m., indicated Resident 28 was in the unit dining room. Resident 38 stated that Resident 28 made contact with his left ear. Immediate interventions were that they were separated, assessments were completed by the nurse, Resident 28 was toileted, coffee and snack was provided. The potential root cause was Resident 28 needed to use the bathroom, prior to him eating breakfast, he rested in bed and denied the use of the bathroom. He was toileted and offered a snack and was calm. The preventative intervention was to offer and encourage activity of choice separate from Resident 38. Offer an a.m. snack between breakfast and lunch meals. Offer and encourage him to use bathroom prior to and following meals as he accepted.

On 5/6/22 at 3:02 p.m., staff were in the shower room providing care to Resident 28, upon staff attempting to pull up pants, he punched staff in nose. Another staff member attempted to pull up his pants when he attempted to swing. They were

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able to pull up his pants and provided space to him, he was offered coffee and accepted. One on one observation was initiated

On 5/6/22 at 3:22 p.m., a referral was made to a psychiatric hospital and awaited a call back with acceptance.

On 5/6/22 at 5:34 p.m., he continued on one on one staff supervision. He was accepted to the psychiatric hospital, however, they did not have any available beds. He would remain one on one throughout weekend.

An IDT note, dated 5/9/22 at 1:31 p.m., indicated Resident 28 was physically aggressive with staff when completing cares. Immediately ceased interaction from staff member that was hit in the nose, other staff member finished care. The nurse completed a head to toe assessment of resident, placed on one on one staff supervision, snack and fluids offered and accepted, and a referral was made to inpatient psychiatric hospital. The potential root cause was his cognitive level. Two CNAs were completing care task when he hit one of the CNAs as the other CNA was helping resident pull his pants up and hit the CNA in nose, making her nose bleed with an abrasion to the bridge of her nose. He was startled while cares were being completed as he seen one aide walk away and did not see the other aide, he was given simple instruction and he accepted, when task was being complete he reacted and hit the CNA in nose. The preventative intervention was he was to have two staff members present while completing all personal cares, assuring staff members safety as well as his. A referral was made for an inpatient psychiatric stay. He would have one on one staff supervision until he was accepted to inpatient psychiatric stay.

On 5/9/22 at 5:45 p.m. he was discharged to psychiatric hospital.

On 5/25/22 at 12:40 p.m., he returned from the psychiatric hospital.

During an interview with the MCSS (Memory Care Social Service), on 6/2/22 at 2:14 p.m., she indicated Resident 28 had a physical decline and was not dressing or toileting himself anymore. he was in Vietnam and hallucination were more vivid. He was on a new medication and had not noticed him having those hallucinations as before. He was pleasant with assistance now. He was having normal conversations with peers now and not about war. He would go up to residents to get their attention, not sure if that's what he is doing with Resident 38. He lived in a war. He had been sweet since he came back. The incident with the staff member, they were done with his care and he punched the staff member and broke her nose.

During an interview with LPN 33, on 6/3/22 at 9:13 a.m., he indicated he had been more peaceful since he has been back for the psychiatric hospital stay. He was difficult and resisting care. They would reapproach and let him calm down. If you get him coffee and snacks it preoccupied him. He occasionally ambulated by himself, he was incontinent of bowel and bladder. They try to have him go to the bathroom every hour or two, cognitively he did not understand when the staff cued him.

During an interview with CNA 37, on 6/3/22 at 2:08 p.m., she indicated her and another CNA assisted him with his shower and he was fine. The other CNA walked away but was still in the same room. She was standing on his left side and was pulling

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	up his pants and he came around with his right hand and hit her in the nose and broke it. The staff had been telling the nurses that he was becoming more combative with care. He was not normally aggressive towards residents, it was mostly during cares. During an interview with Activity Assistant 39, on 6/6/22 at 9:34 a.m., she indicated the resident was in Vietnam, if you come at him a certain way he would freak out. Sometimes he had his moments being aggressive he wound pound on table, pick up chairs and push them. She had never seen him be aggressive to other residents. When he was like that she tried not to get too close to him. She would talk to him, do one on ones with him, play ball, offer him a snack and coffee. A current policy, titled "Abuse Prohibition, Reporting, and Investigation," provided in the survey binder, by the Administrator, at entrance to the facility on 5/31/22, indicated the following: "...Policy: It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse...This includes but is not limited to...physical abuse. American Senior Communities will not permit residents to be subjected to abuse by anyone, including...other residents...." 3.1-27(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-			

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	§483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.			
	Based on observation, interview, and record review, the facility failed to ensure a referral appointment to a retinal specialist was scheduled for 1 of 1 residents reviewed for vision services (Resident 40). Findings include: During an interview, on 5/31/22 at 1:16 p.m., Resident 40 indicated he had seen the eye doctor in the facility a few months prior and was supposed to be referred to a retinal specialist, but he had not yet been seen by one. He liked to read, but the low vision in his left eye prevented him from doing so. Resident 40's clinical record was reviewed on 5/31/22 at 2:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease, and transient ischemic attack and cerebral infarction without residual deficits. A 3/4/22, quarterly, Minimum Data Set assessment indicated he was cognitively intact. Review of a 3/24/22 optometry note indicated he had a complaint of blurred vision for two months. He was diagnosed with a retinal detachment of the left eye and mild cataract of both eyes. An ophthalmology consult was ordered and he was to see a retinal specialist.	F 0685	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 40 has been seen by the retinal specialist. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Any residents receiving ancillary services in the facility have the potential to be affected. Social Services to audit any resident that receive services from Health Drive in the last 3 months to ensure that no referral appointments have been omitted by 6/24/22. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Medical Records In-serviced by ED/Designee by 6/29/22 on reviewing Health Drive notes and identifying any ordered	06/29/2022

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	A 3/25/22 Event note indicated an ophthalmology consult had been ordered with a retinal specialist for retinal detachment. The event note was closed without an appointment being documented. A 3/25/22 progress note indicated he was to be seen by an ophthalmologist and received a new order for ophthalmology consult and retinal specialist for retinal detachment. The resident and his family were made aware. Review of a 5/24/22 activity assessment indicated he enjoyed doing activities of own choice such as watching outdoors shows and news channels. He enjoyed doing word puzzles and playing cards. During an interview, on 6/3/22 at 9:20 a.m., LPN 71 indicated the nursing department scheduled appointments for the residents. A calendar was kept at the desk and the appointments were also entered in the clinical record as an order, so the system would alert staff of the appointment. During an interview, on 6/3/22 at 11:08 a.m., the DON indicated the referral appointment had not been made until the morning of 6/3/22. The resident was scheduled to see the ophthalmologist on June 14, 2022. 3.1-39(a)		appointments needing scheduled. Medical Records to review Health Drive documentation daily in clinical meeting with IDT present. IDT will review appointments daily to ensure appointment has been scheduled and placed on EMAR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. CQI tool titled F685 to maintain vision and hearing will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility**	

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			will need to submit an amended plan of correction with the updated plan of correction date. **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and	F 0761	It is the intent of this provider that	06/29/2022

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	interview, the facility failed to ensure syringes and medicated ointments were securely stored for 1 of 1 random observations (3rd floor treatment cart). Findings include: During a random observation, on 6/2/22 at 10:36 a.m., the treatment cart on the 3rd floor was unlocked and unattended. A review of the contents of the treatment cart, on 6/2/22 at 10:38 a.m. accompanied by the DON, indicated the cart contained, but was not limited to the following, tuberculin syringes, bacitracin ointment, antifungal creams, and Santyl ointment. Review of a current facility policy, titled "Medication Pass Procedure," with a revised date of 12/2016 and provided by the Nurse Consultant on 6/6/21 at 11:41 a.m., indicated "...26. Med room and med/tx carts locked when unattended...." 3.1-25(m)		drugs and biologicals used in this facility are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. It is the intent of this provider that drugs and biologicals used in this facility are stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident affected by the deficient practice. Treatment/medication cart remains locked when unattended. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who reside on the 3rd floor had the potential to be affected by the deficient practice. An in-service for all nursing staff will be conducted on or before 6/29/22. This in-service will review facility policy and procedures for medication storage, treatment storage by DNS/designee. **What measures will be put into**	

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			place and what systemic changes will be made to ensure that the deficient practice does not recur; An in-service for all nursing staff will be conducted on or before 6/29/22. This in-service will review facility policy and procedures for medication storage, treatment storage by DNS/designee. Assigned designee will complete rounds daily to ensure all medication and treatment carts are locked and secured. (Rounding tool sheet will be completed daily) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. CQI tool titled F761 will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency**	

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			will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	
F 0812 SS=D 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.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure staff were knowledgeable on how to test the temperature and sanitizer of the dishwasher during a follow up visit to the kitchen. Findings include: During a follow up visit to the kitchen on 6/2/22 at 10:36 a.m., Culinary Aide 31 indicated the dishwasher was a high temperature washer, she was unable to determine how to test the water temperature or how to test the sanitizer. The Dietary Manager stepped in and indicated to Culinary Aide 31 where and how to read the dishwasher thermometer and the temperature and the temperature should be between 120 and 140 degrees and ran the dishwasher through a cycle. Culinary Aide 31 indicated the temperature read 58. The Dietary Manager indicated the thermometer read 130 and she needed to look under the lip of the thermometer to read it. The Dietary Manager ran the dishwasher through a cycle and tested with the sanitizer strip, she saturated the test strip in the water overflow of the dish machine and a stripe appeared between the saturated portion of the test strip and the dry portion of the test strip, the part of the test strip that was dipped into the overflow of the dishwasher did not change colors. She tried it again and the saturated part of the strip read between 25 ppm (parts per million) and 50 ppm and should read between 50 and 100 ppms. The Dietary Manager indicated Culinary Aide 31 had worked at the facility for a couple months. Culinary Aide 31 indicated she just was testing and reading the thermometer wrong, she had been	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ECOLAB completed a visit immediately to ensure it was running properly. An in-service with all Dietary staff will be completed on or before 6/29/22 regarding the test of the temperature and sanitizer of dishwasher. An in-service with all Dietary staff will be completed on or before 6/29/22 regarding temperatures are accurate and recorded in log book. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. An in-service with all Dietary staff will be completed on or before 6/29/22 regarding the sanitizer solution strength, and temperature of dishwasher by Executive Director/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	06/29/2022

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	trained on it when she started at the facility. The low temp dishwasher temperature/sanitizer log indicated lunch and supper for June 1, 2022 was not completed and breakfast was completed on June 1 and 2, 2022 by Culinary Aide 31. On 6/2/22 at 2:10 p.m. the Administrator indicated the dishwasher servicing company had came into the facility and serviced the dishwasher. Review of a copy of the test strip container instructions, provided by the Administrator on 6/2/22 at 3:08 p.m., it indicated the following: "Dip and Remove quickly. Blot immediately with paper towel. Compare to Color Chart at Once." During an interview with the Dietary Manager, on 6/2/22 at 3:55 p.m., she indicated the dishwasher service company had found that the tubing in the middle tube turner was worn and was not turning and Culinary Aide 31 had tested the dishwasher this morning. Review of the service report, provided by the Administrator, on 6/3/22 at 8:10 a.m., indicated the drain solenoid was not working properly and was replaced and the squeeze tubes were worn and were replaced. A current facility policy titled, "Recording Dish Machine Temperature/Sanitizer," provided by the Administrator, on 6/2/22 at 2:25 p.m., indicated the following: "...4. The Dietary Services Manger will spot check these logs to assure the temperatures/sanitizer concentrations are appropriate, and staff are monitoring dish machine temperatures...." 3.1-21(i)(2)		**practice does not recur;** An in-service with all Dietary staff will be completed on or before 6/29/22 regarding the sanitizer solution strength, and temperature of dishwasher by Executive Director/designee. The Dietary Manager will be in-serviced by the facility's Registered Dietician regarding sanitizer solution strength, and temperature of dishwasher on or before 6/29/22. The Dietary Manager will be in-service by the facility's Registered Dietician Dietary staff on or before 6/29/22 regarding temperatures are accurate and recorded in log book. The Dietary Manager/Designee will complete daily rounds of the kitchen to ensure proper sanitizer strengths and temperatures are occurring. The Dietary Manager/Designee will complete daily audits of Log books to ensure temperatures are recorded accurately and daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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			CQI tool titled F812 will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper compliance review for the GJRK11 survey.	
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.			

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	§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 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			

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	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 control practices and mask use were maintained according to professional standards during medication administration and random observations of mask use (Third Floor Nursing Unit). Findings include: 1. During a medication administration observation, on 6/2/22 at 8:20 a.m. with LPN 73, the following was observed: LPN 73 donned gloves, prepped an insulin pen for Resident 16 and indicated she would need to obtain another pen in order to administer the correct dosage. She did not perform hand	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** LPN 73 and LPN 14 was immediately educated regarding proper hand hygiene with insulin administration and proper placement of mask. Resident 16 had no negative outcome from event. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	06/29/2022

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	hygiene. She administered the injection to the resident, returned to the medication cart, disposed of the needle, and doffed her gloves. She did not perform hand hygiene. She placed the used insulin pen onto the top of the cart and reviewed the orders in the computer. She then went to the medication room, entered the room, and then exited the room with an insulin pen. She returned to the cart, opened it, obtained an alcohol swab and needle, donned gloves, and prepped the new insulin pen. She did not perform hand hygiene prior to donning the gloves or prepping the insulin pen. She administered the remainder of the dosage to the resident, doffed her gloves, and then performed hand hygiene. During the medication administration observation, an insulin pen was observed in the top drawer of the cart, on top of a large pile of loose lancets. LPN 73 indicated it was an empty insulin pen for Resident 34 and she had placed the discarded pen in the top drawer to remind her to pull another insulin pen for the resident. She indicated she should have completed hand hygiene during the medication administration. During an interview, on 6/6/22 at 10:46 a.m., the Infection Preventionist indicated hand hygiene should be completed before prepping insulin and after administering it. 2. During a medication administration observation, on 6/2/22 at 8:43 a.m., LPN 14 was preparing to administer insulin to a resident, her face mask was below her nose. She entered the resident's room and administered the insulin, her face mask remained below her nose. She returned to the cart to prepare that resident's other insulin dose. On 6/2/22 at 9:03 a.m., she had administered the second dose of insulin, her face mask had remained below her nose.		All residents have the potential to be affected by this deficient practice. An in-service with all Nurses will be completed on or before 6/29/22 regarding insulin administration by DNS/designee. An all-staff In-service will be completed on or before 6/29/22 per DNS/Designee regarding PPE and proper mask placement with demonstration. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** An in-service with all Nurses will be completed on or before 6/29/22 regarding insulin administration by DNS/designee. An all-staff In-service will be completed on or before 6/29/22 per DNS/Designee regarding PPE and proper mask placement with demonstration. Insulin skills validation will be completed with all licensed Nurse by ADNS/Designee by 6/29/22. DNS/Designee will complete daily observations of insulin administration to ensure hand hygiene and proper disposal of insulin pen is being performed as indicated. Nursing IDT team to complete daily observations for proper PPE/Mask placement/hand hygiene/insulin administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	06/06/2022

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	During an interview on 6/6/22 at 10:46 a.m., the Infection Prevention Nurse indicated the face mask should be worn above the nose and below the lower lip. Review of a current facility policy, titled "Insulin Pen Administration," dated 10/2019 and provided by the Nurse Consultant on 6/6/22 at 11:41 a.m., indicated the following: "...3. Gather needed supplies. 4. Perform hand hygiene...21. Removed gloves and perform hand hygiene...." Review of a current facility policy, titled "Infection Prevention and Control Program," with a revised date of 3/2022 and provided upon entrance, indicated "POLICY: The facility shall establish and maintain infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections...." 3.1-18(l)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and** Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. CQI tool titled F880 will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. If Threshold of 90% is not met an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **6/29/22** Autumn Ridge Rehabilitation Centre is requesting paper	

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			compliance review for the GJRK11 survey.	