STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 5, 6, 7, 8, and 9, 2024 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 5 Medicaid: 105 Other: 18 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/12/24.	F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 8/30/24.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the			

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

Nathan Wolf | Executive Director | 08/26/2024

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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	facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and interview, the facility failed to provide privacy related to a shared bathroom for 1 of 1 resident reviewed for privacy. (Resident 57) Finding includes: During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she felt she lacked privacy in the bathroom because she had to share the bathroom with the two men residing in the room next door. She no longer utilized the toilet due to her continence status, but felt she should be able to go in the bathroom to wash her hands or face	F 0583	It is the practice of this facility to ensure residents receive privacy and confidentiality in accordance with professional standards, comprehensive plan of care, and residents' preferences. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident # 57 was offered room change, which she refused. **How other residents having the potential to be affected by the**	08/30/2024

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	without a man opening the door or worrying a man could be coming in the bathroom while she was in there. On 8/6/24 at 9:44 a.m., Resident 57's bathroom was observed. The shared bathroom was located in between her room (Room 231) and the room next door (Room 229). There were doors on each side of the bathroom leading to the resident rooms. There were 2 male residents currently residing in Room 229. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing indicated the resident had never voiced any concerns regarding privacy in the bathroom. The resident did not use the toilet, but the bathroom was shared with the room next door where two men currently resided. The resident was currently out at dialysis, but she would follow up with her when she returned. 3.1-3(p)(1)		**same deficient practice will be identified and what corrective action(s) will be taken:** Resident #57 is the only female resident in facility residing next to males in adjoining room. No other residents have the potential to be affected by this same alleged deficient practice. ED/Designee will complete facility audit to ensure resident preferences regarding room placement are met by 8/30/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ED/designee will audit resident preferences regarding room placement weekly for 4 weeks, monthly for 6 months, and quarterly for 2 quarters. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Dignity and Privacy" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be	

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			developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	
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 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	F 0657	It is the intent of this provider to	08/30/2024

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	interview, the facility failed to ensure care plans were reviewed and revised to include changes related to resident infections and dialysis access points for 2 of 29 resident care plans reviewed. (Residents 69 and 57) Findings include: 1. On 8/6/24 at 9:17 a.m., Resident 69 was observed in his room. The resident indicated he had a surgical wound to the top of his right foot. He had been under precautions at one time for having an infection. He no longer had the infection and was not on precautions any longer. There were no signs posted for any TBP (Transmission Based Precautions) or any PPE (Personal Protective Equipment) bins located inside or outside of the room. Record review for Resident 69 was completed on 8/9/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus and a history of MRSA (Methicillin-resistant Staphylococcus aureus - bacterial infection). The Significant Change Minimum Data Set (MDS) assessment, dated 7/5/24, indicated the resident was cognitively intact. The resident had a surgical wound and was not taking an antibiotic. A Care Plan, dated 4/29/24 and revised 6/29/24, indicated the resident had a need for Contact Isolation related to active infectious disease MRSA. Interventions included, but were not limited to, educate visitors on necessary precautions needed for the specific type of infection and to have adequate PPE available for staff and visitors.		develop comprehensive person-centered care plans for each resident, consistent with resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #69 had been under precautions for a previous surgical wound infection to his right foot. He no longer has an infection and is no longer under transmission based precautions. The care plan indicated he was in contact precautions. The Infection care plan was updated immediately to remove contact precautions from the care plan for resident #69. Resident #57 had her dialysis care plan updated to accurately reflect her access site. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All other residents have the potential to be affected by this finding. An audit will be completed	

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	A Physician's Order, dated 3/1/24 and discontinued 6/6/24, indicated the resident was on isolation due to having an active infection related to MRSA in the right foot. During an interview on 8/9/24 at 10:48 a.m., the Wound Nurse indicated the resident did not currently have MRSA and did not require contact precautions. The care plan should have been updated to include a history of MRSA. 2. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact and received hemodialysis. A care plan, updated 7/17/24, indicated the resident received hemodialysis and had a right chest permacath (dialysis catheter) for dialysis access. During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she went to dialysis on Mondays, Wednesdays and Fridays. She had a right upper arm graft for her current dialysis access. She also had an old right arm fistula, but it was not working any longer. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing (DON) indicated she had called the dialysis center to confirm, and the resident had a right upper arm graft dialysis access site. They would update the care plan. 3.1-35(b)(1)		of all Infection and dialysis care plans by the IDT team on or before 8/30/24 to ensure accuracy of residents in transmission based precautions. Infection preventionist and MDS were in-serviced by the DNS/Designee and reviewed the facility policy related to the creation of comprehensive care plans and updating them with changes. **Measures put in place to ensure the deficient practice does not recur:** IDT will review Infection and dialysis care plans daily during clinical meeting to ensure comprehensive care plans have been developed and updated as indicated. DNS/Designee will review physician orders daily for transmission based precautions and care plan will be updated an necessary. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible	

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			for completing the QAPI Audit tool "Comprehensive Care Plan" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Date of completion: 8/30/24	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure a resident with edema was monitored or treated for 1 of 1 resident reviewed for edema (Resident 18), medications were given as scheduled and accuchecks were documented for 2 of 5 residents reviewed for unnecessary medications. (Residents 91 and 120) Findings include: 1. On 8/6/24 at 1:41 p.m., Resident 18 was observed seated in her room in a wheelchair. Her legs were elevated with the footrests and she indicated they were swollen.	F 0684	It is the practice of this facility to ensure comprehensive assessments are completed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 18 had edema observed	08/30/2024

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	On 8/7/24 at 1:19 p.m. the resident was seated in her room in a wheelchair, her call light was on. She indicated she wanted someone to put the footrests on her wheelchair so she could elevate her legs because they were swollen. On 8/9/24 at 1:12 p.m., the resident was seated in her room in a wheelchair. She indicated her legs had been swollen for about a month and she had told the nurses about it, but did not know what they were doing about it. The resident's record was reviewed on 8/7/24 at 2:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, heart disease and chronic obstructive pulmonary disease. The Significant Change Minimum Data Set (MDS) assessment, dated 6/13/24, indicated the resident was cognitively intact and required substantial assistance for bed mobility and transfers. The Weekly Skin and Vitals Assessments, dated 7/26/24, 8/2/24 and 8/9/24, indicated there was no edema. The Daily Shift Report, dated 8/4/24, indicated the resident had bilateral lower extremity edema. There was no documentation in the resident's progress notes or documentation the physician had been notified of the edema. During an interview on 8/9/24 at 1:14 p.m., LPN 1 indicated he had completed the Weekly Skin and Vitals Assessment that day. He asked the East Unit Manager if she knew anything about the resident having edema. The East Unit Manager indicated yes and the Nurse Practitioner (NP) was aware of it. The East Unit Manager indicated there was no documentation because it was a telehealth		to her lower extremities with no documentation that the physician had been notified. NP was immediately notified and confirmed assessment of edema. Care plan was updated. New medications were prescribed. Resident 91 has a physicians order for hydrocodone-acetaminophen. Resident is receiving medication as prescribed at a time convenient for the resident Resident 120 has a physicians order for daily blood sugar checks and Lantus. Resident is receiving the blood sugar checks as ordered All nurses educated on running EMAR compliance report to ensure all administrations have been documented. **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. DNS/Designee will conduct an audit of all residents to ensure that assessments are being completed and change of conditions monitored per policy by 8/30/24. DNS/Designee will complete an EMAR audit of all residents to ensure accuchecks, insulin and pain medication are	

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	visit and not in the electronic record. During an interview on 8/9/24 at 1:30 p.m., the Director of Nursing (DON) indicated the NP thought the edema may be related to recent intravenous fluids given. A Care Plan, dated 4/9/24, indicated adequate tissue perfusion would be maintained as evidence by blood pressure within normal limits, no change in mental status, no complaints of dizziness and no edema. Interventions included, but were not limited to, elevate lower extremities, observe and document pallor, dizziness, variations in blood pressure, edema and notify MD. 2. Resident 91's record was reviewed on 8/7/24 at 9:08 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, chronic pain and anxiety. The Quarterly MDS assessment, dated 7/10/24, indicated the resident had significant cognitive impairment and received anti-anxiety medications and opioids. A Physician's Order, dated 8/16/23, indicated to give hydrocodone-acetaminophen (opioid pain medication) 10 milligrams (mgs)/325 mgs every 6 hours for chronic pain. The July and August 2024 Medication Administration Records indicated the medication was not signed out as given or refused on the following dates and times: 7/5/24 2:00 a.m. 7/13/24 2:00 a.m. 7/16/24 2:00 a.m. 7/17/24 2:00 a.m. 7/18/24 8:00 p.m. 7/27/24 2:00 a.m.		being administered per physician orders by 8/30/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS or Designee will in-service all nursing staff regarding the assessment of change of condition, documentation, and monitoring by 8/30/24. DNS or Designee will in-service all nursing staff regarding documentation of medication administration, insulin administration and accuchecks by 8/30/24. DNS/Designee will review the EMAR compliance daily to ensure residents are receiving medications as prescribed. **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 by what date the systemic changes for each deficiency will be completed;** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool	

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	7/29/24 2:00 a.m. 8/5/24 2:00 a.m. During an interview on 8/8/24 at 3:05 p.m., LPN 1 indicated if a medication was not given or was refused, it should be documented. The resident did not normally refuse medications. During an interview on 8/8/24 at 3:18 p.m., the DON indicated the missing doses were likely because the resident was sleeping at 2:00 a.m., and the schedule should be revisited. The current policy, "General Dose Preparation and Medication Administration", indicated, "...6. After medication administration,...Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms...."3. Resident 120's record was reviewed on 8/7/24 at 8:32 a.m. Diagnoses included, but were not limited to type 2 diabetes mellitus, dementia, and Parkinson's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 5/22/24, indicated the resident was severely cognitively impaired for daily decision making. She received insulin injections. A Care Plan, dated 3/2/24, indicated the resident was at risk for adverse effects related to the use of glucose lowering medications and/or the diagnoses of diabetes mellitus. Interventions included, but were not limited to, monitor blood sugars as ordered, administer medications as ordered, and provide diet as ordered. The July 2024 Physician's Order Summary		"EMAR Compliance" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for two quarters. The ED/designee will be responsible for completing the QAPI Audit tool "Change of Condition" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for two quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	

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	indicated a daily blood sugar check at 6:00 a.m. and Lantus Solostar U-100 (a diabetic medication) insulin pen 100 unit/milliliter 10 units subcutaneous at bedtime. The July 2024 Medication Administration Record (MAR) indicated the blood sugar check at 6:00 a.m. was blank on 7/7, 7/19, 7/22, 7/27, and 7/30/24. The Lantus Solostar medication was blank at 9:00 p.m. on 7/25/24. During an interview on 8/8/24 at 4:13 p.m., the Director of Nursing indicated the nurse who was working those days had not documented on the MAR, however the blood sugar checks and Lantus medication were administered. She was unable to provide any further documentation. 3.1-37(a)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to care for a PICC (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) line in accordance with professional standards of practice, related to flushing the PICC line for 1 of 5 residents observed during medication pass. (Resident 3) Finding includes:	F 0694	It is the practice of this facility to ensure that resident IV access sites are maintained consistent with professional standards of practice and in accordance with physician orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	08/30/2024

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	During medication pass, the Infection Preventionist (IP) was observed preparing an intravenous medication for Resident 3 on 8/8/24 at 2:13 p.m. The IP prepared meropenem (an antibiotic) reconstituted solution 1 gram per 100 cc of normal saline. She washed her hands and donned clean gloves. She bent the connection between the 100 cc normal saline bag and the vial of meropenem, squeezed the normal saline into the vial, and then shook the vial to dissolve the meropenem powder medication. She held the vial above the bag and squeezed air from the bag into the vial to force the liquid back into the bag. She spiked the normal saline bag with new tubing and primed the tubing. She connected the tubing thru the pump and set it to run at 100 cc's per hour. She reached into her scrub top pocket with her gloved hands, pulled out an alcohol swab, opened the package, cleaned off the PICC connection port, and then attached a 10 cc normal saline syringe. She injected 6 cc's of normal saline thru the PICC line, unattached the normal saline syringe, reached into her pocket with the same gloved hands, and pulled out a new alcohol swab. She opened the alcohol swab, cleaned the PICC connection port, and attached the primed tubing. She then started the medication pump and the infusion of meropenem began. Resident 3's record was reviewed on 8/8/24 at 2:30 p.m. The August 2024 Physician Order Summary indicated a normal saline 10 cc syringe injection, flush PICC line before and after antibiotic administration to maintain patency every 8 hours. During an interview on 8/8/24 at 2:33 p.m., the IP indicated she should have flushed with a total of 10 cc of normal saline prior to administering the		Resident 3's PICC line was flushed with 10ml normal saline on 8/8/24. **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 finding. An audit for all residents with IV access will be completed by 8/30/24 to ensure that orders are in place for flushing IV catheters. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service Nursing department on resident PICC line management on or before 8/30/24. DNS/Designee will round each day to observe PICC lines and ensure PICC lines are flushed per protocol. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Parenteral Therapy" weekly for 4	

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	155166	A. BUILDING 00 B. WING	08/09/2024

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	antibiotics thru the PICC line. A facility policy, titled "Vascular Access Device Flush Ordered," received as current, indicated, "...Peripherally Inserted Central Catheter (PICC) valved catheters, flush with normal saline-10 ml before and after IV medication administration..." 3.1-47(a)(2)		weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	
F 0695 SS=D 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 a resident received the necessary care and treatment related to incorrect oxygen flow rate and a humidity bottle not changed for 1 of 4 residents reviewed for respiratory care. (Resident 70) Finding includes: On 8/5/24 at 1:29 p.m., Resident 70 was observed in a wheelchair. He had a nasal cannula in place and attached to a portable oxygen tank on the back of the wheelchair. The flow rate was set at 4 liters per minute (lpm). On 8/6/24 at 9:08 a.m., the resident was observed	F 0695	It is the practice of this facility to ensure residents receive respiratory care in accordance with professional standards, comprehensive plan of care, and residents' preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 8/5/24, Resident 70 received new humidification bottle and had flow rate adjusted to 2 liters as ordered per physician.	08/30/2024

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	lying in bed with a nasal cannula in place attached to the portable oxygen tank. The tank was set to a flow rate of 4 lpm. The oxygen concentrator was also on and set at 4 lpm. The water bottle on the concentrator was dated 7/29/24. The resident's record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set assessment, dated 7/31/24, indicated the resident had moderate cognitive impairment and required substantial/maximum assistance for bed mobility and transfers. A Physician's Order, dated 2/27/24, indicated the resident was to be on oxygen at 2 lpm continuously. A Physician's Order, dated 7/18/23, indicated the oxygen tubing and water bottle was to be changed weekly on Sunday. The August 2024 Medication Administration Record indicated the water bottle had been changed on 8/4/24. During an observation and interview on 8/6/24 at 9:15 a.m., the Cottage Unit Manager observed the oxygen and indicated it was set at 4 lpm and the water bottle was dated 7/29/24. 3.1-47(a)(6)		. **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 receiving oxygen therapy have the potential to be affected by this same alleged deficient practice. A facility audit will be completed by DNS/designee on or before 8/30/24 for all residents that require oxygen. All residents identified in this audit will be reviewed for proper flow rates and that all humidification bottles are dated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses and respiratory therapy on physician orders related to oxygen water bottles and following physician orders pertaining to oxygen flow rates on or before 8/30/24. DNS/designee will conduct rounds to ensure oxygen flow rate is per physician order and to ensure humidification bottles are changed per MD order. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Oxygen Therapy" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	
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 observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis, related to not monitoring the dialysis access site, for 1 of 1 resident reviewed for dialysis. (Resident 57)	F 0698	It is the practice of the facility to ensure residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person centered care plan, and the residents goals and	08/30/2024

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	Finding includes: During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she went to dialysis on Mondays, Wednesdays and Fridays. She had a right upper arm graft for her current dialysis access. She also had an old right arm fistula, but it was not working any longer. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact and received hemodialysis. A care plan, updated 7/17/24, indicated the resident received hemodialysis. Interventions included, "...assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth, bruit/thrill. Document findings..." The Physician's Order Summary, dated 8/2024, indicated the resident had dialysis on Mondays, Wednesdays, and Fridays at 11:00 a.m. and to check for bruit and thrill every shift. There was no location specified on the order for the bruit and thrill. There were no orders related to monitoring the dialysis access site for excessive bleeding, drainage, swelling, redness or warmth. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 8/2024, lacked any monitoring of the right arm graft site for excessive bleeding, drainage, swelling, redness or warmth.		preferences. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 57 receives dialysis services. The MAR and TAR lacked any monitoring for the right arm site. Physician orders were immediately obtained to include monitoring of the dialysis site. **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:** Residents receiving dialysis services have the potential to be impacted by this deficient practice. The DNS/designed will complete an audit for all residents receiving dialysis services to ensure they have physician orders for access site on or before 8/30/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will in service Nurses on the dialysis policy to include monitoring dialysis access site on or before 8/30/24. DNS/Designee will review	

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	There were Dialysis Appointment Assessments completed on the resident's dialysis days which included monitoring of the dialysis access site on those days. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing (DON) indicated she would clarify the orders to include where the dialysis access site was and to monitor for excessive bleeding, drainage, swelling, redness or warmth along with the bruit and thrill. A Facility Policy, titled "Dialysis Care," received as current, indicated, "...1. Physician orders will be received at time of admission specific to the resident: dialysis access care...9. It is recommended that peritoneal and hemodialysis residents be kept on hot charting to monitor for complications [access sites, change in condition, pain, signs of fluid overload, etc.]..." 3.1-37(a)		MAR/TAR to ensure resident dialysis access sites are monitored per MD order. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Dialysis” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	
F 0761 SS=E 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.			

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	§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 interview, the facility failed to ensure medications were stored properly, with appropriate labeling and not expired, for 2 of 4 medication carts observed. (East Cart and Cottage Cart) Findings include: 1. On 8/9/24 at 1:28 p.m., the following was observed on the East Cart with LPN 1: - A Basaglar KwikPen (insulin) was dated with an open date on 6/15/24. - A Rezvoglar KwikPen (insulin) was dated with an open date on 6/21/24. - A Toujeo SoloStar (insulin) pen was opened with no open date written on the pen.	F 0761	It is the practice of this facility to label insulins used in the facility in accordance with currently accepted professional principles. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All expired medications were disposed of in accordance with the pharmacy policies on 8/9/24 to include Basaglar Kwik Pen, Rexvoglar KwikPen, Toujeo SoloStar pen, lispro vial, lantus pen,and lispro pen, . All medications are stored appropriately in accordance with the pharmacy policies.	08/30/2024

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	- A Basaglar KwikPen was opened with no open date written on the pen. During an interview on 8/9/24 at 1:35 p.m., the East Unit Manager indicated the open insulins should have been dated and disposed of 30 days after opening. 2. On 8/9/24 at 1:41 p.m., the following was observed on the Cottage Cart with QMA 1: - An insulin lispro vial was dated with open date on 6/18/24. - A Lantus (insulin) pen was opened with no open date written on the pen. - An insulin lispro pen was opened with no open date written on the pen. During an interview on 8/9/24 at 1:50 p.m., LPN 1 indicated the open insulins should have been dated and disposed of 30 days after opening. A policy titled, "5.3 Storage and Expiration Dating of Medications and Biologicals," and received as current from the Director of Nursing, indicated, "...11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened..." " ...11.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial..."		**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 finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure there are no expired medications present on or before 8/30/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DNS/designee will in-service nurses on Medication Storage on or before 8/30/24. DNS/designee will conduct rounds to ensure there are no expired medications. **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:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” weekly for 4 weeks, monthly for 6 months and	

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	3.1-25(j)		quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 8/30/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must			

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	include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.			

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	The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure a resident with a peripherally inserted central catheter (PICC) was placed in enhanced barrier precautions (EBP) for high contact resident care activities, and for improper glove use for 1 of 5 residents reviewed during medication administration. Finding includes: During medication pass, the Infection Preventionist (IP) was observed preparing an intravenous medication for Resident 3 on 8/8/24 at 2:13 p.m. Upon entrance to Resident 3's room, there was no signage noted in or around the doorway for EBP and no personal protective equipment bins. The IP prepared meropenem reconstituted solution (an antibiotic) 1 gram per 100 cc of normal saline. She washed her hands and donned clean gloves. She bent the connection between the 100 cc normal saline bag and the vial of meropenem, squeezed the normal saline into the vial, and then shook the vial to dissolve the meropenem powder medication. She held the vial above the bag and squeezed air from the bag into the vial to force the liquid back into the bag. She spiked the normal saline bag with new tubing and primed the tubing. She connected the tubing thru the pump and set it to run at 100 cc's per hour. She reached into her scrub top pocket with her gloved hands, pulled out an alcohol swab, opened the package, cleaned off the PICC connection port, and then attached a 10 cc normal saline syringe. She injected 6 cc's of normal saline thru the PICC line, unattached the normal saline syringe, reached into her pocket with the same gloved hands, and pulled out a new	F 0880	It is the practice of this facility to maintain an infection control program designed to provide a safe sanitary, and comfortable environment to help prevent the development of and transmission of communicable diseases and infections. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Physician order was obtained for enhanced barrier precautions for resident #3. Signage was placed in room for resident #3 indicating that resident requires enhanced barrier precautions. **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 the alleged deficient practice. DON/designee will complete an audit of all residents in need of enhanced barrier precautions to ensure physician orders are obtained and proper signage is in place by 8/30/24. The IP nurse will be re-educated regarding resident enhanced barrier precautions and proper glove/PPE usage on or before 8/30/24. DON/Designee will	08/30/2024

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	alcohol swab. She opened the alcohol swab, cleaned the PICC connection port, and attached the primed tubing. She then started the medication pump and the infusion of meropenem began. Resident 3's record was reviewed on 8/8/24 at 2:30 p.m. There were no Physician's Orders for EBP. During an interview on 8/8/24 at 2:33 p.m., the IP indicated any resident with a central line or PICC should have been placed in EBP and she would correct it immediately. During an interview on 8/9/24 at 8:57 a.m., the Director of Nursing indicated the resident should have been in EBP and the IP should have performed hand hygiene and changed her gloves after reaching into her pockets while administering a medication thru a PICC line. A facility policy, titled, "Standard and Transmission-Based Precautions (Isolation) Policy," provided as current, indicated ..."Standard Precautions...The following infection prevention and control practices should be used during the delivery of care to all residents: Hand Hygiene... Perform hand hygiene: Before having direct contact with a resident, before performing clean/aseptic procedure, after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces, after touching resident surroundings (objects and surfaces in the resident's environment)...Gloves...Change gloves during care and hand hygiene performed if hands will move from a contaminated site to a clean site...Enhanced Barrier Precautions... It is also used for any resident with any of the following: wounds and/or indwelling medical devices (e.g.,		provide education and training to clinical personnel regarding obtaining physician order for enhanced barrier precautions, proper signage for enhanced barrier precautions is in place, and proper glove/PPE usage on or before 8/30/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/Designee will round each day to ensure residents who need enhanced barrier precautions have the proper signage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** DON/designee will be responsible for the completion of the “transmission-based precautions” QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** 8/30/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	central line) ...." 3.1-18(b)			