STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey and the Investigation of Complaints IN00371127 and IN00370852. Complaint IN00371127 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F610, F684, and F689. Complaint IN00370852 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 19 and 20, 2022 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 11 Medicaid: 61 Other: 21 Total: 93 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2022.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on January 20, 2022.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Thank you,** **Monica Dirbas, LNHA**	
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			

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

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	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 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 resident	F 0550	**F 550 Resident Rights/Exercise of Rights**	02/23/2022

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	rights related to meal preferences were honored for 1 of 4 resident's reviewed for resident rights. (Resident L) Findings include: During an observation, on 1/20/22, at 12:11 p.m., CNA (Certified Nursing Aide) 4 delivered Resident L's tray to her room. Resident L was served ground meatloaf with ketchup glaze. The clinical record for Resident L was reviewed on 1/20/22 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, irritable bowel syndrome, muscle weakness, need for assistance with personal care, constipation, and gastro-esophageal reflux disease without esophagitis. The Annual MDS (minimum data set) assessment, dated 11/4/21, indicated the resident was cognitively intact, had no natural teeth or tooth fragments, and had a mechanically altered diet requiring a change in texture of food or liquids. The physician's order, dated 4/29/21, indicated the resident had a regular diet with dysphagia advanced texture, thin consistency. The nutrition review, dated 1/19/22, indicated the resident required a dysphagia advanced diet, with ground meats. The Resident Profile on the facility's meal tracking system, indicated the resident had allergies to all tomatoes and tomato soup. The resident's meal order slip for 1/20/22 indicated the resident was to receive ground baked chicken breast for a sandwich and a hamburger bun with		**Corrective action for the residents found to have been affected by the deficient practice:** Resident L was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. A review of food preferences for all residents has been completed to ensure resident preferences are honored. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and expectations as it relates to “Resident Rights” and providing resident their preferred meals. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Registered Dietician/Director of Nursing/Unit Manager/ Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure the meal preferences are honored. This will occur for no	

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	mayonnaise as her entree. The order slip did not indicated the resident's preference for not receiving tomato products, or list any food allergies for tomatoes. During an interview, on 1/19/22 at 12:29 p.m., Resident L indicated she was supposed to get ground meats because she had a hiatal hernia, and she often got food that was not ground. She indicated it happened nearly every day. During an interview, on 1/20/22 at 12:12 p.m., Resident L indicated she couldn't eat the meatloaf. She could not eat tomatoes or tomato products because they were acidic. "They know that. I've told them before and they still bring them to me all the time." During an interview, on 1/20/22 at 12:20 p.m., CNA 4 indicated there had been a problem the last few weeks with residents not always receiving what was on their order slips. They sometimes wouldn't have the right food or the right drinks. Resident's had paper slips that indicated what their orders and preferences were on their trays. During an interview, on 1/20/22 at 2:01 p.m., the RD (Registered Dietician) indicated when it came time to make the resident's tray, they did not have the ground chicken prepared for her, so she whited it out on her order slip and gave the resident ground meatloaf instead. The sauce for the meatloaf was tomato based. In the resident's meal tracker, it did not list tomatoes as an allergy, but she had talked to the resident that day and she told her it was because of digestive issues. She didn't know if the resident was allergic to tomatoes, or if it was just a preference. The resident had told her the meatloaf was good, but it just had too much tomato and she could not		less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	tolerate it. The resident's request of not wanting tomatoes was not on her order slip and it probably should have been. The Resident Rights policy and procedure, dated 8/11/17, last revised 5/30/19, provided on 1/20/22 at 2:50 p.m., included, but was not limited to, "... It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents... Residents have a Right to... Be treated with respect... Residents have the right to decide when to go to bed, rise in the morning, and eat meals..." This Federal tag relates to Complaint IN00371127. 3.1-3(a)(1) 3.1-3(u)(1)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on observation, record review, and interview, the facility failed to ensure a complete and thorough investigation of a injury of unknown origin for 1 of 3 residents reviewed for incident investigation. (Resident K) Findings include: During an observation, on 1/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. The clinical record for Resident K was reviewed on 1/19/22 at 10:30 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, unspecified mood disorder, unspecified convulsions, history of transient ischemic attack (TIA) without residual side deficits, dysphagia, anxiety disorder, panic disorder, depression, insomnia, abnormal weight loss, difficulty in walking, and need for assistance with personal care. The Admission MDS (minimum data set) assessment, dated 1/12/22 indicated the resident was severely cognitively impaired, required extensive assistance of 2 plus staff for bed mobility, walking in room, extensive assistance of 1 staff with transfer and locomotion. He was not steady and only able to stabilize with staff assistance, had no impairment to upper or lower extremities, and used a wheelchair. He had falls prior to admission and one fall since admission with no injury, no documented skin impairments, and did not receive any anticoagulants.	F 0610	**F 610** **Investigate/Prevent/Correct Alleged Violation** **Corrective action for the residents found to have been affected by the deficient practice:** Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents having an injury of unknown origin have the potential to be affected by the deficient practice. A 30 day look back of progress notes has been completed to ensure any identified injury of unknown origin has been completely and thoroughly investigated. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and expectations as it relates to "Occurrence Incident Reporting" and **Corrective actions to be monitored to ensure the deficient practice will not**	02/23/2022

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	The care plan, dated 1/6/22 and last revised on 1/18/22, indicated the resident was at risk for falls. The care plan, dated 1/6/22 and last revised on 1/18/22, indicated the resident was at risk for altered skin integrity. Interventions included, but were not limited to, complete skin at risk assessment upon admission or readmission, quarterly, and as needed. The skin/wound note, dated 1/6/22 at 1:33 p.m., indicated the resident had a comprehensive skin and wound evaluation for new admission to the facility and intact skin with no rashes or wounds identified. The nurse's note, dated 1/12/22 at 4:19 p.m., indicated the resident's family member had called the writer into the room to observe a bruise on his left knee. The writer made the DON (Director of Nursing) aware of the situation. The DON spoke with the family member in person and assess the patient. The writer had been informed by the off coming shift the resident had fallen on night shift. The facility could not provide documentation prior to 1/19/22 of any investigation into the origin of the bruise to the resident's left knee, including, but not limited to, any review of staffing schedules, resident assessment, staff interviews or statements, incident report or investigation. The weekly skin check, dated 1/12/22 at 2:00 p.m., indicated the resident had no skin impairments. During an interview, on 1/19/22 at 1:52 p.m., the resident's family member indicated he noticed the resident had a bruise on 1/12/22 and brought it to the facility's attention. They could not tell him how it happened.		**recur:** The Director of Nursing/Unit Manager/ Designee will audit 3 residents per week x 4 weeks, then 2 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure any identified injury of unknown origin is completely and thoroughly investigated. This will occur for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	During an interview, on 1/20/22 at 2:43 p.m., the DON indicated she had talked to the resident's family and he asked her about the bruise. She didn't see anything charted on it. She did talk to a QMA who had been outside the room and asked her if he had fallen, and she indicated he had not. She talked to a nurse the next day as well, but she did not get any written statements, look at any schedules, document any further investigation. If there was something reported that was unknown she would expect it to be reported further up. The Occurrence Incident Reporting policy, last revised 5/3/18, provided on 1/20/22 at 2:50 p.m., by the RDCO included, but was not limited to, "... Occurrences or incidents will be investigated using the Risk protocol for tier reporting and investigation... documentation will be placed in the progress notes in the event the information related to a specific resident... Level 1 Reporting... a. Staff will complete the incident / occurrence report in the secure electronic program that describes the incident, the investigation, reporting, and follow-up. b. The Director of Nursing or Administrator will review the report and provide direction for additional reporting if required. This Federal tag relates to Complaint IN00371127. 3.1-28(c)			
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			

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	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 appropriate assessment, documentation, and follow-up monitoring of a bruise for 1 of 3 resident's reviewed for Quality of Care. (Resident K) Findings include: During an observation, on 1/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. The clinical record for Resident K was reviewed on 1/19/22 at 10:30 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, unspecified mood disorder, unspecified convulsions, history of transient ischemic attack (TIA) without residual side deficits, anxiety disorder, panic disorder, depression, insomnia, and difficulty in walking. The Admission MDS (minimum data set) assessment, dated 1/12/22 indicated the resident was severely cognitively impaired, required extensive assistance of 2 plus staff for bed mobility, walking in room, extensive assistance of 1 staff with transfer and locomotion. He was not steady and only able to stabilize with staff assistance, had no impairment to upper or lower extremities, and used a wheelchair. He had falls prior to admission and one fall since admission with no injury, no documented skin impairments,	F 0684	**F 684 Quality of Care** **Corrective action for the residents found to have been affected by the deficient practice:** Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents having a bruise identified have the potential to be affected by the deficient practice A 30 day look back of resident's having a bruise has been completed to ensure an appropriate assessment, documentation and follow-up monitoring of the bruise has been completed. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and expectations as it relates to "Skin and Wound Management" with focus on appropriate assessment, documentation and follow-up	02/23/2022

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	and did not receive any anticoagulants. The care plan, dated 1/6/22 and last revised on 1/18/22, indicated the resident was at risk for altered skin integrity. Interventions included, but were not limited to, complete skin at risk assessment upon admission or readmission, quarterly, and as needed. The skin/wound note, dated 1/6/22 at 1:33 p.m., indicated the resident had a comprehensive skin and wound evaluation for new admission to the facility and intact skin with no rashes or wounds identified. The nurse's note, dated 1/12/22 at 4:19 p.m., indicated the resident's family member had called the writer into the room to observe a bruise on his left knee. The writer made the DON (Director of Nursing) aware of the situation. The DON spoke with the family member in person and assessed the patient. The weekly skin check, dated 1/12/22 at 2:00 p.m., indicated the resident had no skin impairments. The hand written physician's order, dated 1/13/22, indicated the resident had orders for a bilateral knee X-ray to be conducted related to swelling post fall. The nurse's note, dated 1/14/22 at 9:42 p.m., indicated the resident had no fracture but was noted to have infrapatellar (below the knee cap) soft tissue swelling to the left knee. The clinical record lacked documentation of any description of any bruise to the left knee including color, measurements, or pain and swelling.		monitoring of a bruise. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/ Designee will audit 3 residents per week x 4 weeks, then 2 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure any identified bruise has an appropriate assessment, documentation and follow-up monitoring of the bruise. This will occur for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	During an interview, on 1/19/22 at 1:52 p.m., the resident's family member indicated he had noticed the bruise on 1/12/22. The bruise covered his whole knee cap and was solid black and blue with yellow all around it. During an interview, on 1/20/22 at 2:43 p.m., the DON indicated for the resident's bruising it needed to be documented what day it was found, where it was, anything patient said about it, and include measurements and a description of the wound. She would expect them to do skin assessments to make sure its not getting any bigger or darker and would expect it to be charted. She hadn't seen anything charted on it. The Skin Care & Wound Management Policy, last reviewed 10/5/21, provided on 1/20/22 at 2:50 p.m. by the RDCO (Regional Director of Clinical Operations), included, but was not limited to, "... The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying conditions contributing to it and description of impairment to determine appropriate treatment... Treatment... b. Skin Impairment Documentation. Complete for all skin impairment issues that require measurements to indicate if healing is occurring... 6. Monitor and document progress... 9. Communicate changes to the caregiving team..." This Federal tag relates to Complaint IN00371127. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure appropriate fall management, including post-fall assessment, monitoring, documentation, and investigation, for 1 of 3 resident's reviewed for accidents. (Resident K) Findings include: During an observation, on 1/20/22 at 2:08 p.m., Resident K was observed lying abed. There was a light, fading bruise to the left knee. The bruise was yellow to light green in color and surrounded approximately three-quarters of the circumference of the knee. The nurse's note, dated 1/12/22 at 4:19 p.m., indicated the resident's family member had called the writer into the room to observe a bruise on his left knee. The writer made the DON (Director of Nursing) aware of the situation. The DON spoke with the family member in person and assess the patient. The writer had been informed by the off coming shift the resident had fallen on night shift. The clinical record lacked documentation of any description of a fall, neurological checks, post fall assessment, or follow-up monitoring. The hand written physician's order, dated 1/13/22, indicated the resident had orders for a bilateral knee X-ray to be conducted related to swelling	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **Corrective action for the residents found to have been affected by the deficient practice:** Resident K was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents having a fall have the potential to be affected by the deficient practice A 30 day look back of falls has been completed to ensure appropriate fall management, including post fall assessment, monitoring, documentation and investigation has been completed. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and	02/23/2022

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	post fall. The nurse's note, dated 1/14/22 at 9:42 p.m., indicated the resident had no fracture but was noted to have infrapatellar (below the knee cap) soft tissue swelling to the left knee. During an interview, on 1/19/22 at 1:52 p.m., the resident's family member indicated he had not ever been informed of the resident having a fall. They had told him a nurse that worked on 1/11/22 had said the resident had fallen but they could not find any written report on it. He noticed the resident had a bruise on 1/12/22, but they could not tell him how it happened. During an interview, on 1/20/22 at 2:53 p.m., the ED (Executive Director) indicated she believed the DON had talked to the resident's family a few days prior and the interim DON had been involved in a fall or something. If a fall was reported the facility would start an investigation immediately. There should have been a fall note on the 1/11/22 night shift. During an interview, on 1/20/22 at 2:41 p.m., the RDCO indicated she had not been able to reach the staff who documented on 1/12/22. They had talked to a nurse who they thought was the agency staff member who had written the note, but she stated she had never heard the resident had fallen, and they now did not believe she was the nurse involved. They could not determine who the nurse was the wrote the note on 1/12/22. During an interview, on 1/20/22 at 2:43 p.m., the DON indicated if a resident had a fall, it should be reported up. Staff should do an incident report, report it to the oncoming shift, call the physician and family. They should do an assessment, make		expectations as it relates to “Fall Prevention and Management Policy” with focus on post fall assessment, monitoring, documentation and investigation. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/ Designee will audit 3 residents per week x 4 weeks, then 2 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure an appropriate post fall assessment, monitoring, documentation and investigation has been completed. This will occur for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	sure there were no open areas, cuts, bleeding, bruising. Assessment would also include vital signs, range of motion, especially if they fell. The resident's family said something about a fall, but she didn't see anything charted. When she walked out of the room there was a QMA out there, and she asked her in report if they said anything about a fall and she said no. The clinical record for Resident K was reviewed on 1/19/22 at 10:30 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, unspecified mood disorder, unspecified convulsions, history of transient ischemic attack (TIA) without residual side deficits, anxiety disorder, panic disorder, depression, insomnia, abnormal weight loss, and difficulty in walking. The Admission MDS (minimum data set) assessment, dated 1/12/22 indicated the resident was severely cognitively impaired, required extensive assistance of 2 plus staff for bed mobility, walking in room, extensive assistance of 1 staff with transfer and locomotion. He was not steady and only able to stabilize with staff assistance, had no impairment to upper or lower extremities, and used a wheelchair. He had falls prior to admission and one fall since admission with no injury, no documented skin impairments, and did not receive any anticoagulants. The care plan, dated 1/6/22 and last revised on 1/18/22, indicated the resident was at risk for falls. Interventions included, but were not limited to, initiate neurological checks if fall is unwitnessed, or the head is involved. The Fall Prevention and Management policy, dated 5/25/21, provided on 1/20/22 at 1:50 p.m. by			

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	the RDCO, included, but was not limited to, "... Process after a fall... Assessment... the assessment should include vital signs, inspection of the full body to assess for any injuries, a check of neurological status. The resident should be asked if they are in pain... If the resident hit their head or it was an unwitnessed fall begin neurochecks per the neurocheck policy... Investigation... once the resident is safely transferred, a fall investigation should begin... Documentation... Complete the 'Post Fall Assessment'... If the resident suffered an injury or has a change of condition complete the eInteract Change of Condition Assessment... Complete the Fall Follow Up UDA [assessment] every shift X [times] 72 hours... a report should be initiated in Risk Watch... Interdisciplinary Team [IDT] Review... The IDT team should review all information for all falls the next Daily Clinical Meeting. The team should discuss the fall, potential causes of the fall, interventions put into place and if they are effective. A deep root cause investigation should be discussed. The care plan should be reviewed to identify if interventions are appropriate or if new interventions should be asses. A progress note of the discussion should be placed in the resident's chart..." This Federal tag relates to Complaint IN00371127. 3.1-45(a)			
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum,			

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	for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.			

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	§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on record review, and interview the facility failed to ensure the clinical record contained documentation for COVID-19 testing dates, test results and actions to prevent the transmission of COVID-19 for 5 out of 8 residents reviewed for documentation. (Residents C, D, G, H, and M) Findings include: 1. The clinical record for Resident C was reviewed, on 1/19/22 at 1:00 p.m. The diagnoses included, but were not limited to, acute kidney failure, muscle weakness, type 2 diabetes, myocardial infarction, and stage 3 chronic kidney disease. The Quarterly MDS (Minimum Data Set) assessment, dated, 10/25/21, indicated the resident was moderately cognitively intact.	F 0886	**F 886 COVID 19 Testing – Residents and Staff** **Corrective action for the residents found to have been affected by the deficient practice:** Resident C was identified as being affected by the deficient practice. Resident D was identified as being affected by the deficient practice. Resident H was identified as being affected by the deficient practice. Resident M was identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:**	02/23/2022

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	The nurse's note, dated 1/10/22 at 2:31 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident C tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation indicating the COVID-19 test dates, results of the test and action taken to prevent the transmission of COVID-19 when the resident tested positive for COVID-19 on 1/13/22. 2. The clinical record for Resident H was reviewed on 1/19/22 at 1:45 p.m. The diagnoses included, but were not limited to, acute combined systolic (congestive) and diastolic heart failure, anxiety disorder, history of COVID-19, altered mental status, and difficulty walking. The Quarterly MDS assessment, dated 10/20/21, indicated the resident was moderately cognitively intact. The nurse's note, dated 1/10/22 at 2:49 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident H tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation indicating the COVID-19 test dates, results of the test and action taken to prevent the transmission of COVID-19, when the resident tested positive for COVID-19 on 1/13/22.		Residents requiring COVID 19 testing have the potential to be affected by the deficient practice A 30 day look back of COVID 19 resident testing has been completed for documentation of the COVID 19 testing dates, testing results and actions to prevent the transmission of COVID 19. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service with nursing and dietary staff to provide education and expectations as it relates to "The Facility Testing Requirements Policy and Procedure" with focus on documentation of the COVID 19 testing dates, testing results and actions to prevent the transmission of COVID 19. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/ Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure documentation of the COVID 19 testing dates, testing results and actions to prevent the transmission of COVID 19 has been completed. This will	

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	3. The clinical record for Resident G was reviewed, on 1/19/22 at 2:30 p.m. The diagnoses included, but were not limited to, protein calorie malnutrition, anorexia, colostomy, muscle weakness, absence of a kidney, cognitive communication deficit, nausea and absence of the left and right hand. The Quarterly MDS assessment, dated 8/2/21, indicated the resident was cognitively intact. The nurse's note, dated 1/10/22 at 3:59 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident G tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation indicating the COVID-19 test dates, results of the test and action taken to prevent the transmission of COVID-19, when the resident tested positive for COVID-19 on 1/13/22. 4. The clinical record for Resident M was reviewed, on 1/19/22 at 1:45 p.m., the diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease with exacerbation, type 2 diabetes, COVID-19, hypertension, and atrial fibrillation. The Quarterly MDS assessment, dated 1/6/22, indicated the resident was moderately intact. The nurse's note, dated 1/10/22 at 3:59 p.m., indicated the resident was tested for outbreak		occur for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed.	

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	testing. A rapid COVID-19 test was performed. The test results were positive. The clinical record lacked documentation indicating the action taken to prevent the transmission of COVID-19. 5. The clinical record for Resident D was reviewed, on 1/19/22 at 3:30 p.m. The diagnoses included, but were not limited to, type 2 diabetes, Parkinson's disease, congestive heart failure and hypertension. The Quarterly MDS assessment, dated 1/7/222, indicated the resident was cognitively intact. The nurse's note, dated 1/10/22 at 2:31 p.m., indicated the resident was tested for outbreak testing. A rapid COVID-19 test was performed. The test results were negative. The Resident Positive Tracker Form, dated 1/13/22, indicated Resident D tested positive for COVID-19 during outbreak testing. The clinical record lacked documentation indicating the COVID-19 test dates, results of the test and action taken to prevent the transmission of COVID-19 when the resident tested positive on 1/13/22. During an interview, on 1/19/22 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) indicated documentation of testing would be located under the UDA (user-defined assessments) assessments, and COVID symptom monitoring would be completed on the MAR (Medication Administration Record) for the order for symptom screening or under a UDA assessment for COVID symptoms.			

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	During an interview, on 1/20/22 at 1:35 p.m., the DON (Director of Nursing) indicated when a resident tested positive for COVID-19 the test results, date of test, and what action was taken should be documented in the clinical record by the nursing staff. The Facility Testing Requirements policy and procedure, last revised 5/4/21, provided on 1/19/22 at 9:35 a.m. by the RDCO, included, but was not limited to, ..."1. For symptomatic residents and staff, document the date(s) and time(s) of the identification of the sign and symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results ..."			