STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN 46996

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22 and 23, 2022 Facility number: 000553 Provider number: 155660 AIM number: 100267430 Census Bed Type: SNF/NF: 35 SNF: 1 Total: 36 Census Payor Type: Medicare: 6 Medicaid: 21 Other: 9 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/28/22.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long-term care facility and this Plan of Correction in its entirety, constitutes this provider's credible allegation of compliance. Completion dates are provided for procedural purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is of the opinion that is was in compliance with the requirements of participation. We are respectfully requesting a desk review to clear any and all proposed or implemented	

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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			remedies that have been presented to date.	
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on record review and interview, the facility failed to ensure a resident or their representative was informed of diagnostic results for 1 of 1 residents reviewed for care planning. (Resident 23) Finding includes: The record for Resident 23 was reviewed on 9/21/22 at 1:48 p.m. The resident was admitted on 6/27/18. Diagnoses included, but were not limited to, peripheral vascular disease and CVA.	F 0552	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Resident #23 and her representative was advised of the results of the arterial doppler. Resident #23 was scheduled for follow up with doctor for further discussion/review. Education provided to nurses on notification to resident/ resident representative	10/21/2022

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	The Quarterly Minimum Data Set assessment, dated 8/9/22, indicated the resident was cognitively intact. A Progress Note, dated 8/5/22, indicated the Physician had ordered an arterial Doppler (an ultrasound of the arteries) of both lower extremities. A Progress Note, dated 8/19/22 at 2:53 p.m., indicated the resident's Doppler results had been received and faxed to the Physician. There was no documentation the resident or her representative had been notified of the results. Interview with the resident on 9/19/22 at 4:15 p.m., indicated she had a Doppler done on her legs "about a month ago", but had never been informed of the results. Interview with the Infection Prevention Nurse, on 9/22/22 at 11:19 a.m., indicated the resident's representative had been notified of the Doppler results, and did not believe she had been notified of the results previously. 3.1-3(n)(2)		of results of procedures and or diagnostic testing. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: Director of Nursing or designee will audit all residents charts who have had procedures or diagnostic testing to ensure proper notification to the resident/resident representative. This audit will be completed by October 21, 2022. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: DON or designee will continue to monitor scheduled procedures, testing and notifications during IDT morning meetings utilizing the tool named " Notification of Procedures" for 6 months. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: The results of the initial audit and ongoing monitoring and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review the audit results monthly and make	

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			revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout			

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	the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the			

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	administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on record review and interview, the facility failed to ensure a resident's grievance was documented and acted upon for 1 of 1 residents reviewed for grievances. (Resident 23) Finding includes: On 9/19/22 at 4:12 p.m. during an interview with Resident 23, she indicated her air conditioner didn't work right and her room was too hot. She had complained about it several times.	F 0585	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Social Services met with resident on 9/22/22 and completed a grievance in regards to her PTAC unit. PTAC unit was replaced on 9/22/22. Maintenance worker was immediately educated on the grievance process. A staff in-service on the grievance process was initiated on 9/22/22.	10/21/2022

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	A list of grievances for the past six months did not include any grievance made by the resident regarding the air conditioner. Interview with Maintenance 1, on 9/21/22 at 11:20 a.m., indicated he was aware of the resident's complaint regarding her room being too hot. He indicated she liked her room cool, around 62 degrees, but her air conditioning unit would only go down to around 68 degrees. He had ordered a new air conditioning unit about a month ago, but had put it on the back burner because her room temperature was within normal limits. He later indicated the air conditioner had been received and was in storage. He indicated he had not completed a grievance form and was not aware he should have. The invoice for the air conditioning unit, dated 8/31/22, indicated it was scheduled for delivery on 8/5/22, but the Administrator indicated it had been on backorder. The current policy, "Grievance Policy ad Procedure", indicated, "...The resident has the right to and the facility must make prompt efforts to resolve grievances the resident may have...." and, "...Grievances will be investigated and documented on a Grievance form by appropriate staff and overseen by the Grievance official and resolved within 10 days...."		2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents in facility have the potential to be affected. Social Service Director or designee will educate all residents and/or resident representative on the grievance process by October 21, 2022 including where to obtain grievance forms. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: Social Service Director or designee will complete education/reminders to residents and/or representatives of the grievance process and where to locate the forms and address any concerns weekly x4 weeks, bi-weekly x 8 weeks then monthly x 3 months. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: Social Service Director will complete grievances and will report any new grievance to the IDT team during morning meetings and address immediately.	

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			Grievance logs will be given to Administrator to review with Quality Assurance Committee during monthly QA meetings. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed related to medications for 1 of 15 MDS assessments reviewed. (Resident 12) Finding includes: Resident 12's record was reviewed on 9/21/22 at 11:04 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident had not received any anticoagulant medications during the assessment look back period. The Medication Administration Record (MAR), dated 8/2022, indicated the resident had received Xarelto (rivaroxaban, an anticoagulant medication) 15 milligrams (mg) daily.	F 0641	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: The MDS entry for resident #12 was immediately corrected and submitted by the DON/MDS Coordinator. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents of the facility could potentially be affected. Don/MDS Coordinator will complete an audit of section N for all MDS's submitted within the last 60 days to determine accuracy and will make corrections as needed.	10/21/2022

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	Interview with the Director of Nursing (DON) on 9/22/22 at 2:23 p.m., indicated the anticoagulant medication should have been marked. She would correct it.		3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: DON/MDS Coordinator will utilize the audit tool named" MDS Audit Tool" for each MDS Assessment Reference Period prior to submitting MDS. This tool will be used on-going. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: The results of the audits and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review the audit results monthly and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop and implement a care plan for an anticoagulant medication for 1 of 16 resident care plans reviewed. (Resident 33)	F 0656	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Care plan for anti-coagulant	10/21/2022

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	Finding includes: The record for Resident 33 was reviewed on 9/20/22 at 11:16 a.m. The resident was admitted on 8/30/222. Diagnoses included, but were not limited to, artherosclerotic heart disease. The Admission Minimum Data Set assessment, dated 9/6/22, indicated the resident received an anticoagulant medication. A Physician's Order, dated 8/30/22, indicated the resident was to take Eliquis (an anticoagulant) 5 milligrams, twice daily. The record lacked a care plan for anticoagulant medications. Interview with the Director of Nursing, on 9/21/22 at 10:57 a.m., indicated there was not a care plan for anticoagulant medications. They were doing an audit on all care plans at that time. 3.1-35(a)		therapy was created immediately for resident #33 on 9/20/22. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents in facility have the potential to be affected. Director of Nursing or designee will conduct an audit of each resident's medication list to ensure a care plan is in place. This audit will be completed by October 21, 2022. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: IDT will review care plans during each assessment reference period and make any corrections as needed. All new orders will be reviewed during IDT morning meetings to ensure care plans are in place. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: Ongoing monitoring and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the	

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			basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a dependent resident related to unclean and untrimmed fingernails for 1 of 4 residents reviewed for activities of daily living. (Resident 22) Finding includes: On 9/19/22 at 10:20 a.m., Resident 22 was observed lying in bed. The resident's fingernails were long with dark debris underneath them. On 9/20/22 at 11:17 a.m., Resident 22 was observed lying in bed. The resident's fingernails were long with dark debris underneath them. On 9/21/22 at 10:53 a.m., Resident 22 was observed lying in bed. The resident's fingernails were long with dark debris underneath them. Record review for Resident 22 was completed on 9/20/22 at 11:34 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, diabetes mellitus, stroke, and dysphagia. The Quarterly Minimum Data Set (MDS)	F 0677	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Resident #22 nails checked, cleaned and trimmed on 9/21/22. An immediate audit of all residents nails were completed by nurse and care provided as necessary. Nursing department staff education provided on nail care. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents in facility have the potential to be affected. An immediate audit of all residents nails were completed by nurse and care provided as necessary. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice	10/21/2022

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	assessment, dated 8/4/22, indicated the resident was cognitively moderately impaired. The resident required an extensive 2+ person assist for personal hygiene and a total 2+ assist for bathing. The resident had an impairment on both his upper and lower extremities for functional limitation in range of motion. Interview with CNA 1 on 9/21/22 at 10:55 a.m., indicated she was unaware of any times the resident had refused any care. They are supposed to do nail care with bathing or at anytime they do resident care and notice if they are dirty or long. Interview with LPN 1 on 9/21/22 at 11:00 a.m., indicated the resident did not refuse any care or bathing that she was aware of. The aides should be cleaning and clipping the resident's nails. Nail care should be done on bathing days but also should be completed at any time if they are observed to be long or dirty. 3.1-38(a)(3)(E)		does not recur? A: Nail care will be scheduled. Director of Nursing or designee will audit nail care weekly x 6 months utilizing the audit tool named "Audit of Nail Care for Residents". 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: Audit results and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent			

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	155660	A. BUILDING 00 B. WING	09/23/2022

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	with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing, related to inaccurate staging of a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. (Resident 22) Finding includes: On 9/22/22 at 10:26 a.m., Resident 22's pressure ulcer on his coccyx was observed. The Wound Nurse removed the bandage to his coccyx. The wound area was deep, red and beefy. The Wound Nurse indicated the wound had granulation tissue (tissue that fills in a wound that is healing). She further indicated the area was a healing Stage 2 pressure ulcer. Record review for Resident 22 was completed on 9/20/22 at 11:34 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, diabetes mellitus, stroke, and dysphagia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/22, indicated the resident was cognitively moderately impaired. The resident required an extensive 2+ person assist for bed mobility, dressing, and personal hygiene, and a total 2+ toilet use and bathing. The resident had an impairment on both his upper and lower extremities for functional limitation in range of motion. The resident had a Stage 2 pressure ulcer on admission. A Care Plan, dated 3/9/22 and revised on 8/22/22, indicated the resident was re-admitted from the	F 0686	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Resident #22 wound was reviewed by 2 nurses and appropriate staging of wound completed. AMT Wound Care Consultant rounded with and educated newly assigned Wound Nurse and former wound nurse. These 2 nurses will be scheduled for weekly wound measurements, staging and review. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents in facility have the potential to be affected. Pressure Ulcer Education including staging for all nurses will be completed by October 21, 2022 and quarterly and with each new hire. AMT Wound Care Consultant will provide on-going education to the wound nurses monthly or more frequent as needed. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: New wound nurse assigned.	10/21/2022

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	hospital with multiple pressure wounds to his coccyx and extremities. The center coccyx was unstageable. Wound Management assessments indicated: -3/9/22: unstageable pressure ulcer to coccyx; admitted from hospital with -measured: 8.5 cm (centimeters) x 6.5 cm -depth cannot be measured -unstageable due to slough (dead tissue) and/or eschar (dry, dead tissue) -granulation tissue: 10% -slough tissue: 25% -eschar tissue: 65% -Comments: First observation wound noted to have thick layer of necrotic and slough tissue to wound bed. Edges of wound noted to have clean granulation tissue. Weekly assessments were completed of the coccyx pressure ulcer. Each assessment indicated the wound was unstageable. On 7/6/22, a new area was observed under the existing pressure ulcer. The assessment indicated: -7/6/22: Stage 2 coccyx (new area below larger wound) -measured: 0.7 cm x 0.2 cm -depth could not be measured -Granulation tissue: 100% -Comments: First observation. Small wound opening below larger wound. The last Wound Management assessments of the 2 pressure ulcers of the coccyx completed in the computer were on 7/20/22. After that date the wound assessments were completed on paper.		Director of Nursing or designee will monitor the weekly wound information utilizing the Weekly Pressure Ulcer Tracking Tool and the Weekly Non-Pressure Ulcer tracking tool to ensure proper staging and treatment. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: Audit results and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	

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	-7/20/22: unstageable coccyx -measured: 2 cm x 1.5 cm, 2.3 cm -exudate: moderate, purulent, with wound odor -undermining present with measurement: 3.8 cm -Granulation tissue: 30% -Slough tissue: 70% -Comments: Wound is decreasing is size. Deeper in depth with more drainage this assessment. 7/13/22: Stage 2 coccyx -measured 0.7 cm x 0.2 cm -depth could not be measured -Granulation tissue: 100% On 7/20/22, The Wound Nurse began documenting the pressure ulcers on paper. The paper was titled the Weekly Pressure Ulcer Tracking Report. Weekly Pressure Ulcer Tracking Report, dates 7/20/22 - 9/21/22, indicated the resident had a Stage 2 pressure ulcer to his coccyx. -7/20/22: Stage 2 coccyx -measured: 2 cm x 1.5 cm x 2.3 cm (same measurements from the computer Wound Management that had it staged as an unstageable -9/21/22: Stage 2 coccyx -measured: 2.3 cm x 1 cm x 0.5 cm -smooth edges; growth in center of wound The resident was seen in the hospital for a consultation on 6/23/22. The consultation was related to the pressure ulcer and placing a colostomy to keep the wound clean and to help it heal. The doctor indicated the resident had a stage 4 pressure ulcer of the sacral region. Interview with the Wound Nurse on 9/21/22 at			

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	2:11 p.m., indicated the resident's pressure ulcer was a Stage 2. She indicated the resident's pressure ulcer did have slough/eschar at one point since he had it. Interview with the Director of Nursing (DON) on 9/21/22 at 3:44 p.m., indicated they went from computer charting to paper charting for the wound in July 2022. The nurse was incorrectly staging the wound. She had put the measurements from the unstageable as the stage 2. Then the next week, they think the unstageable and stage 2 merged together and she was still staging the entire wound as a stage 2. A facility policy titled, "Pressure Ulcers/Injuries Overview", and received as current from the Administrator on 9/22/22, indicated, "...Staging..." "...Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis..." "...Granulation tissue, slough and eschar are not present..." "...Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss..." "...If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed...." 3.1-40(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:			

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	(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to have completed daily nurse staffing postings for review. This had the potential to affect all 36 residents residing in the facility. Finding includes: On 9/22/22 at 2:36 p.m., the daily nurse staffing posting was posted on a bulletin board by the nurse's station. The sheet included a grid for two days. The top grid was dated Wednesday 9/21 and the bottom grid was dated 9/22. Neither dates	F 0732	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Resident Services Coordinator immediately added the daily census information to the posted nurse staffing hours form and audited the past forms to ensure census information was correct. 2.) How other residents having	10/21/2022

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	had the facility census written on the sheet. The daily nurse staffing sheets for 9/5/22 - 9/22/22 were reviewed on 9/22/22 at 2:50 p.m. The daily facility census was not written on any of the daily sheets. Interview with Resident Services on 9/22/22 at 2:56 p.m., indicated the facility census should have been completed each day on the sheets and was not completed.		the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents in facility have the potential to be affected. Resident Services Coordinator audited the past forms to ensure census information was correct. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: Director of Nursing or designee will complete the nurse staffing form including the census and will post daily. Business Office Manager or designee will audit the nurse staffing hours forms utilizing the tool named “Audit of the Posting of Nursing Staff & Census” weekly x 24 weeks. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: Audit results and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed?	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to maintain a sanitary kitchen related to boxes of food stored on the floor in dry storage and freezer, boxes stacked to the ceiling and around the fan in the freezer and a dirty vent above the food preparation counter. This had the potential to affect 34 residents that received food prepared in the Main Kitchen. Findings include: 1. During the initial kitchen tour with Dietary Aide (DA) 1, on 9/19/22 at 10:15 a.m., the following was	F 0812	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: Dietary staff immediately put all boxes on shelves and cleaned all vents on the ceiling. Education provided to all dietary staff on food storage guidelines. 2.) How other residents having the potential to be affected by the same alleged deficient practice	10/21/2022

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	observed: - In the dry storage room, there were boxes of applesauce, cups, salt and cherry pie filling sitting directly on the floor. - In the walk in freezer, there were boxes of food items sitting directly on the floor. There were also boxes stacked on shelves to the ceiling and resting next to to the freezer fan. The DA indicated they had received a shipment that morning and had not put items away yet, but they should not be on the floor. 2. During a follow up visit to the kitchen, on 9/23/22 at 10:00 a.m. with Cook 1, a blackened, dirty vent was observed above the preparation counter. Interview with the Cook at that time, indicated she was not aware when the vent had been cleaned last, and that it was in need of cleaning. The current policy, "Food Storage", was received from the Administrator on 9/19/22 at 10:55 a.m., indicated, "...11. Food is stored a minimum 6 inches above the floor and 18 inches from the ceiling...." and, "...15 e. All foods will be stored to allow adequate circulation...." and, "...all food will be stored off the floor." 3.1-21(i)(3)		will be identified and what corrective action(s) will be taken? A: All residents who utilize dietary services in the facility have the potential to be affected. Dietary staff immediately put all boxes on shelves and cleaned all vents on the ceiling. Education provided to all dietary staff on food storage guidelines and will be completed by 10/21/22. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: Cleaning the ceiling vents has been added to the weekly cleaning duties. A designated staff member will be scheduled for putting away the deliveries on the date of delivery to ensure boxes and food stored properly and off the floor. A staff member assigned weekly to complete the cleaning. Education was provided to all dietary staff on food storage guidelines. The Dietary Manager or designee will monitor the kitchen areas to ensure proper storage of food utilizing the audit tool named “Delivery Storage Sign Off page” weekly for 6 weeks, then bi-weekly for 6 weeks, then monthly for 3 months. 4.) How the corrective action(s) will be monitored to ensure the	

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			alleged deficient practice will not recur; what quality assurance program will be put into place? A: Audit results and any corrective action taken, will be reported to the Quality Assurance Committee monthly. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	
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			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	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 guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed after contact with a garbage can and the floor during a dressing change, and not wearing the appropriate personal protective equipment (PPE) when entering transmission based precaution (TBP) isolation rooms for 1 of 1 residents in transmission based precautions. (RN 1 and Wound Nurse) Findings include: 1. On 9/21/22 at 3:15 p.m., wound care was observed with RN 1 and the Wound Nurse. The resident was seated in his chair, his legs were extended and resting on his footrests. He had dressings wrapped around both lower legs. RN 1 removed scissors from her pocket and cut off the dressing on the right leg, then cut off the dressing on the left leg and placed the scissors back in her pocket. The Wound Nurse indicated she was going to sit on the floor to see the wounds on the back of his legs better. She had completed hand hygiene and donned gloves. As she sat on the floor, she used her left gloved hand to balance herself on the edge of the garbage can. She then used the same gloved hand and touched the area around the	F 0880	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A: The Director of Nursing immediately educated the 2 nurses involved in the incident. The Infection Preventionist Immediately initiated education for all nurses on the process of cleaning of scissors and for all staff the Proper Use of PPE and understanding the TBP signage posted on doors. Infection Preventionist scheduled trainings for staff which included return demonstration for hand hygiene and donning and doffing PPE and proper cleaning of equipment. The education will be complete by 10/21/22. QSOURCE Quality Improvement Advisor/Infection Preventionist Consultant completed a Directed Plan of Correction and will follow the plan as written. 2.) How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? A: All residents of the facility	10/21/2022

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	wound on the right leg. The Wound Nurse later went to sit on the floor again. She had donned new gloves, and as she sat down she used her right gloved hand to steady herself on the floor, she then touched the resident's left leg around his wound with the same gloved hand. After the dressings had been changed, RN 1 reached into her pocket and retrieved the scissors to cut the new dressing from the roll. She indicated at that time that she had rinsed off the scissors when she had washed her hands. When the dressings had been completed, RN 1 went in the bathroom to wash her hands. She left the bathroom with the water running and approached the resident. There was a steristrip (a removable dressing for incisions and skin tears) on his his left hand that was loose. She used her bare hand and removed the dressing and threw it away. She then checked another dressing on the back of his left arm that was coming loose, she used her hand to smooth it back in place. She then went back in the bathroom, turned the water off, and exited the room. Interview with the Wound Nurse on 9/21/22 at 3:40 p.m., indicated she should not have touched the garbage can or the floor. Interview with RN 1 on 9/21/22 at 3:40 p.m., indicated she had washed her scissors, but should have cleaned them with an alcohol wipe, but she didn't have any on her. Interview with the Director of Nursing on 9/22/22 at 2:18 p.m., indicated she expected scissors to be cleaned after use with an alcohol wipe or		could potentially be affected. On-going staff education following the Directed Plan of Correction. 3.) What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur? A: Director of Nursing and/or Infection Preventionist or designee will audit the cleaning of equipment utilizing the Audit tool named “Proper Equipment Sanitation” daily x 6 weeks, weekly x 2 months then monthly x 2 months. Director of Nursing and/or Infection Preventionist or designee will audit hand hygiene practices utilizing the audit tool named “Hand Hygiene Use During Resident Care” daily x 6 weeks, weekly x 2 months then monthly x 2 months. Director of Nursing and/or Infection Preventionist or designee will audit the use of PPE utilizing the audit tool named “Proper Protective Equipment Use” daily x 6 weeks, weekly x 2 months then monthly x 2 months. 4.) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur; what quality assurance program will be put into place? A: The results of the audits and any corrective action taken, will be reported to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING 00 B. WING	09/23/2022

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	disinfectant wipe. The current policy, "Procedure for Handwashing", was received from the Administrator on 9/22/22 at 11:55 a.m., indicated, "...When to wash hands (at a minimum)...After touching a resident...after handling contaminated items...." The current policy, "Procedure for General Cleaning and Maintenance of Equipment", indicated..."Equipment if first cleaned of surface soil with soap and water or facility disinfectant. Equipment is then decontaminated with and EPA and facility approved disinfectant...."2. On 9/21/22 at 4:18 p.m., RN 1 was observed preparing medication at the medication cart for Resident 184 who resided in Room E 2. The nurse had prepared the medication and proceeded to go into Room E 2 to administer the resident's medications. The nurse was only wearing a surgical mask. At that time, a sign on the resident's door indicated "Droplet/Contact Isolation. Proper Personal Protective Equipment (PPE): an isolation gown, protective eye wear, a N95 face mask and gloves to both hands before entering." There was also a PPE bin located right outside the door. Interview with RN 1 on 9/21/22 at 4:24 p.m., after leaving the resident's room, indicated the resident was not on precautions and was unsure why there were signs on the door or a PPE bin outside the door. Interview with the Director of Nursing (DON) on 9/21/22 at 4:40 p.m., indicated the resident was on droplet/contact isolation due to being a re-admission to the facility and unvaccinated for COVID-19. The RN should have donned the appropriate PPE before entering the resident's room.		Committee monthly. The QA Committee will review the audit results monthly and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 21, 2022	

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	An updated and current facility policy titled, "COVID-19 Emergency Plan, Policies and Procedures", and received during the entrance conference, indicated, "...PERSONAL PROTECTIVE EQUIPMENT (PPE). All employees must take notice of the signage on isolation rooms and follow the required PPE procedures..." "...The PPE to be utilized includes masks, gloves, goggles/shields, gowns, etc...." 3.1-18(b)			