STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155006	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WABASH SKILLED NURSING FACILITY EAST THE	1900 N ALBER ST WABASH, IN 46992

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 26, 27, 28, 29 and 30, 2023. Facility number: 000006 Provider number: 155006 AIM number: 100290220 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 5 Medicaid: 24 Other: 8 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 10, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 1, 2023. 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 August 15, 2023.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. 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	F 0689	1. It is the policy of this facility	07/24/2023

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

Michael Wolfe | Administrator | 07/24/2023

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	interview, the facility failed to ensure adequate supervision was provided and individualized interventions were implemented to prevent falls for 1 of 2 residents reviewed for falls (Resident 16). Findings include: During an observation, on 6/26/23 at 2:17 p.m., Resident 16 ambulated with a front-wheeled walker in his room without staff assistance. Non-skid strips were on the floor in front of his recliner. On 6/28/23 at 10:25 a.m., he was sitting in a recliner with his feet elevated. A front-wheeled walker and a wheelchair were along a wall across the room from him. On 6/28/23 at 10:41 a.m., he was ambulating in his room, unassisted and without a walker, towards the bathroom while holding onto his oxygen tubing. His clinical record was reviewed on 6/28/23 at 9:30 a.m. He was admitted to the facility on 5/15/23. Diagnoses included, congestive heart failure, unsteadiness on feet, other abnormalities of gait and mobility, weakness, and repeated falls. Current physician orders included the following: a. Skin tear to left forearm, place non-adherent pad over area then wrap with rolled gauze to keep in place daily. The order date was 6/28/23. b. Skin tear to left forearm, keep steri strips in place until they fall off. The order date was 6/28/23.		that all residents receive adequate supervision and assistance in order to prevent accidents. It is also the policy of this facility that the resident's environment remains free of accidental hazards. Resident 16 returned to the facility on 6/13/23. Care plans and interventions were reviewed and updated as needed. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. An audit of the facility "At Risk" residents was completed and their care plans and interventions regarding falls were updated 7-24-23. All staff were in-serviced on 7/20/23 and 7/21/23 on the policies of; "Fall Management", "Change of Condition", "Care Planning" education completed by DON and/or designee. Staff will be in-serviced on each of these policies again at next month all staff meeting as well. Medical Records and DON and/or designee is responsible for the in-services. Nursing staff was in-serviced by 7/21/23 by the DON or designee on the policy "Head Injuries/Neurological Assessments" as well as the "Fall Management" policy. Any employee who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. Medical Records and	

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	c. Skin tear to left upper arm, wash area and pat dry, apply absorbent foam dressing over area, every three days. The order date was 6/28/23. d. Skin tear to right forearm, place non-adherent gauze over steri strips then wrap with rolled gauze to keep in place. The order date was 6/28/23. e. Skin tear to right forearm, keep steri strips in place until they fall off. The order date was 6/28/23. f. Skin tear to right hand, keep steri strips in place until the fall off. The order date was 6/28/23. g. Skin tear to right upper arm, keep steri strips in place until they fall off. The order date was 6/28/23. h. May cover skin tears with steri strips, gauze and tape to bilateral upper extremities for drainage or protection. The order date was 6/30/23. A 5/22/23 admission MDS (Minimum Data Set) assessment indicated he had moderate cognitive impairment. He required extensive assistance for bed mobility, transfers, to walk in room, locomotion on and off unit, dressing, toilet use, and personal hygiene. He had a fall in the last month prior to admission/entry or re-entry. A current care plan, with a revised date of 5/24/23, indicated he was at risk for falls due to his condition and risk factors: history of falls, unsteady gait with or without assistive device for mobility (walker, cane, wheelchair, or rollator), and weakness. The goal, with a target date of 8/14/23, indicated his fall risk factors would be reduced in an attempt to avoid significant injury related to falls. Current interventions, dated 5/22/23,		DON and/or designee is responsible for the in-services. 4. Audit tools F689 entitled “24 Hour Review” and “At Risk” residents were implemented on 7/21/23 and will be monitored 5 times weekly by the IDT Team for 8 weeks, 3 times weekly for 4 weeks, and then weekly for 3 months. Audit toll entitled “Fall Compliance” has been initiated and is the responsibility of the DON and/or designee. This audit will be conducted five days a week for 4 weeks, 3 days a week for 4 weeks, then weekly for four months. The daily CQI will also include daily communication regarding falls, and their corresponding interventions and care plans. Any findings will be immediately addressed and included in monthly QAPI meeting as patterns and trends identified. An action plan may be developed as needed. 5. 7/24/23	

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	included call light in reach and explain use of it upon admission and reinforce as needed, monitor changes in gait/positioning, notify physician of changes in condition, and notify therapy of changes in condition. A current intervention, dated 6/29/23, indicated safety strips on floor in front of recliner. A current care plan, dated 6/29/23, indicated he had an alteration in skin integrity as evidenced by skin tears to right posterior hand, right forearm, right upper arm, left forearm, and left upper arm from a fall. Interventions included provide treatment as ordered by physician and monitor for sign and symptoms of infection. A Fall Risk Review note, dated 5/15/23 at 8:01 p.m., indicated was at high risk for falls. A progress note, dated 5/28/23 at 9:48 p.m., indicated Resident 16 had gotten up to use the bathroom and hit his head. A skin flap was noted to his left posterior head. A late entry IDT (Interdisciplinary Team) note, dated 6/1/23 at 7:20 a.m., with an effective date of 5/30/23 at 10:09 a.m., indicated staff had heard the resident yell "hey" and he was found sitting on the floor towards the foot of the bed with the call light tangled at his feet. He indicated he was getting up to go to the bathroom. He was being treated for pneumonia since admission, had intermittent confusion, and his oxygen saturation rate was 87% on 3 liters of oxygen per nasal cannula. Bleeding was noted to the back of his head. It appeared he hit his head on the nightstand. He had skin tears noted to both wrists. He was sent to the emergency room for evaluation and treatment.			

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	A Fall Risk Review, dated 5/31/23 at 10:41 p.m., indicated was at high risk for falls. The clinical record lacked additional interventions implemented to reduce his risk for additional falls. A report from the hospital, dated 5/31/23, indicated he had admitted to the hospital on 5/28/23 and discharged back to the facility on 5/31/23. The resident had presented to the emergency room after a fall during which he had hit his head, resulting in a left occipital scalp hematoma. A CT (Computed Tomography) of his head without contrast, dated 5/28/23, indicated left parietal scalp soft tissue swelling. A Daily Skilled Nursing Note, dated 6/2/23 at 9:50 a.m., indicated he had re-admitted to the facility for weakness, confusion, and post fall. He required assistance of one with ADLs (Activities of Daily Living) and transferred via stand and pivot with walker and wheelchair. A progress note, dated 6/15/23 at 4:45 p.m., indicated he had been found on the floor near his bed, sitting up with his back against the wall. He indicated he had gotten out of his recliner and walked with walker across the room to his wheelchair. He fell when he tried to turn the wheelchair around. No injury was noted at the time. A Fall Risk Review, dated 6/15/23 at 4:47 p.m., indicated was at high risk for falls. An SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers note, dated 6/15/23 at 4:52 p.m., indicated a fall had occurred and the nursing recommendation was to keep his wheelchair next to the resident when not			

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	in use. A Daily Skilled Nursing Note, dated 6/17/23 at 7:52 a.m., indicated he required assist of one with transfers, stand and pivot with wheelchair and walker. A Fall Risk Review, dated 6/28/23 at 6:47 p.m., indicated was at high risk for falls. An SBAR Summary for Providers note, dated 6/28/23 at 8:55 p.m., indicated a fall had occurred. Nursing observations, evaluation, and recommendations were the resident had fallen during an unassisted transfer. An Incident Note, dated 6/29/23 at 10:21 a.m., indicated skin tears remained to multiple places to his bilateral arms. An IDT note, dated 6/29/23 at 11:50 a.m., indicated he had fallen in his room, which resulted in multiple skin tears to both arms. He was intermittently confused, a poor historian, and had decreased safety awareness. He was unable to specify why/how he had fallen other than to indicate the chair had thrown him. The recliner was in the normal sitting position, he had shoes and clothes on, and the walker was on top of him. He indicated the skin tears hurt a little. Non-skid strips had been noted to be worn in front of his recliner, and the non-skid strips were replaced with new ones. During an interview, on 6/30/23 at 11:24 a.m., the DON indicated the resident has had two falls since he admitted to the facility. The non-skid strips that had been in front of his recliner were there from a previous resident. Since his last fall had been in front of the recliner, and those			

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	non-skid strips looked worn, they replaced them. During an interview, on 6/30/23 at 1:48 p.m., LPN 21 indicated interventions in place to reduce the resident's risk of falling included encouraging him to ask for assistance, but he didn't ask for, or wait for, assistance. Review of a current, undated facility policy, titled "INCIDENTS/ACCIDENTS/FALLS," provided by the Nurse Consultant on 6/30/23 at 3:27 p.m., indicated the following: "...11. All falls will have a site investigation by appropriate staff in an effort to define the "root cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new intervention roll out...." Review of a current, undated facility policy, titled "IDT Care Planning Policy and Procedure (Person-Centered Plan of Care)," provided by the Nurse Consultant on 6/30/23 at 3:27 p.m., indicated the following: "...1. Each resident will have a comprehensive assessment completed by the Interdisciplinary team upon admission, quarterly and with significant changes and an individualized care plan will be developed and updated as needed with quarterly assessments, re-admissions, and changes in conditions...7. Residents care plans will be reviewed and updated as needed with re-admissions, quarterly re-assessments, annually and with changes in conditions (Example: revisions to the problem statement, goals and interventions).... 3.1-45(a)			
F 0710 SS=D	483.30(a)(1)(2) Resident's Care Supervised by a Physician			

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Bldg. 00	§483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. Based on interview and record review, the facility failed to ensure the physician was notified of a significant weight loss for 2 of 3 residents reviewed for nutrition (Resident 30 and Resident 31). Findings include: 1 During an interview, on 6/27/23 at 11:16 a.m., Resident 31 indicated he had lost a lot of weight since he was admitted to the facility. Resident 31's clinical record was reviewed on 6/27/23 at 3:17 p.m. Diagnoses included type 2 diabetes mellitus, morbid obesity, gastroesophageal reflux disease, diarrhea, dysphagia, oropharyngeal phrases, major depressive disorder, chronic respiratory failure with hypoxia, acute pulmonary edema, and cardiomegaly.	F 0710	1. It is the policy of the facility that each resident must remain under the care of a physician. In conjunction with this a physician, PA, NP, or clinical nurse specialist must provide orders for the resident's immediate care and needs. It is also the policy of the facility to ensure that the resident's attending physician and representative are notified of changes in resident's condition or status. Resident 30 and 31 still reside in facility, MD notified on weight loss 6-30-23. 2. All residents have the potential to be negatively impacted by this deficient practice. A 90 day look back of residents with weight loss was completed and MD notification completed on	07/24/2023

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	Current physician orders included mechanical soft diet with ground meat texture (2/13/23), fluoxetine (for depression) 20 mg daily (6/21/23), insulin glargine (for diabetes mellitus) 40 units daily at bedtime (1/10/23), Lasix (for swelling) 20 mg daily (10/19/22), metformin (for diabetes mellitus) 500 mg two times a day (4/20/23), and omeprazole delayed release (for gastrointestinal upset) 20 mg daily (6/3/23). A 6/7/23 quarterly MDS assessment indicated the resident required extensive assistance with eating of one staff member. A care plan, initiated 10/19/22 and revised on 12/7/22, indicated the resident was at nutritional risk related to a body mass index of greater than 25, a mechanically altered diet, and refusal to be weighed frequently. The goals, initiated 10/27/22, indicated the resident would have no significant weight loss of five percent or greater in one month, seven and a half percent or greater in three months, and 10 percent or greater in six months. The interventions included monitor weight and intakes (initiated 10/19/22) and notify physician and resident/resident representative of significant weight changes (initiated 10/27/22). The resident's Weight Summary indicated he weighed 260.1 pounds on 3/1/23, 262.6 pounds on 5/2/23, and 239.8 pounds on 6/14/23. The weight loss from 3/1/23 to 6/14/23 was a significant weight loss of 7.8% in a three-month period. The weight loss from 5/2/23 to 6/14/23 was a significant weight loss of 8.7% in a month. A Physician Note, dated 6/15/23 at 7:24 a.m., indicated the physician had provided a routine visit for the resident. The resident's weight and weight loss were not addressed.		7-24-23 3. All nursing staff has been educated on the policy “Change in Residents Condition or Status” policy by the DON and/or designee on 7/21/23. Any employee who fails to comply with the points of the in-service will be further educated and/or disciplined. 4. QAPI tool titled “Physician notification log” will be utilized five days a week for four weeks, three days a week for four weeks, then monthly for four months. Any conclusions from the audit will be further addressed in QAPI. Additionally, any concerns noted will be immediately addressed and corrected. 5. 7/24/23	

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A Nursing Progress Note, dated 6/22/23 at 5:21 p.m., indicated the resident had raised red bumps on his upper chest and beard area. The Nurse Practitioner (NP) was notified. There was no mention of the resident's weight loss being reported or evaluated.

A Summary for Providers Note, dated 6/22/23 at 5:22 p.m., indicated a change in condition summary. The resident's weight was included in the note. The change in condition was identified as "Other change in condition." Recommendations for the change in condition was an order for nystatin powder (antifungal) every shift until resolved. Weight loss was not addressed.

During an interview, on 6/29/23 at 3:35 p.m., RN 31, the resident's assigned nurse, indicated she was unaware of a weight loss for the resident.

During an interview, on 6/29/23 at 3:39 p.m., RN 33 indicated the resident often ate take-out food provided by his wife. She did not know he had lost weight.

During an interview, on 6/29/23 at 4:01 p.m., LPN 32 indicated the resident's wife brought in food to the resident most days. The resident's wife had been on vacation for a week recently.

2. Resident 30's clinical record was reviewed on 6/28/23 at 3:14 p.m. Diagnoses included major depressive disorder, unspecified mood disorder, delusional disorders, and Alzheimer's disease.

Current physician orders included a general diet (1/13/23), divalproex (for mood disorder) 250 mg two times a day (6/7/23), donepezil (for

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	Alzheimer's disease) 10 mg daily at bedtime (12/7/22), fluoxetine 20 (for depression) mg daily (1/4/23), and memantine (for Alzheimer's disease) 10 mg two times a day (6/2/23). A 6/8/23 quarterly MDS (Minimum Data Set) assessment indicated the resident was moderately cognitively impaired and required limited assistance of one staff member with eating. A current care plan, initiated 9/11/21 and revised on 3/14/23, indicated the resident was at nutritional risk related to cognitive impairment. Weight gain was planned and desired. The goals, initiated 9/13/21 and revised on 3/14/23, included maintenance of weight at a healthy range for the resident without any unwarranted significant weight changes. The interventions included monitor weights and intakes (initiated 9/11/21) and notify physician and resident's representative of significant weight changes (9/7/22). The Weight Summary indicated the resident weighed 123 pounds on 12/8/22, 120.4 pounds on 5/2/23, and 102.6 pounds on 6/14/23. The weight loss from 12/8/22 to 6/14/23 was a significant weight loss of 16.59% in a six-month period. The weight loss from 5/2/23 to 6/14/23 was a significant weight loss of 14.78% in a month. A Summary for Providers Note, dated 6/28/23 at 1:11 p.m., indicated the physician was notified of a weight of 100.3 pounds obtained on 6/26/23. A Dietary Progress Note, dated 6/28/23 at 8:24 p.m., indicated the resident had triggered for a significant weight loss for a 30-day period. During an interview, on 6/29/23 at 3:43 p.m., RN 31, the resident's assigned nurse, indicated she			

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	was unaware the resident had lost weight. The resident became agitated when the staff attempted to encourage her to eat. During an interview, on 6/30/23 at 10:49 a.m., RN 31 indicated the weights were given to the ADON. The ADON followed up on any weight concerns. The ADON indicated, during an interview on 6/30/23 at 10:50 a.m., if a resident had a significant weight change, she would have the CNAs reweigh the resident. The resident had been reweighed on 6/26/23. She had been following the resident weights with the prior interim DON. During an interview, on 6/30/23 at 10:53 a.m., the DON indicated the medical record software program had not triggered the weight loss, and the facility had a new dietician. The weight loss had been missed. The facility did not have a system for who documented weights and followed up on those weights. Sometimes the nurses documented the weights, and sometimes the DON/ADON documented the weights. The physician should have been notified with any significant weight loss of five percent or greater. A current facility policy, provided by the DON on 6/30/23 at 12:15 p.m., titled "Change in Resident's Condition or Status," indicated the following: "...Policy: It is the policy of the facility to ensure that the resident's attending physician and representative are notified of changes in the resident's condition or status. Procedure: 1. The nurse will notify the resident's attending physician when: ...There is a significant change in the resident's physical, mental, or psychological status ...3. A significant change in condition is a decline or improvement in the resident's status that will not normally resolve itself without			

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	intervention by staff ...impacts more that one area of the resident's health status; and requires interdisciplinary review and/or revision of the care plan. 4. Except in medical emergencies, notification will be made within 24 hours of a change occurring in the resident's condition or status...." 3.1-22(b)(1)			
F 0880 SS=E 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 include, but are not limited to: (i) A system of surveillance designed to			

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	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. The facility will conduct an annual review of its IPCP and update their program, as			

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	necessary. Based on observation, interview, and record review, the facility failed to provide physician-ordered enhanced barrier precautions (EBP) for 3 of 6 residents reviewed for transmissions-based precautions (Resident 3, Resident 37, and Resident 95). Findings include: 1. Resident 37's clinical record was reviewed on 6/28/23 at 9:23 a.m. Current physician orders included clean area to right coccyx with wound cleanser, pat dry, apply collagen to area, and apply foam dressing daily and as needed for dislodgement or soilage (6/15/22), enhanced barrier precautions every shift for open wound (5/11/23), and monitor area to right buttocks daily until resolved (4/29/23). A 6/21/23 significant change MDS (Minimum Data Set) assessment indicated the resident had a stage 2 pressure injury (a partial thickness of loss of skin with exposed dermis). A current care plan indicated the resident had an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to two open areas present on admission (initiated 6/15/23). During an interview, on 6/28/23 at 10:21 a.m., CNA 34 indicated when a resident was on enhanced barrier precautions, they had a sign on their door and a cart with personal protective equipment (PPE) was beside their door. When she performed care on a resident with enhanced barrier precautions, she wore a gown and gloves. During an observation, on 6/28/23 at 11:02 a.m.,	F 0880	1. It is the policy of this facility to follow our Infection prevention and control program and review it at least annually. It is also the policy of this facility to provide signage, stating to see the nurse prior to entering, for those resident rooms currently under contact isolation protocols. 2. Any residents who are at risk for infection may be negatively impacted by this deficient practice. All residents under contact isolation have had their rooms audited for proper equipment and signage. Residents 3,37 and 95 were placed in enhanced barrier precautions, signs placed on doors, physician order obtained, and PPE made available to staff effective 6-30-23. An audit was completed for all residents requiring enhanced barrier precautions, physician orders obtained, signs placed on doors and PPE made available to staff. Audit was completed 7-24-23. 3. All staff has been educated on the policy “Enhanced Barrier Precautions-EBP” as well as the “Infection Control Policy and Procedure” policy under the “Infection Preventionist” policy by the ADON and/or designee on 7/21/23. Any employee who fails to comply with the points of the in-service will be further educated. 4. QAPI tool titled “Infection	07/24/2023

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	the resident's door lacked signage of enhanced barrier precautions and lacked a PPE cart beside her door. CNA 35 and CNA 36 entered the resident's room without taking in gowns or wearing gowns. During an interview, on 6/28/23 at 11:13 a.m., CNA 35 indicated the CNAs had gotten the resident ready for an appointment and transferred her to the wheelchair. On 6/29/23 at 10:01 a.m., during a wound care observation, RN 31 applied a gown prior to performing wound care on the resident. CNA 35 and 39 assisted with turning the resident, adjusting the resident's clothing and brief, and adjusting the linens. They did not wear gowns. The resident's brief was removed. The resident had two open areas approximately the size of the end of a pencil eraser to the right buttock near the coccyx and lacked dressings. RN 31 performed the wound treatment, and a dressing was applied. On 6/29/23 at 11:34 a.m., Housekeeper 37 placed an enhanced barriers precautions sign on the resident's door and a PPE cart beside the resident's door. The sign indicated providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use, wound care - any skin opening requiring a dressing. During an interview, at the time of the observation, Housekeeper 37 indicated she had been asked to put the sign on the door and bring the PPE cart. She did not remember the resident previously being on enhanced barrier precautions. During an interview, on 6/29/23 at 11:39 a.m., CNA		Compliance Audit" will be utilized five days a week for four weeks, three days a week for four weeks, then monthly for four months. Any conclusions from the audit will be further addressed in QAPI. Additionally, any concerns noted will be immediately addressed and corrected. 7/24/23	

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	38 indicated the resident had not been on enhanced barrier precautions as far as she knew until now. During an interview, on 6/29/23 at 3:57 p.m., the ADON indicated when a resident has orders for enhanced barrier precautions, gowns should be worn during resident care. 2. During an observation of a left foot heel wound dressing change for Resident 3 on 6/26/23 at 2:41 p.m., the registered nurse performing the dressing change did not wear a gown during the dressing change. No signage relating to enhanced barrier precautions (EBP) was posted on the resident's door or anywhere in the room. No EBP cart was observed outside the room. A record review on 6/27/23 at 1:28 p.m. of physician orders dated 5/11/2023 indicated Enhanced Barrier Precautions every shift for a wound with a history of Methicillin-resistant Staphylococcus aureus (MRSA). On 6/28/23 at 10:37 a.m., EBP signage was posted on Resident 3's door and a personal protective equipment (PPE) cart was located directly outside the resident's door. 3. During a medication observation, on 6/29/23 at 8:45 a.m., RN 7 entered Resident 95's room. A sign on the door indicated he was on enhanced barrier precautions, providers and staff must wear gloves and a gown for high-contact resident care activities that included device care or use, such as a central line or urinary catheter. RN 7 reconstituted the antibiotic into the 100 ml (milliliter) normal saline bag, spiked the IV tubing into the antibiotic solution bag, threaded the IV tubing through the IV pump, accessed the port on his PICC line, flushed the port with 10 ml normal saline, then connected the IV tubing with the			

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	antibiotic solution into the port on the resident's PICC (a type of central line). RN 7 did not don a gown during the high-contact activity when she accessed the resident's PICC line. During an interview, on 6/29/23 at 10:07 a.m., RN 7 indicated Resident 95 was on enhanced barrier precautions due to an infection. Resident 95's clinical record was reviewed on 6/29/23 at 9:45 a.m. Diagnoses included, bacteremia due to Escherichia coli (E-coli) and Extended Spectrum Beta-Lactamase (ESBL) (enzymes produced by some bacteria that may make them resistant to some antibiotics). Current physician orders, all with an order date of 6/28/23, included the following: Enhanced barrier precautions related to PICC (Peripherally Inserted Central Catheter) line and Foley catheter every shift for preventative. Meropenem (antibiotic), intravenous solution reconstituted, use two grams intravenously two times a day for infection until 8/3/23. SASH (Saline-Administration-Saline-Heparin) kit for PICC line, flush line with 10 ml of normal saline before and after each medication administration followed by 5 ml of heparin (anti-coagulant). Indwelling urinary catheter, catheter care every shift and ensure catheter drainage bag was below the waist and covered. A current care plan, dated 6/28/23, indicated he was on enhanced barrier precautions related to PICC line and indwelling catheter. The goals, with			

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	a target date of 9/26/23, indicated current isolation precautions would be maintained as long as the infection was active and he wound tolerate antibiotic treatment through duration without side effects or complications. The interventions included, set up isolation per facility protocol, educate resident/family on isolation, notify physician of any changes, and monitor for side effects of antibiotics. During an interview, on 6/30/23 at 11:22 a.m., the ADON indicated enhanced barrier precautions were used when staff provided high-contact resident care. This included accessing IVs. Review of a current facility policy, titled "ENHANCED BARRIER PRECAUTIONS-(EBP) An extension of Personal Protective Equipment-(PPE)," with a revised date of December 2022 and provided by the DON on 6/30/23 at 11:02 a.m., indicated the following: "...Enhanced Barrier Precautions (EBP): Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDRO's in the form of blood or body fluids, onto the hand and/or clothing of the rendering caregiver...Who is at "High Risk" for acquiring or spreading a MDRO?...* Resident(s) with an indwelling medical device including but not limited to: a) Central Venous Catheters...* Residents with wounds regardless of MDRO status. Examples of MDRO's are:...b) Extended Spectrum B lactamase-(ESBL) producing gram-negative bacteria...Examples of "High Contact" Resident Care Activities at which time EBP is to be practiced are: a) Dressing care/changes/management of dressings...g) Device Care or Use of to include: *Central Lines...*Wound Care (any related device) Procedure: 1) When engaging in any of the afore			

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	mentioned "High Contact" Resident Care Activities with a resident who has a known MDRO, or a colonized MDRO, or who would be a at a high risk to contact a MDRO-use gloves and gowns (EBP), with the same technique/practice as in Contact Precautions use. This includes all required Hand Hygiene before and after donning/doffing gloves and gowns. 2) Obtain a physician's order for the Enhanced Barrier Protection (EBP) and any additional precautions other than Universal/Standard Precautions. 3) Ensure that proper signage is posted on the resident's room door instructing those who plan to enter the room to check first at the Nurses' Station for education/instruction...." 3.1-18(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (6) Care of cognitively impaired residents. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given,	F 9999	1. In accordance with regulation, it is the policy of this facility to ensure all employees receive both the first and second steps of their Tuberculin Purified Protein Derivative (Mantoux). The first step shall be read prior to beginning employment and the second step three weeks into employment. Both Mantoux's should be read between 48 and 72 hours after injection. In accordance with regulation, it is the policy of the facility to ensure all employees receive 6 hours of dementia training upon hire and 3 hours annually thereafter. 2. Any employee or resident could be impacted by this	08/01/2023

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	date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: A. Based on record review and interview, the facility failed to ensure employees completed the required dementia training for 2 of 5 employee files reviewed for annual training (Laundry Assistant 40 and QMA 41). B. Based on record review and interview, the facility failed to perform a two-step baseline tuberculin skin test for three randomly selected students enrolled in the on-site nurse aide training		deficient practice. An employee audit has been concluded and any change needed completed as well. 3. An audit of employee files was completed on 7-17-23 for required dementia training and completion of two step Mantoux. Any employee without the two step Mantoux and dementia training will receive by 7-31-23. The Administrator and DON were in-serviced by the RDO on 7/20/23 as the procedures and expectations of the Mantoux process and staff education. 4. Audit tool “F9999” will be implemented and utilized by the Administrator and/or designee with 100% compliance of all new hires. Any conclusions made from the audit will be further discussed in QAPI. Any concerns noted will be immediately addressed and corrected. 5. 8/01/23	

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	program (Student 4, Student 5, and Student 6). Findings include: A. Employee records provided by the Administrator on 6/29/23 reviewed on 6/29/23 at 2:07 p.m. indicated the following: A.1. Laundry Assistant 40's employee file lacked 0.5 hours of annual dementia training. A.2. QMA 41's employee file lacked 1.5 hours of annual dementia training. A current, undated policy, provided by the Administrator on 6/30/23 at 4:50 p.m., titled "Orientation Guideline: To include scheduled Dementia Training," indicated the following: "...Policy: It is the policy of the facility to ensure that new staff members receive the required training and in-servicing as required by state and federal regulations, as well as by the facility's policies and procedures. This includes required Dementia Training..." While providing the policy the Administrator indicated this was all the facility had on annual dementia training and the phrase on the policy "training and inservicing as required by state and federal regulations" was what made the policy appropriate. B.1. Student 4's pre-employment document titled "Mantoux Tuberculin Skin Test Screening" provided by the DON on 6/30/23 at 3:45 p.m., indicated a first step tuberculin test was done on 9/13/22 at 10:30 a.m. No documentation was provided for the required second step tuberculin test. B.2. Student 5's pre-employment document titled "Mantoux Tuberculin Skin Test Screening,"			

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	provided by the DON on 6/30/23 at 3:45 p.m. indicated a first step tuberculin test was completed on 9/16/22 at 2:44 p.m. No documentation was provided for the required second step tuberculin test. B.3. Student 6's Student 5's pre-employment document titled "Mantoux Tuberculin Skin Test Screening," provided by the DON on 6/30/23 at 3:45 p.m. indicated a first step tuberculin test was completed on 7/27/22 at 9:25 a.m. No documentation was provided for the required second step tuberculin test. All three students completed the Nurse Aide Training Program in which they were enrolled. In an interview with the Administrator on 6/30/23 at 2:27 p.m., he indicated his understanding was the prior owner of the facility required only a one-step Mantoux tuberculin test for employees.			