STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING 00 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILL POND HEALTH CAMPUS	1014 MILL POND LANE GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 27, 28, 29, 30, October 3, 4, and 5, 2022 Facility number: 004550 Provider number: 155736 AIM number: 200526450 Census Bed Type: SNF: 8 SNF/NF: 33 Residential: 32 Total: 73 Census Payor Type: Medicare: 5 Medicaid: 26 Other: 10 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 17, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maurice Woolfolk	Executive Director	11/04/2022

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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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure privacy was provided during a catheter (a tube inserted into the bladder to drain urine) care observation (Resident 22) and a resident was not dressed in	F 0550	1. Resident 22 and 36 suffered no ill effects from the alleged deficient practice. 2. All residents have the potential to be affected by the alleged	11/08/2022

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	pants with holes in them (Resident 36) for 2 of 2 residents reviewed for dignity. Findings include: 1. On 9/29/22 at 1:25 p.m., Resident 22's catheter care was observed. Upon entrance to the resident's room, Resident 22 was observed lying in bed, pants off, in a brief (adult diaper), uncovered. Qualified Medication Aide (QMA) 15 and Certified Nursing Assistant (CNA)13 were in the resident's bathroom, washing their hands. QMA 15 and CNA 13 completed catheter care, and left the resident's bedside to wash their hands and retrieve a clean brief. During the time they were away from the bedside, the resident was left nude from the waist down, and uncovered. After QMA 15 and CNA 13 washed their hands and retrieved a clean brief, they returned to the resident's bedside, put the clean brief on the resident, and covered the resident up with a sheet. Resident 22's record was reviewed on 9/28/22 at 11:37 a.m. An annual Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident had a moderate cognitive impairment, an indwelling catheter, and required extensive assistance of 1 staff member for toileting and personal hygiene. A physician's order, dated 1/21/21, indicated Foley (a tube inserted through the urethra into the bladder to drain urine) catheter 16 French (F) (catheter size) with 5 milliliter (ml) balloon. A care plan, initiated 5/19/22, indicated the resident had a Foley catheter. Interventions included, but were not limited to, provide assistance with catheter care.		deficient practice. Residents clothing have been inspected for further holes. Privacy was provided with foley cath care AEB the curtain and door were closed during care. 3. Nursing staff will be educated on providing dignity to residents during foley catheter care and inspect clothing for any holes/ill fitting clothing. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	During an interview, on 9/29/22 at 2:07 p.m., Registered Nurse (RN) 14 indicated the resident should have been provided privacy during catheter care. On 9/29/22 at 11:31 a.m., the Director of Health Services (DHS) provided a document titled, "Urinary Catheter Care," and indicated it was the policy currently being used by the facility. The policy indicated, "...OVERVIEW: To prevent infection of the resident's urinary tract. SOP DETAILS: ...20. To perform the procedure: ...i. Provide privacy. Cover the resident with a sheet, exposing on the perineal area...." 2. During an observation, on 9/27/22 at 12:04 p.m., Resident 36 was observed in the restorative dining room with other residents and staff. A large hole in the right hip area of his sweat pants was observed, and his leg was clearly visible through the hole. Resident 36's record was reviewed on 10/3/22 at 10:07 a.m. Diagnoses on the resident's profile included, but were not limited to cerebral palsy (a congenital disorder of movement, muscle tone, or posture) unspecified and severe intellectual disabilities. A quarterly Minimum Data Set (MDS) assessment, dated 8/25/22, indicated the resident had a severe cognitive impairment and required extensive assistance of 2 staff members for dressing. A care plan, goal target dated 12/1/22, indicated the resident had potential for decline in current functional and cognitive status related to cerebral palsy. Interventions included, but were not limited to, provide required level of assistance for			

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	activities of daily living (ADL) (daily tasks related to resident care and hygiene) care including, but not limited to, dressing. During an interview, on 9/30/22 at 11:44 a.m., Licensed Practical Nurse (LPN) 12 indicated staff should not have dressed Resident 36 in clothes with holes in them. During an interview, on 9/30/22 at 11:47 a.m., Certified Nursing Assistant (CNA) 13 indicated she was aware Resident 36 had a hole in his pants on 9/27/22, and she assisted him with getting dressed that day. The resident's pants had holes in them from staff pulling them up. Sometimes they would put the pants with holes in them on the resident if he did not have anything else to wear. He needed new clothes, and she had told the nurse. During an interview, on 9/30/22 at 12:48 p.m., the Social Services Director (SSD) indicated she was not notified the resident needed clothes. The facility staff would have assisted in purchasing the resident's clothes because he did not have family to help him. The staff should not have dressed the resident in clothes with holes in them. On 10/3/22 at 12:00 p.m., the Director of Health Services (DHS) provided a document titled, "Resident Rights Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Resident Rights Guidelines. PURPOSE: To ensure resident rights are respected and protected and provide an environment in which they can be exercised. PROCEDURES: Procedure: ...2. Our residents shave a right to...a. Be treated with dignity and respect...."			

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F 0558 SS=D Bldg. 00	3.1-3(t) 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure a call light was kept within the resident's reach for 1 of 16 residents reviewed for call lights (Resident 25). Findings include: On 9/27/22 at 10:26 a.m., An unidentified staff member was observed leaving Resident 25's room. Resident 25 was observed up in the chair, in her room. The call light was lying on the resident's bed, not within the resident's reach. On 9/28/22 at 2:57 p.m., Resident 25 was observed sitting in the chair, in her room. The call light was lying across the bed, out of the resident's reach. On 9/29/22 at 1:11 p.m., Resident 25 was observed sitting in the chair, in her room, eating lunch. The call light was observed lying on the floor at the foot of the bed. At the same time, the resident indicated she was supposed to press the call button in order to get staff assistance, and the call light was, "over there," and pointed towards the foot of the bed. The resident indicated she was not able to reach the call light. On 9/29/22 at 1:24 p.m., Resident 25 was observed sitting in the chair, in her room. She yelled out,	F 0558	1. Resident 25 suffered no ill effects from the alleged deficient practice. Call light was put within reach of resident when found out of place. 2. All residents have the potential to be affected by the alleged deficient practice. Residents are observed to ensure call lights are within reach. 3. Nursing staff will be educated on call lights are within residents reach. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	11/08/2022

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	"Come here, come here, I need help!" Registered Nurse (RN) 14 entered the resident's room. On 9/29/22 at 1:34 p.m., Resident 25 was observed sitting in the chair, in her room, and her call light was within reach. At the same time, RN 14 indicated she was the nurse who entered the resident's room when she yelled out. She noticed the resident's call light was not within reach, and was on the floor. Call lights should have been kept within residents' reach. Resident 25 was able to use the call light if she could reach it. Resident 25's record was reviewed on 9/29/22 at 1:17 p.m. Diagnoses on the resident's profile included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere with behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 8/25/22, indicated the resident had a moderate cognitive impairment and required extensive assistance from staff for activities of daily living (ADL) (daily tasks related to resident care and hygiene). A care plan, goal target dated, 12/1/22, indicated the resident was at risk for falls. Interventions included, but were not limited to, keep call light within reach. On 10/4/22 at 10:46 a.m., the Executive Director (ED) provided a document titled, "Guidelines for Answering Call Lights," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Guidelines for Answering Call Lights. PURPOSE: To respond to the resident's request and needs. PROCEDURES: ...2. Ensure the call light is plugged in securely to			

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	the outlet and in reach of the resident...." 3.1-3(v)(1)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure residents were provided showers as preferred for 1 of 2 residents reviewed for	F 0561	1. Resident 27 suffered no ill effects from the alleged deficient practice. All residents are scheduled for showers per their	11/08/2022

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	choices (Resident 27). Findings include: During an interview, on 9/27/22 at 11:02 a.m., Resident 27 indicated she was scheduled for a shower twice a week but had only been getting a shower occasionally. Resident 27's record was reviewed on 9/29/22 at 2:10 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/17/22, indicated the resident was cognitively intact, required supervision-oversight for dressing, toilet use and personal hygiene, and required one-person physical help in part of bathing activity with impairments on both lower extremities. A profile care guide care plan, dated 4/5/22, indicated to shower resident per schedule. The medical record lacked documentation of refusal of showers. On 9/29/22 at 3:43 p.m., the Director of Health Services (DHS) indicated Resident 27 was scheduled for showers twice a week, on Mondays and Thursdays, with a staff setup for the showers, but the resident had not received two showers weekly, according to the shower sheets documentation. The DHS provided Resident 27's shower sheets documents for August and September 2022. The shower sheets documentation titled, "Point of Care ADL Report (MDS 3.0)," indicated the resident had received showers on 8/1/22, 8/5/22, 8/15/22, 8/18/22, 8/22/22, 8/25/22, 8/29/22, 9/1/22, 9/5/22, 9/8/22, 9/12/22, 9/19/22, 9/22/22, and 9/29/22. On 9/29/22 at 4:28 p.m., Clinical Support provided		preference. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been audited to ensure showers were given at least 2 times a week per their preference. 3. Nursing staff will be educated on giving showers twice a week per their preference and document any refusals. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	and identified a document as a current facility policy, titled "Guidelines for Bathing Preference," dated 5/11/16. The policy indicated, "...Purpose ...To establish a personal preference bathing routine...Procedures...1. The resident will be advised of Trilogy's guidelines for residents to self determine their plan of care and schedule during their stay in the campus...2. The resident shall determine their preference for bathing upon admission...a. Day of the week...b. Time of day - morning or evening...c. Type of bathing - tub bath, bed bath or shower...4. Bathing shall occur at least twice a week unless resident preference states otherwise...." 3.1-3(u)(3)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in			

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	§483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview the facility failed to ensure staff notified the physician that a resident was experiencing difficulty breathing, received timely intervention to reduce or alleviate anxiety and improve respiratory function for 1 of 3 residents reviewed for respiratory care. Finding include: The medical record was reviewed on 9/26/22 at	F 0580	1. Resident 8 was affected by alleged deficient practice. Residents have been reviewed for change in condition events. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been audited to ensure change in condition events have been completed. 3. Nursing staff will be educated	11/08/2022

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	12:55p.m. An entry in the progress notes by Registered Nurse (RN) 8, dated 9/5/22 at 4 p.m., indicated that Licensed Practical Nurse (LPN) 9 had reported that Resident 8 experienced difficulty breathing during the night shift. Resident 8 continued to complain of difficulty breathing in the morning. RN 8 administered Residents 8's albuterol inhaler that was ordered as needed and routine Ativan 1 milligram with poor results. RN 8 indicated that Resident 8 was not eating and had not had an appetite and complained of not feeling well at lunch. RN 8 assessed Resident 8 and noted faint crackles (abnormal lung sounds characterized by discontinuous clicking or rattling sounds) throughout the lungs, an increase in edema (puffiness caused by excess fluid trapped in the body's tissues) in arms and legs and a large weight increase. RN 8 notified the physician and orders were received to increase Lasix (a medication used to treat fluid retention). A nutrition progress note dated 9/25/22 indicated that resident's weight was 188.3 pounds, a loss of 16 pounds in 34 days. On 9/30/22 at 9:45 a.m., the Director of Nursing indicated that she was unaware that Resident 8 had been having difficulty breathing on 9/5/22 and 9/6/22. The Director of Nursing indicated that LPN 9 should have assessed Resident 8 and notified the physician. LPN 9 would receive education. On 9/30/22 at 1:15 p.m., the Director of Nursing provided a form titled "Notification of change in condition" and indicated it was the policy used for the notification to the physician. The policy indicated reasons to notify the physician immediately," ...A need to alter treatment significantly, ...A deterioration in health ....or		on completing change in condition events. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	clinical complications, ...". 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
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 accuracy of an Minimum Data Set (MDS) assessment for 1 of 17 residents MDS assessments reviewed (Resident 43). Findings include: Resident 43's closed record was reviewed on 10/4/22 at 11:03 a.m. The census indicated the resident had been admitted to the facility on 7/13/22 and discharged on 7/29/22. A social services progress note, dated 7/28/22 at 2:16 p.m., indicated the resident's family had met with the facility team to discuss his transfer to the AL. A recapitulation of stay, dated 7/28/22, indicated the resident was being discharged to an assisted living (AL) facility. An Interdisciplinary Team (IDT) progress note, dated 7/29/22 at 3:06 p.m., indicated the resident was discharging to the AL residence. A discharge, return not anticipated MDS assessment, dated 7/29/22, indicated the resident had been discharged on 7/29/22 to an acute	F 0641	SS=A Campus commits to correcting.	11/08/2022

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	hospital. During an interview, on 10/04/22 at 11:14 a.m., the Clinical Support indicated the MDS was coded in error related to the resident being discharged to their AL residence and not the hospital. On 10/4/22 at 11:37 a.m., the MDS Support provided a copy of the Center for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...A2100: OBRA (Omnibus Budget Reconciliation Act) Discharge Status...Coding Instructions: Code 01, community (private home/apartment, board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home...." 3.1-31(c)(8)			
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 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			

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	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 ensure that Resident care plans were person centered for 1 of 14 residents reviewed for depression. Findings include: On 9/28/22 at 1:10 p.m., the clinical record was reviewed for Resident 8. Diagnoses included but was not limited to, unspecified dementia, and major depressive disorder.	F 0656	1. Resident 8 suffered no ill effects from the alleged deficient practice. Residents with depression have been reviewed for person centered care plans. 2. All resident's with depression have the potential to be affected by the alleged deficient practice. Resident's care planned for psychotropic medications have been audited to ensure patient centered care plans are in place	11/08/2022

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	On 9/28/22 at 1:15 p.m., Resident 8's physician orders were reviewed and indicated that on 3/9/21 Sertraline (an antidepressant) 150 milligrams everyday was initiated for depression and on 6/6/22 Zoloft (an antidepressant) 150 milligrams everyday was initiated for Depression. On 9/28/22 at 1:36 p.m., Resident 8's care plan initiated on 3/8/21 for depression was reviewed. The problem indicated that Resident 8 demonstrated altered mood due to recent life losses and placement in facility. The care plan goal was listed as "Resident's altered mood will not result in uncompensated depression". The interventions listed were added on 3/8/21 and included, Adjustment counseling as needed, encourage healthy reminiscing, Medications as ordered, monitor for signs and symptoms of depression, observe residents' adjustment to facility, offer routine schedule and consistency of care, and refer to psych services. " On 9/29/22 at 2:52 p.m., in a progress note, dated 7/1/22 at 5:20 p.m., RN 8 documented that Resident 8 was crying uncontrollably and that multiple visits to Resident 8's room was made during the shift and Resident 8 was tearful each visit. On 9/27/22 at 11:04 a.m., during an interview with Resident 8, she was tearful and indicated feelings of loneliness and that no one at facility takes an interest in her problems. On 9/30/22 at 10:15 a.m., the Social Services Director (SSD) indicated that if a staff member needed to know how to care for Resident 8 specifically, they could ask her what her interest were. The SSD indicated that she would make		during CCM. 3. The SSD will be educated on ensuring care plans are patient centered. As a measure of ongoing compliance, executive director (ED) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Resident 8's care plan interventions person centered moving forward. On 9/30/22 at 1:15 p.m., the Director of Nursing provided a form titled "Comprehensive care plan guideline" and identified it as the facility care plan policy, The policy indicated " ...Care plan interventions should be reflective of risk areas or disease processes that impact the individual resident, ...Comprehensive care plans need to remain accurate and current ...." 3.1-35(a)			
F 0657 Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's			

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	needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a resident had been invited and been given opportunity to attend his care plan meeting (Resident 39), and that a care plan was revised (Resident 8) for 2 of 14 resident care plan meetings and care plans reviewed. Findings include: 1. During an interview, on 9/27/22 at 11:16 a.m., Resident 39 indicated he could not remember ever having or attending a care plan meeting. Resident 39's record was reviewed on 9/29/22 at 9:54 a.m. The census indicated the resident had been admitted to the facility on 7/15/19. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe) and type 2 diabetes mellitus with diabetic neuropathy (impairment in the way the body regulates and uses sugar [glucose] as a fuel with nerve damage that can occur if you have diabetes). A quarterly Minimum Data Set (MDS), dated 9/7/22, indicated the resident had moderate cognitive deficit. Review of Resident First Meeting (care plan) minutes indicated the following:	F 0657	1. Resident 39 and 8 suffered no ill effects from the alleged deficient practice. Residents will be invited to resident care conferences and will ensure interventions are in place per care plan. 2. All resident's have the potential to be affected by the alleged deficient practice. All resident's have been audited to ensure being invited to care conferences and interventions are in place according to care plans. 3. The SSD will be educated on inviting residents to care conferences and all nursing staff will be educated on ensuring interventions are in place per care plan. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	11/08/2022

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	a. A meeting note, dated 9/23/21, indicated the resident representative had participated in meeting via electronic device (phone, conference call, video chat, etc). The record lacked documentation of the resident participating, being invited, or refusal/declining to attend. the meeting. b. A meeting note, dated 12/16/21, indicated the resident representative had participated in meeting via electronic device (phone, conference call, video chat, etc). The record lacked documentation of the resident participating, being invited, or refusal/declining to attend. the meeting. c. A meeting note, dated 3/23/23, indicated the resident representative had participated in meeting via electronic device (phone, conference call, video chat, etc). The record lacked documentation of the resident participating, being invited, or refusal/declining to attend. the meeting. d. A meeting note, dated 6/6/22, indicated the resident representative had participated in meeting via electronic device (phone, conference call, video chat, etc). The record lacked documentation of the resident participating, being invited, or refusal/declining to attend. the meeting. e. A meeting note, dated 9/23/22, indicated the resident representative had participated in meeting via electronic device (phone, conference call, video chat, etc). The record lacked documentation of the resident participating, being invited, or refusal/declining to attend. the meeting. During an interview, on 9/29/22 at 2:37 p.m., the Social Services Director (SSD) indicated the resident had never attended the care plan meeting and wouldn't even remember if her had attended, since he had dementia. His step-son is involved			

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	and had participated via telephone in his care plan meetings. Their policy indicated all resident's should be invited to their meetings. She had not documented the resident had not attending the meetings. On 9/29/22 at 2:52 p.m., the Executive Director (ED) provided a document, with a revision dated of 3/7/19, titled, "Resident First Meeting Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: To facilitate communication and participation regarding the resident's plan of care, medical condition, and care needs between the resident, family, resident representative, and care givers. Procedures...6. Director of Social Services or designee should send invitations to the resident and/or representative notifying them of the date and time of the conference...12. Review of the resident's condition since the last meeting...and any areas of concern should be discussed with the team, family, and resident...13. Review the resident's goals and discuss with the team, family, and resident...."2. On 9/28/22 at 1:15 pm Resident 8's medical record was reviewed. Resident 8's diagnosis included but was not limited to Unspecified dementia, and Hairy cell leukemia not having achieved remission. The Minimum Data Set (MDS) completed on 7/21/22 indicated that Resident 8 requires extensive assist of two persons with transfers, dressing, toileting and personal hygiene. On 9/28/22 at 2:23 p.m., Resident 8's fall care plan that was initiated on 3/18/21 was reviewed and noted to have been updated on 6/8/22 to include dycem in the wheelchair as an intervention to the Resident 8's fall from 6/7/22.			

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	On 9/29/22 at 2:43 p.m., Resident 8's wheelchair was observed in the presence of the Director of Nursing and the dycem was not found in the wheelchair or the resident's room. The Director of Nursing indicated that she would obtain dycem and place it in Resident 8's wheelchair. On 9/30/22 at 12 p.m., the Director of Nursing provided a form titled, "Falls Management Programs and Guidelines," and indicated that it was a facility policy. The policy indicated " .... that care plan interventions should be implemented that address the resident's risk factors ...." 3.1-35(c)(1) 3.1-35(a)			
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 nail care was provided to a dependent resident for 1 of 16 residents reviewed for activities of daily living (ADL) (daily tasks related to resident care and hygiene) (Resident 25). Findings include: On 9/27/22 at 10:29 a.m., Resident 25 was observed with long, untrimmed fingernails on bilateral (both) hands with chipped nail polish and dark debris underneath them. On 9/28/22 at 2:57 p.m., Resident 25 was observed with long, untrimmed fingernails on bilateral	F 0677	1. Resident 25 suffered no ill effects from the alleged deficient practice and nail care had been provided by hospice services. 2. All resident's have the potential to be affected by the alleged deficient practice. All resident's have been observed that nail care has been provided per preference. 3. All nursing staff will be educated on providing nail care to residents. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2	11/08/2022

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	hands with chipped nail polish and dark debris underneath them. On 9/29/22 at 1:11 p.m., Resident 25 was observed with long, untrimmed fingernails on bilateral hands with chipped nail polish and dark debris underneath them. The resident was eating a grilled cheese sandwich. On 9/30/22 at 10:10 a.m., Resident 25 was observed with long, untrimmed fingernails on bilateral hands with chipped nail polish and dark debris underneath them. Resident 25's record was reviewed on 9/29/22 at 1:17 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/25/22, indicated the resident had a moderate cognitive impairment, required extensive assistance from 1 staff member for personal hygiene, received hospice (specialized care for the terminally ill) care while a resident, and lacked documentation the resident rejected care. Diagnoses on the resident's profile included, but were not limited to, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere with behavioral disturbance. A care plan, initiated 1/26/22, indicated the resident required assistance with ADL care related to a diagnosis of Parkinson's disease. A physician's order, dated 4/12/22, indicated hospice services related to terminal diagnosis of end stage Parkinson's disease. Progress notes, dated August and September		months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	2022, lacked documentation the resident refused nail care. Hospice visit task lists, dated 9/2/22, 9/7/22, 9/9/22, 9/14/22, 9/16/22, and 9/20/22, indicated nail care was provided by hospice staff. A hospice facility visit note, dated 9/27/22, indicated a shower and ADL care was provided. The note lacked documentation nail care was offered, provided, or refused. During an interview, on 9/29/22 at 3:25 p.m., the Director of Health Services (DHS) indicated the resident received showers twice weekly from the hospice service. During an interview, on 9/29/22 at 10:35 a.m., the DHS indicated hospice staff should have provided nail care during showers. Facility staff should have provided nail care if they noticed it needed done. If the resident refused ADL care it should have been documented. During an interview, on 10/3/22 at 11:32 a.m., the DHS indicated there was no facility policy for nail care. Nail care should have been provided with showers and as needed. Nail care should have included trimming, filing, and cleaning underneath the fingernails. 3.1-38(a)(3)(E)			
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			

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the facility failed to ensure a resident was safely transferred resulting in a resident sustaining a fracture of the left ankle during a transfer and failed to implement a post fall intervention (Resident 8) for 1 of 3 residents reviewed. Findings include: Resident 8's medical record was reviewed on 9/29/22 at 10:58 a.m. A review of the quarterly Minimum Data set (MDS) assessment, dated 4/22/22, indicated that Resident 8 required extensive assistance of one with toileting. The progress notes, on 6/7/22 at 12:15 p.m., indicated that CNA 10 was assisting Resident 8 to transfer from the toilet to the wheelchair. During the transfer, Resident 8's legs buckled, and the Resident was lowered to the floor, on her left foot. Resident 8 complained of pain and an ice pack was applied to left ankle. A progress note, dated 6/7/22, indicated an X-ray was ordered with the results as an acute nondisplaced fracture of the lateral malleolus and distal tibial diaphysis (Ankle). On 9/29/22 at 3:08 p.m., Certified nursing assistant (CNA) 10 was interviewed and indicated that on 6/7/2022 she was assisting Resident 8 off the toilet and into her wheelchair when Resident's legs buckled, and she sat on her left foot. CNA 10 indicated that her assignment sheet instructed	F 0689	1. Resident 8 was affected. Resident was provided the adequate supervision during transfer exercise. 2. All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and educating nursing staff will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All residents who have fallen with in the last 30 days have been reviewed for appropriate supervision. 3. Falls will be reviewed during CCM for adequate supervision. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	11/08/2022

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	155736	A. BUILDING 00 B. WING	10/05/2022

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	that Resident 8 requires two assistants to transfer and toilet. CNA 10 indicated that she did not remember why she had assisted Resident 8 without assistance. On 9/30/22 at 2:50 p.m., the Director of Nursing (DON) provided a form titled,"Teachable moment" dated 6/8/22 that was addressed to CNA 10, a certified nursing assistant, that listed "Education provided to verify resident transfer status on CRCA (CNA) assignment sheet prior to providing care." The DON indicated that in-servicing and education was not performed for other nursing staff. A review of the quarterly Minimum Data set (MDS) assessment, dated 7/21/22, indicated that Resident 8 required extensive assistance of two with transfers and toileting. On 9/29/22 at 2:43 p.m., the care plan was reviewed and had been revised on 9/28/22. An intervention was added to the care plan after the fall on 6/7/22 to apply dycem in the resident's wheelchair. An observation of Resident 8's wheelchair was made in the presence of the DON, and dycem was not present in the wheelchair. The DON looked in the resident's wheelchair and indicated that dycem was not found in the wheelchair and that she would go and get some for the chair. On 9/30/22 at 12 p.m., the DON provided a document titled "Fall Management Program Guidelines" and indicated it was the policy being used for falls. The policy indicated " ...Trilogy Health Services recognizes even the most vigilant efforts may not prevent falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury .... communicate		will be reviewed and updated as warranted.	

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	interventions during shift report .... a review by the Interdisciplinary team to evaluate thoroughness of the investigation and appropriateness of the interventions .... " 3.1-45(a)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must			

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	ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview, observation, and record review, the facility failed to ensure catheters (a tube inserted into the bladder to drain urine) were not inserted without a clinical justification resulting in actual harm when a resident had multiple urinary tract infections (UTI) and 2 hospital transfers for UTI's (Resident 22) and catheter tubing and bags were not in direct contact with the floor (Residents 22 and 19) for 2 of 3 residents reviewed for catheters and UTI's. Findings include: 1. During an interview, on 9/27/22 at 10:51 a.m., Resident 22 indicated she was not sure why she had a catheter, and wished she did not have it. She had severe bladder pain, and was not sure if she had been checked for a UTI. At the same time, the resident was observed up in her wheelchair in the lounge area, with the catheter bag partially inside a dignity bag (bag to cover up the urine drainage system to provide privacy). The dignity bag was dragging the floor. On 9/27/22 at 12:46 p.m., Resident 22 was observed up in her wheelchair, on the patio, with the Foley (a flexible tube inserted through the urethra into the bladder to drain urine) catheter bag dragging the floor. On 9/27/22 at 3:14 p.m., Resident 22 was observed up in her wheelchair, propelling herself down the hallway, and the Foley catheter tubing was touching the floor. The Foley catheter bag was partially inside the dignity bag, and the dignity bag was dragging the floor.	F 0690	1. Resident 22 was affected by alleged deficient practice. Resident did have appropriate diagnosis for foley catheter. 2. All resident's with foley catheters are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the residents have the appropriate diagnosis to have a foley catheter to remain in place and foley catheter bags will not come in contact to the floor. All residents with foley catheters have been reviewed for appropriate clinical documentation to remain in place as needed. Foley catheter has been removed and monitoring for output was initiated. 3. Residents will be reviewed in CCM for clinical documentation for foley catheters. Education to nurses will be completed on appropriation if foley catheters and ensuring catheter bags don't touch the floor. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	11/08/2022

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	Resident 22's record was reviewed on 9/28/22 at 11:37 a.m. An annual Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident had a moderate cognitive impairment, an indwelling catheter, and required extensive assistance of 1 staff member for toilet use. Census information indicated the resident was admitted to the facility on 10/8/19. An admission assessment, dated 10/8/19, indicated was continent of the bladder and did not have an indwelling catheter. A physician's order, dated 1/19/21, and discontinued 10/15/21, indicated Foley catheter 16 French (F) (size of catheter tubing) and 5 milliliter (ml) balloon. A progress note, dated 1/20/21, indicated the resident's hospice (specialized care for the terminally ill) nurse placed a Foley catheter the day before, 16 F and 5 ml balloon. The note lacked documentation of a clinical indication for the catheter or any indication the resident had urinary retention. A progress note, dated 1/21/21, indicated an Interdisciplinary Team (IDT) review of the Foley catheter placement for urinary retention. The note lacked documentation of the urinary retention or any other clinical indication for the catheter. A diagnosis, dated 1/21/21, indicated neuromuscular dysfunction of the bladder (lacking bladder control due to brain,, spinal cord, or nerve problems). The diagnosis lacked documentation of any supporting documentation.		least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	A physician's order, dated 10/23/21 and discontinued 9/13/22, indicated furosemide (a diuretic medication) 40 milligrams (mg) by mouth daily. A progress note, dated 10/24/22, indicated the resident no longer received hospice services. A physician's progress note, dated 12/21/21, indicated the resident urinated too much and wanted a catheter. The physician's assessment indicated incontinence and the plan was to discontinue torsemide (a diuretic) to see if it helped with urination and to possibly increase the oxybutynin at the next visit if no improvement. A re-admission nursing assessment, dated 3/5/22, indicated the resident did not have an indwelling catheter. A physician's progress note, dated 4/7/22, indicated the resident complained frequently of urination and leaking, and wanted to try something. The resident was on furosemide for chronic swelling of legs, still some edema (swelling), planned to try oxybutynin 10 mg every day. A physician's progress note, dated 5/5/22, indicated the resident was seen related to sore right upper quadrant of abdomen, complained of bloating, and gas. Physician's orders included, but were not limited to, discontinue oxybutynin to see if it helped gas. A progress note, dated 5/16/22, indicated the resident had a non-healing wound to the right inner groin, history of urinary incontinence, usual inability to know when incontinent, and increased moisture when up in wheelchair due to sweating			

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	and briefs (adult diaper). Physician ordered a Foley catheter be inserted through 5/30/22, and removed on 5/31/22, if improvements were noted. If none noted, the physician was to be updated for further direction. The note lacked documentation the resident had urinary retention or another diagnosis to support the insertion of a Foley catheter. A progress note, dated 5/16/22, indicated an 18 F, 30 ml balloon Foley catheter was inserted with sterile technique. The notes lacked documentation the resident had urinary retention or another diagnosis to support the insertion of a Foley catheter. A progress note, dated 5/16/22, indicated IDT review of Foley catheter, placement was to promote healing to inner groin from urine excoriation. The note lacked documentation the resident had urinary retention. A care plan, date initiated 5/19/22, indicated the resident had a Foley catheter for neurogenic bladder. Interventions included, but were not limited to, observe for signs or symptoms of UTI. A progress note, dated 5/21/22, indicated the Foley catheter, 18 F, 30 ml, was replaced using sterile technique due to occlusion. Cloudy urine with sediment was immediately returned. The note lacked documentation the resident had urinary retention or another diagnosis to support the insertion of a Foley catheter. Progress notes lacked documentation the Foley catheter was followed up on 5/30/22, as ordered by the physician. A progress note, dated 6/13/22, indicated the			

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	nurse attempted to flush the Foley catheter but was unsuccessful. The Foley catheter was repositioned, and flush attempted again, but was unsuccessful. The catheter was removed, and re-anchored with an 18 F and 30 ml balloon. Cloudy yellow urine was immediately returned. The note lacked documentation the resident had urinary retention or another diagnosis to support the insertion of a Foley catheter. A progress note, dated 6/18/22, indicated the resident had a yeast like odor to the vaginal area, and white discharge was noted. The physician was notified. A physician's order, dated 6/19/22, indicated Diflucan (a medication for fungal infections) 150 mg by mouth one time only for vaginal yeast infection. A progress note, dated 6/19/22, indicated the resident remained with a yeast like odor to the peri (groin) area. A Diflucan was administered that morning. A progress note, dated 7/6/22, indicated the physician was notified a urine chemical strip (detects changes in a person's urine such as potential infections) was performed with positive results. The resident complained of burning and discomfort. The resident's urine was noted with a strong, foul odor, and visible sediment. A sample was sent to the lab. A progress note, dated 7/7/22, indicated the resident was tearful the last evening and complained of urinary and back pain related to UTI. As needed pain medications were administered as ordered and a new order for pyridium (a urinary pain relief medication) was			

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	obtained. A progress note, dated 7/8/22, indicated the lab was unable to do a culture on the urine sample sent related to multiple organisms were present A recollection was indicated. The physician ordered the urine to be re-collected and sent to the lab for further work up. A progress note, dated 7/8/22, indicated a new urine sample was collected for lab pick up. A physician's order, dated 7/8/22, indicated Azo urinary pain relief (a medication to ease bladder pain) 99.5 mg by mouth 4 times a day as needed for urinary burning. A progress note, dated 7/10/22, indicated the resident had a fever earlier in the shift and had positive urinalysis results after recollection due to contamination. The physician was notified of the results and ordered Cipro (an antibiotic) 500 mg by mouth twice daily for 7 days. A physician's progress note, dated 7/11/22, indicated the resident was seen for multiple problems including, but not limited to, upset stomach and back pain. The resident was previously on hospice services, but was discharged when she had a fecal impaction. The assessment indicated the resident had a UTI, and the plan was to change the Cipro to Levaquin (an antibiotic) 500 mg by mouth for 10 days. A physician's order, dated 7/10/22 and discontinued on 7/11/22, indicated Cipro 500 mg by mouth twice daily for UTI. A physician's order, dated 7/12/22 and completed 7/22/22, indicated levofloxacin 500 mg daily.			

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	A progress note, dated 7/25/22, indicated the resident complained of bladder pain, and the catheter had a moderate amount of cloudy yellow urine. Water intake was encouraged and the resident was given an as needed Azo tablet. A progress note, dated 7/27/22, indicated the resident complained of generalized pain throughout the abdomen. The resident was not able to say exactly where the pain was, but responded when the area near the bladder was palpated. The resident had a functional Foley catheter. The physician was notified. A physician's progress note, dated 7/27/22, indicated the resident was seen related to complaints of right upper quadrant and epigastric (upper abdomen) pain and cried during the exam. The resident was not sure if she wanted to go to the emergency room, but eventually agreed to go. The resident had a Foley catheter for urinary retention. The note lacked documentation of when or how the urinary retention was diagnosed. A diagnosis, dated 7/27/22, indicated acute cystitis (infection of the bladder or lower urinary tract) without hematuria (blood in urine). Hospital records, dated 7/27/22, indicated the resident was treated for an acute UTI with cystitis, no hematuria. The resident was prescribed Macrobid (an antibiotic) 100 mg by mouth every 12 hours for 7 days. The resident present to the hospital with a Foley catheter, which was changed while she was there. A computed tomography (CT) scan (medical imaging technique used to obtain detailed internal images of the body) of the abdomen and pelvis was performed at the hospital and indicated the left ureter (thin tube between			

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	kidney and bladder) was dilated and no urethral calculus (stone) was noted. The dilation was possibly due to a recently passed stone. A progress note, dated 7/27/22, indicated the resident returned from the hospital, and Macrobid 100 mg twice daily for 7 days was ordered. A physician's order, dated 7/28/22 and completed 8/3/22, indicated Macrobid 100 mg by mouth twice daily for UTI. A physician's order, dated 7/30/22, indicated Foley catheter, indwelling urinary catheter size 18 F with 10 ml balloon for neuromuscular dysfunction of the bladder. A physician's progress note, dated 8/31/22, indicated the resident was seen related to complaints of bladder spasms, and had chronic Foley for neurogenic bladder and urine retention. The progress note lacked documentation the Foley catheter was actually inserted related to urine excoriation and any support for how the neurogenic bladder or urinary retention were diagnosed. The physician ordered oxybutynin 5 mg twice daily. A physician's order, dated 9/13/22, indicated oxybutynin 10 mg by mouth twice daily for bladder spasms. A physician's order, dated 9/13/22, indicated furosemide 40 mg by mouth twice daily for edema. A physician's progress note, dated 9/13/22, indicated the resident was seen related to complaints of bladder spasms and pain. The resident had a standard Foley catheter in place and increased swelling to the left leg. The			

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	physician ordered to increase the oxybutynin to 10 mg twice daily and increase Lasix to 40 mg twice daily. A progress note, dated 9/18/22, indicated the resident complained of abdominal pain at a 10 out of 10 on the pain scale despite medication being administered. The resident had watery stool, nausea and vomiting, and abdominal distention with a history of bowel obstructions. The resident was sent to the emergency room for evaluation and treatment. Hospital records, dated 9/18/22, indicated the resident was treated for an acute UTI with cystitis and hematuria. The resident complained of abdominal pain and was not sure when it started. The resident was prescribed Macrobid 100 mg by mouth every 12 hours for 7 days. A CT scan of the abdomen and pelvis was performed at the hospital and indicated the bladder was decompressed with a Foley catheter in place, and there were nonobstructing stones in the left kidney. Impressions of the CT scan included, but were not limited to, inflamed appearing urinary bladder with Foley catheter in place with possible cystitis, correlate with urinalysis (urine test to check for infection). A progress note, dated 9/19/22, indicated an IDT review of the hospitalization. The resident was sent to the hospital for abdominal pain and the resident returned from the emergency room with a diagnosis of UTI, to be treated with an antibiotic. The clinical record lacked documentation the resident was referred to a urologist (a physician who specializes in the urinary system) or any supporting documentation the resident had urinary retention.			

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During an interview, on 9/29/22 at 9:39 a.m., the Director of Health Services (DHS) indicated the resident had a diagnosis of neuromuscular dysfunction of the bladder prior to the catheter insertion in May 2022. She was not sure why the catheter was inserted in May or what testing or clinical justification was found for the diagnosis.

During an interview, on 9/29/22 at 10:48 a.m., the DHS indicated the Foley catheter was inserted in May 2022 for moisture associated skin breakdown, and this was not a normal reason a catheter would have been placed. She was not able to find any follow up was done for the catheter as per the physician's order, and the catheter was left in place. She reviewed the documentation from when the resident had a Foley catheter from January to October 2021, and was unable to find any supportive documentation for the diagnosis of urinary retention or neuromuscular dysfunction of the bladder. The resident was on hospice services at the time, but was not any longer. Foley catheter tubing and bags should not have been in contact with the floor. The resident was not referred to a urologist.

On 9/29/22 at 11:31 a.m., the DHS provided a document titled, "Guidelines for the Use of Indwelling Catheter," and indicated it was the policy currently being used by the facility. The policy indicated, "...OVERVIEW: The purpose of urinary catheterization is to provide urinary drainage when medically necessary and to evaluate its continued use. A resident who enters the campus with an indwelling urinary catheter, or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary...An indwelling

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	catheter is not used unless there is a valid medical justification; An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted by the attending physician and/or urologist...A resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible...SOP DETAILS: 1. Urinary catheters are deemed medically necessary for the following reasons and must have supporting diagnosis for its use (per the interpretive guidelines): a. Resident has acute urinary retention or bladder outlet obstruction...f. Other conditions as deemed valid by the attending physician and/or urologists with supporting documentation. Examples of Inappropriate Uses of Indwelling Catheters: g. As a substitute for nursing care of the resident with incontinence...." 2. On 9/28/22 at 9:36 a.m., Resident 19 was observed sitting in a wheelchair by the nurses' station. Resident 19's catheter (a tube inserted into the bladder to drain urine) tubing was observed touching the floor underneath his wheelchair. On 9/28/22 at 2:34 p.m., Resident 19 was observed lying in bed with his eyes closed, the catheter bag was observed hanging from bed frame with the catheter tubing on the floor. On 9/29/22 at 10:51 a.m., the Director of Health Services (DHS) indicated catheter tubing should not be on the floor. On 9/30/22 at 12:19 p.m., Resident 19 was observed sitting in a wheelchair in the main dining room eating lunch with the catheter tubing touching the floor.			

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	155736	A. BUILDING 00 B. WING	10/05/2022

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	On 9/30/22 at 12:28 p.m., Resident 19 was observed sitting in a wheelchair propelling himself from the dining room with the catheter tubing dragging onto the floor. At that time, the Clinical Support observed the resident propelling himself with the catheter tubing touching the floor and indicated Resident 19's catheter tubing should not be touching the floor. The Clinical Support indicated she would go and assist Resident 19 with his catheter tubing to get the tubing off the floor. On 10/5/22 at 12:42 p.m., Resident 19 was observing sitting in a wheelchair propelling himself from the dining room with the catheter tubing dragging the floor. Resident 19's record was reviewed on 9/29/22 at 10:26 a.m. Diagnoses included but were not limited to, benign prostatic hyperplasia (prostate gland [a gland surrounding the neck of the bladder] enlargement that can cause urination difficulty), retention of urine, and obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract). A quarterly Minimum Data Set (MDS) assessment, dated 9/22/22, indicated the resident was cognitively intact, had an indwelling catheter, required extensive assistance of one person for toilet use, required extensive assistance of two persons for dressing and personal hygiene, and had impairments of the lower extremities (hip, knee, ankle, foot) on both sides. A bowel and bladder care plan, initiated on 12/6/19, indicated Resident 19 required a suprapubic (S/P) (a surgically created connection between the urinary bladder and the skin used to			

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	drain urine from the bladder in individuals with obstruction of normal urinary flow) catheter. Interventions included but were not limited to leg strap in place to prevent resident's catheter from being pulling out, provide assistance with catheter care and change catheter per physician orders with the goal, target dated 12/29/22, of the resident will be free from adverse effects from catheter use. A physician's order, dated 4/10/22, indicated Resident 19 required a S/P catheter with daily and as needed care to cleanse area around S/P site and the catheter to be changed every four weeks. On 9/29/22 at 11:31 a.m., the DHS provided a document titled, "Urinary Catheter Care," and indicated it was the policy currently being used by the facility. The policy indicated, "...OVERVIEW: To prevent infection of the resident's urinary tract. SOP DETAILS: ...11. Be sure the catheter tubing and drainage bag are kept off the floor...." 3.1-41(a)(1) 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight			

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	range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview, record review, and observation, the facility failed to ensure fresh water was consistently provided to the residents, for 1 of 1 resident reviewed for hydration (Resident 42) and for 2 of 2 residents during a random observation (Residents 39 and 5). Findings include: During an interview, on 9/27/22 at 3:10 p.m., Resident 42 indicated she did not regularly get fresh water. Resident 42's record was reviewed on 9/28/22 at 11:53 a.m. The profile indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (stroke) affecting left non-dominant side. An admission Minimum Data Set (MDS), dated 9/14/22, indicated the resident had moderate cognitive deficit and required set-up with eating. During a random observation of the 200 hall, on 9/28/22 at 1:48 p.m., fresh ice water was being	F 0692	1. Resident 42, 39, 5 were not affected by alleged deficient practice. All residents have been observed for fresh ice water consistently and corrected. 2. All residents have the potential to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the residents have fresh ice water on a consistent basis. 3. Residents rooms will be observed for fresh ice water. Nursing staff will be educated on process of ensuring fresh ice water is offered. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus	11/08/2022

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	passed to all of the residents on the hall. During an observation of Resident 42's room, on 9/28/22 at 2:36 p.m., the resident was not in her room. A Styrofoam cup of ice water was sitting on the resident's bed side table (BST). The cup was dated 9/28/22. During an observation of the resident's room, on 9/29/22 at 9:52 a.m., the resident was not in her room. A Styrofoam cup was observed sitting on the resident's BST. The cup was dated 9/28/22. During a random observation, on 9/30/22 at 9:22 a.m., the resident was in therapy. At the same time, when asked if she had received fresh water, she indicated she only gets it sometimes. During a random observation of the resident's room, on 9/30/22 at 2:44 p.m. the resident's was not in her room. A Styrofoam cup was observed sitting on the resident's BST. The cup was dated 9/28/22. During an interview, on 9/30/22 at 3:00 p.m., Certified Nursing Assistant (CNA) 19 indicated water was supposed to be passed on the night shift. The day shift would pass if they had time to pass to. If a resident requested water during the day shift the staff would get them some fresh water. During an interview, on 9/30/22 at 3:24 PM CNA 13 indicated the CNAs typically would pass water daily. It may have been overlooked the past couple of days due to the State being in the building and them being very busy. Lack of staff would play a small part in this, but it should still be done.		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	During a random observation, on 9/30/22 at 3:28 p.m., Resident 39 and Resident 5 were observed in their room. No water was observed on either of their BSTs. At the same time, Resident 39 indicated no one had passed water to them today and it was "hit and miss" if the night shift would give them fresh water. Resident 5 indicated she could use a cup of cool water as she was thirsty. During an interview, on 10/03/22 at 2:20 p.m., the Director of Health Services (DHS) indicated she was unsure if there was a facility policy regarding passing of fresh water. The staff were supposed to pass fresh water twice daily. Staff must have just missed passing the water from 9/28/22 until 9/30/22. During an interview, on 10/03/22 at 3:32 p.m., the MDS Support indicated she had not been able to locate a policy on passing fresh water. 3.1-46(b)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure an as needed (PRN) antianxiety medication was not ordered for longer than 14 days and PRN administrations of the medication were monitored for 1 of 5 residents reviewed for unnecessary medications (Resident 25).	F 0758	1. Resident 25 suffered no ill effects from the alleged deficient practice and MD has documented his clinical justification to keep PRN psychotropic for the resident. 2. All residents with PRN psychotropics have the potential	11/08/2022

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	Findings include: Resident 25's record was reviewed on 9/29/22 at 1:17 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/25/22, indicated the resident had a moderate cognitive impairment. Diagnoses on the resident's profile included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere with behavioral disturbance and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). A physician's order, dated 4/12/22, indicated hospice (specialized care for the terminally ill) services related to terminal diagnosis of end stage Parkinson's disease. A progress note, dated 8/15/22, indicated the resident's hospice nurse was in the facility to assess the resident. An order was given for lorazepam. The note lacked documentation of any support the PRN order was to be in place longer than 14 days. A physician's order, dated 8/16/22, indicated lorazepam intensol (an antianxiety medication) concentrate 2 milligrams (mg) per milliliter (ml), administer 0.25 ml by mouth every 4 hours PRN for anxiety and restlessness. The order lacked documentation of a clinical justification for leaving it in place longer than 14 days. A medication administration record (MAR), dated August 2022, indicated the lorazepam intensol 0.25 ml was administered 1 time. The MAR lacked documentation of any non-pharmacological		to be affected. All residents with PRN psychotropic medication orders were audited for 14 day stop date or MD clinical indication to continue PRN medication. 3. All nursing staff have been in serviced on 14 day PRN stop date. Systemic change is campus will review PRN medications daily in CCM to assure stop dates or MD clinical indication to continue are in place. As a measure of ongoing compliance, director of health services (DHS) or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	interventions attempted prior to the administration of the medication. A MAR, dated September 2022, indicated lorazepam intensol 0.25 ml was administered 20 times. The MAR lacked documentation of any non-pharmacological interventions attempted prior to the administration of the medication. A care plan, date initiated 9/1/22, indicated the resident was at risk for adverse consequences related to receiving antianxiety medication for anxiety. Interventions included, but were not limited to, attempt non-pharmacological interventions prior to the administration of the PRN antianxiety medication. During an interview, on 9/30/22 at 11:11 a.m., the Clinical Support Registered Nurse (RN) indicated when a PRN antianxiety medication was administered the staff should have documented non-pharmacological interventions attempted prior to administration. This should have been documented on the MAR with the PRN administration documentation. During an interview, on 9/30/22 at 12:50 p.m., the Director of Health Services (DHS) indicated there should have been an area on the MAR for non-pharmacological interventions to be documented with the documentation of the administration of the medication. She was unable to find any supporting documentation from the physician for the PRN antianxiety medication to be in place longer than 14 days. Normally hospice would have provided documentation, but there was nothing available from them. On 9/30/22 at 1:14 p.m., the MDS Corporate Support provided a document titled,			

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	"Psychotropic Medication Usage and Gradual Dose Reductions," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Psychotropic Medication Usage and Gradual Dose Reductions. PURPOSE: To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. PROCEDURES: 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...8. Orders for PRN medications will have designated purpose for use. Administration of PRN medications will be documented in the eMAR and indicate prior interventions to include; non-pharmacological interventions. 9. PRN order for psychotropic drugs are limited to 14 days. Except as provided if the attending physician or prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order...." 3.1-48(a)(4)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(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, interview, and record review, the facility failed to ensure hand hygiene was completed when assisting residents to eat during 2 of 2 restorative dining observations (Residents 36, 2, 11, 93, and 25). Findings include: During a continuous restorative dining room observation, on 9/27/22 from 11:56 a.m. to 12:15 p.m., Certified Nursing Assistant (CNA) 13 was observed wearing gloves and assisting Residents 36 and 2 to eat. CNA 13 rubbed her nose through her surgical mask with a gloved hand, and continued to assist Resident 36 to eat. Resident 2 picked up her plate and attempted to lick the food that was on it. CNA 13 removed the plate from Resident 2's hands and placed on the table, removed her gloves, and gave Resident 36 a bite of food. No hand hygiene was performed between residents. CNA 13 then performed hand hygiene, put on new gloves, gave Resident 36 a bite of food, removed her gloves again, and gave Resident 11 a bite of food. No hand hygiene was	F 0812	1. Residents 36, 2, 11, 93, and 25 suffered no ill effects of alleged deficient practice. Staff were educated on proper had hygiene during restorative dining activity. 2. All restorative dining residents have the potential to be affected. Restorative dining processes have been observed to ensure proper hand hygiene is in place during feeding activity. 3. All nursing staff have been educated on proper hand hygiene. As a measure of ongoing compliance, executive director (ED) or designee will observe 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred	11/08/2022

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	performed between residents. CNA 13 performed hand hygiene, put on new gloves, gave Resident 36 a bite of food, removed gloves, retrieved another drink for Resident 2 and assisted her to take a drink upon returning to the table. No hand hygiene was performed between the residents. During a continuous restorative dining room observation, on 9/30/22 from 12:14 p.m. to 12:30 p.m., CNA 13 was observed wearing gloves and assisting Resident 36 to eat. CNA 13 then assisted Resident 93 to get a drink, touching her straw, wearing the same gloves. No hand hygiene was performed between residents. CNA 13 removed the gloves, performed hand hygiene, and put on new gloves. CNA 13 gave Resident 25 a bit of food, then returned to Resident 36 and assisted him to eat. CNA 13 touched Resident 2's plate and moved it closer to the resident. CNA 13 then returned to Resident 93, assisted her to get a drink, touching her straw with a gloved hand. No hand hygiene was performed between residents. CNA 13 removed the gloves, performed hand hygiene, and put on new gloves. CNA 13 assisted Resident 25 to get a bite of food and take a drink, then returned to Resident 36 and assisted him to eat. CNA 13 returned to Resident 93 and assisted her to get a drink. No hand hygiene was performed between residents. CNA 13 then performed hand hygiene, retrieved a napkin, and wiped Resident 93's mouth bare handed. CNA 13 washed her hands, put on new gloves, returned to Resident 36, and assisted him to eat. CNA 13 moved Resident 2's plate closer to her on the table and assisted her to eat. CNA 13 returned to Resident 25 and attempted to give her a bite of food, but she refused. No hand hygiene was performed between residents. During an interview, on 9/30/22 at 12:40 p.m., CNA		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	13 indicated she should have performed hand hygiene between resident contacts and anytime she removed her gloves. During an interview, on 9/30/22 at 12:50 p.m., the Director of Health Services (DHS) indicated hand hygiene should have been performed in the dining room between residents. Gloves were not required to be worn, but if they were worn, they should have been removed, and hand hygiene performed between residents. On 9/30/22 at 1:17 p.m., the Minimum Data Set (MDS) Corporate Support provided a document titled, "Guideline for Handwashing/Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Guideline for Handwashing/Hand Hygiene. PURPOSE: Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol based hand rub (ABHR). 1. All health care workers shall utilize hand hygiene frequently and appropriately...3. Health Care Workers shall use hand hygiene at times such as: ...b. Before/after preparing/serving meals, drinks...c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions...." 3.1-21(i)(3)			
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			

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	155736	A. BUILDING 00 B. WING	10/05/2022

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	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 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			

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	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 necessary.			
	Based on observation, record review, and interview, the facility failed to ensure gloves were worn during insulin administration during 1 of 1 observations of insulin administration (Resident 40). Findings include: On 9/28/22 at 9:53 a.m., Registered Nurse (RN) 17 was administered Humalog (fast acting insulin) 7 units (u) subcutaneously (SQ) (the fatty layer between the skin and muscle) to Resident 40. RN 17 administered the insulin injection bare handed, no gloves were donned.	F 0880	1. Resident 40 suffered no ill effects of alleged deficient practice. RN 17 was immediately educated on following standard precautions. 2. Root Cause determined that RN 17 needed to be re-educated, competency performed and monitored for compliance more frequently. Root Cause also determined to be that RN 17 was nervous being observed and ensuring all other processes were followed.	11/08/2022

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	Resident 40's record was reviewed on 10/3/22 at 2:23 p.m. An admission Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident had a severe cognitive impairment. A physician's order, dated 9/6/22, indicated Humalog 5 u SQ three times a day, before each meal, in addition to sliding scale. A physician's order, dated 9/6/22, indicated Humalog SQ three times a day via sliding scale, 2 u were administered per sliding scale during the 9/28/22 observation. During an interview, on 10/3/22 at 11:58 a.m., RN 14 indicated gloves should have been worn during insulin injections. During an interview, on 10/3/22 at 2:21 a.m., the Director of Health Services (DHS) indicated gloves should have been worn during insulin injections. On 10/3/22 at 3:30 p.m., the MDS Corporate Support provided a document titled, "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES," and indicated it was the policy currently being used by the facility. The policy indicated, "...Put on gloves. Intradermal, Subcutaneous, Intramuscular...." 3.1-18(a)		The LTC Infection Control self-assessment was reviewed, and applicable changes were made. Training was completed for RN 17 with return demonstration to ensure competency. RN 17 did rectify her actions by utilizing gloves appropriately during insulin administration. 3. Training was initiated for all licensed nurses on infection control practices regarding insulin administration and wearing gloves when being administered. 4. The IP Nurse/DON/Designee will complete daily infection control rounds, as well as visual rounds, throughout the campus to ensure staff are practicing appropriate infection control practices. The rounds will include monitoring for compliance with the solutions identified in the root cause analysis. The rounds will occur 5 days a week for six weeks, then 3 days a week for four weeks, then weekly for two quarters. Results of rounds will be submitted to QAPI for review to ensure increased compliance goals. QAPI Committee will update and make changes to DPOC as needed to sustain substantial compliance for no less than six months. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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F 9999 Bldg. 00	1. 410 IAC 16.2-3.1-14 Personnel (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, 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. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as eveidenced by: Based on record review and interview, the facility failed to ensure an annual TB (tuberculin) skin test (a tool for screening for tuberculosis and for	F 9999	1. Employee #21 had employee file updated with required screening. Employee #21, #22 and #8 had employee file updated with the required inservices completed. 2. There were no other employees affected and through quarterly employee training reports will ensure compliance is maintained. 3. AP/Payroll will educated on ensuring employee records are complete. They will run employee training reports quarterly, will audit required TB screenings and submit to QAPI committee for review/recommendations. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	11/08/2022

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	tuberculosis diagnosis) was completed on an facility employee for 1 of 10 employee record reviewed. Findings include: A review of the facility's employee records was completed on 10/2/22 at 10:10 a.m. The record indicated Licensed Practical Nurse (LPN) 21 had a hire date of 6/29/21. The record lacked documentation of an annual TB skin test. During an interview, on 10/4/22 at 1:32 p.m., the Accounts Payable (AP)/Payroll Manager indicated she was unable to verify that LPN 21 had completed their annual TB skin test. 2. 410 IAC 16.2-3.1-14 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: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. This state rule was not met as evidenced by:			

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	Based on record review and interview, the facility failed to ensure existing employees had completed required annual inservice training for 3 of 10 employee records reviewed. Findings include: A review of the facility's employee records was completed on 10/2/22 at 10:10 a.m. The record indicated Licensed Practical Nurse (LPN) 21 had a hire date of 6/29/21. The record lacked documentation the annual Resident Rights, Dementia, and Abuse had been completed. The record indicated Qualified Medication Aide (QMA) 22 had a hire date of 11/29/17. The record lacked documentation the annual Resident Rights, Dementia, and Abuse had been completed. The record indicated Registered Nurse (RN) 8 had a hire date of 6/23/20. The record lacked documentation the annual Resident Rights, Dementia, and Abuse had been completed. During an interview, on 10/4/22 at 1:32 p.m., the Accounts Payable (AP)/Payroll Manager indicated she was unable to verify that any of the employee's required annual inservice training had been completed.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.	R 0000	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are	

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	Survey dates: September 27, 28, 29, 30, October 3, 4, and 5, 2022 Facility number: 004550 Residential Census: 32 Mill Pond Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on October 17, 2022		accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	