STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING 00 B. WING	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, IN 47944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. Survey dates: November 29, 30, December 1 and 2, 2021. Facility number: 000288 Provider number: 155743 AIM number: 100287380 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 9 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/7/21.	F 0000	This plan of correction is to serve as Sugar Creek Nursing and Rehab Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek Nursing and Rehab Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed related to medications for 1 of 14 MDS assessments reviewed. (Resident 35)	F 0641	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 35 will have no negative	12/25/2021

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

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	Finding includes: Resident 35's record was reviewed on 12/1/21 at 11:03 a.m. Diagnoses included, but were not limited to, anxiety disorder, hypertension, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/30/21, indicated the resident had not received any diuretic medications during the assessment look back period. The Medication Administration Record (MAR), dated 10/2021, indicated the resident had received Lasix (furosemide, a diuretic medication) 40 milligrams (mg) twice a day. Interview with the Administrator on 12/1/21 at 12:23 p.m., indicated she was not aware of the error. 3.1-31(c)(6) 3.1-31(d)(3)		affect related to this alleged deficient practice. MDS assessment for Resident 35 has been corrected. Resident 35 will have an accurately completed MDS per schedule. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. All residents will have an accurately completed MDS per schedule. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All residents will have an accurately completed MDS per schedule. MDS coordinator in-serviced over “Resident Assessment Instrument” policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** MDS coordinator/Designee will monitor all completed resident MDS’s for accurate completion weekly times 2 months, then every 2 weeks times 2 months, then	

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			monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in			

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	paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review, and interview, the facility failed to develop an initial plan of care within 48 hours of admission for 1 of 14 residents whose care plans were reviewed. (Resident 186) Finding includes: The record for Resident 186 was reviewed on 12/1/21 at 9:52 a.m. Diagnoses included, but were not limited to, psychotic disorder with delusions, bipolar disorder, and general anxiety disorder. The resident was admitted to the facility on 11/19/21. There was a lack of documentation any baseline care plan had been completed upon admission. Interview with the Administrator on 12/1/21 at 12:23 p.m., indicated the baseline care plan had not been completed. 3.1-35(c)(2)(C)	F 0655	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 186 will have no negative affect related to this alleged deficient practice. A baseline care plan has been developed for Resident 186 **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. A baseline care plan will be developed within 48hours of a new resident admitting to the facility.	12/25/2021

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			What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: A baseline care plan will be developed within 48hours of a new resident admitting to the facility. All licensed nursing staff will be in-serviced over the “Care Plan Development and Review” policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** ADON/Designee will audit new admissions chart on the next scheduled workday to ensure the baseline care plan has been developed timely. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide proper respiratory care and or services for residents receiving oxygen for 2 of 2 residents reviewed for oxygen. (Residents 34 and 14) Findings include: 1. On 11/29/21 at 10:18 a.m., Resident 14 was observed lying in her bed. She had a nasal cannula on for oxygen delivery. There was no date on the oxygen tubing or humidification bottle to indicate when it was last changed. The resident's record was reviewed on 11/30/21 at 1:07 p.m. The resident was admitted on 8/1/19. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and she was receiving hospice services. A Physician's order, dated 2/7/20, indicated the resident was to receive oxygen by nasal cannula at 2 liters per minute, with humidity, continuously. There was not an order to indicate when the tubing and humidity bottle should be changed. The November 2021 Treatment Administration Record (TAR) did not have any information as to when the tubing and humidity bottle were last changed. Interview with the Administrator, on 11/30/21 at 1:36 p.m., indicated oxygen tubing and humidity bottles should be changed weekly, and documented on the TAR. She indicated there was no documentation when the resident's tubing was last changed, but would correct it at that time.2.	F 0695	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 14 and 34 will have no negative affect due to this alleged deficient practice. Resident 14's O2 tubing, and humidification bottle was dated, and order obtained to change O2 tubing and humidification bottle and to date them weekly. MD order for Resident 34 was verified that O2 was to be on 2LPM. O2 level on concentrator was adjusted to 2LPM. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. O2 for resident's will be administered at the flow directed by the physician order. O2 tubing, humidification bottle, and/or other disposable O2 equipment will be changed weekly and will be dated for the day it was changed. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To**	12/25/2021

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	On 11/29/21 at 2:23 p.m., Resident 34 was observed lying in bed. The resident had oxygen infusing per a nasal cannula. The oxygen concentrator was on and set at 2.5 liters. On 11/30/21 at 11:38 a.m., Resident 34 was observed lying in bed. The resident had oxygen infusing per a nasal cannula. The oxygen concentrator was on and set at 2.5 liters. Record review for Resident 34 was completed on 11/30/21 at 12:02 p.m. Diagnoses included, but were not limited to, traumatic brain dysfunction and respiratory failure. The Annual Minimum Data Set (MDS) assessment, dated 10/18/21, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist for bed mobility and transfers. The resident received oxygen therapy. A Physician's Order, dated 10/11/21, indicated an order for O2 (oxygen) at 2 liters every shift. Interview with LPN 1 on 11/30/21 at 11:41 a.m., indicated she thought the resident was supposed to be on 3 liters. She would have to double check the orders. The oxygen concentrator was not set to the correct flow rate. A policy titled, "Oxygen Therapy", and received as current from the Assistant Director of Nursing on 12/2/21, indicated, "...Procedure: 12. Start oxygen flow rate at the prescribed liter flow or appropriate flow for administration device..." "...Supply Change Out 1. All disposable supplies used by a resident MUST be dated...." 3.1-47(a)(6)		**Ensure That The Deficient Practice Does Not Recur:** O2 for resident's will be administered at the flow directed by the physician order. O2 tubing, humidification bottle, and/or other disposable O2 equipment will be changed weekly and will be dated for the day it was changed. All licensed nursing staff will be in-serviced over the "Oxygen Therapy" policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** ADON/Designee will monitor O2 tubing, humidification bottle, and/or other disposable O2 equipment and O2 flow weekly times 2 months, then 2 times a month times 2 months, then monthly tims 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	

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F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 4 out of 11 days reviewed. this had the potential to affect all 34 residents in the facility. Findings include: On 12/2/21 at 10:19 a.m., the Nursing Staff Schedules, dated 11/22/21 through 12/2/21 were reviewed. There was no RN scheduled for 11/24/21, 11/26/21, 11/29/21, and 12/2/21. Interview with the Assistant Director of Nursing and the Administrator on 12/2/21 at 12:07 p.m., indicated there was not 8 hours of RN coverage on the above dates. 3.1-17(b)(3)	F 0727	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The facility will have 8 consecutive hours of RN coverage 7 days a week. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice.	12/25/2021

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			The facility will have 8 consecutive hours of RN coverage 7 days a week. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will have 8 consecutive hours of RN coverage 7 days a week. Assistant Administrator and Administrative nursing staff in-serviced over regulation regarding required RN coverage. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator/Designee will monitor staffing on scheduled workdays daily ongoing to ensure appropriate daily RN coverage. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record	F 0744	**What Corrective Action(s) Will**	12/25/2021

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	review, the facility failed to provide appropriate services for a resident with dementia for 1 of 1 residents reviewed for dementia care. (Resident 26) Finding includes: The following observations of Resident 26 were made: On 11/30/21 at 9:40 a.m., the resident was observed seated in the dining room at a table alone, his eyes were closed. At 2:25 p.m., he was laying in his bed with his eyes closed. There was no television or radio in his room. On 12/1/21 at 11:29 a.m., 1:30 p.m., and 3:03 p.m., he was laying in his bed with his eyes closed. On 12/2/21 at 10:15 a.m., the resident was in bed with his eyes closed. At 12:12 p.m., the resident was seated in the dining room at a table alone with his eyes closed. At 1:20 p.m., the resident was propelling himself backward down the hallway. The resident's record was reviewed on 11/30/21 at 2:27 p.m. The resident was admitted to the facility on 9/8/20. Diagnoses included, but were not limited to, Alzheimer's dementia. The Annual Minimum Data Set assessment, dated 11/12/21, indicated the resident had significant cognitive impairment and needed extensive assistance for bed mobility and transfers. The Dementia care plan indicated the resident enjoyed listening to music, keeping up with the news, and doing things with groups of people. The care plan indicated he will participate in 1 on		**Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 26 will have no negative affect related to this alleged deficient practice. Resident does receive 1 on 1 with activities and documentation of such will occur. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected by this alleged deficient practice. All residents that receive 1 on 1 with activities will have such activity documented after each occurrence. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All residents that receive 1 on 1 with activities will have such activity documented after each occurrence. Activity Director and activity assistants will be in-serviced over the “One to One Programming” policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**	

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	1 activities with staff three times a week. There was no documentation the resident had received 1 on 1 visits from staff since 7/21/21. The resident's November activity log indicated he participated in one group activity a week; he had attended two other activities but did not participate. Interview with the Dietary Manager, who was temporarily assisting with the activity program, on 12/2/21 at 10:35 a.m., indicated they had not had an Activity Director since July. A new Activity Director had been hired the previous Monday. An assistant would come in three times a week to provide 1 on 1's with residents, but did not document any of those activities. 3.1-37		Activity Director/Designee will monitor all 1 on 1 visits for appropriate documentation 2 times a week times 2 months, then weekly times 2 months, then 2 times a month times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 26 opportunities for errors during medication administration. This resulted in a medication error rate of 7.69%. (Residents 5 and 21) Findings include: 1. On 12/1/21 at 9:33 a.m., the Director of Nursing (DON) was observed giving medications	F 0759	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 5 and 21 will have no negative affect related to this alleged deficient practice. Nasal spray for Resident 5 was primed. MD was notified of Resident 21 only receiving 5mg of Glyburide. **How Other Residents Having The Potential To Be Affected By**	12/25/2021

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	to Resident 5. She had a bottle of fluticasone (a nasal spray), she inserted the tip of the bottle into one nostril and sprayed once, then into the other nostril and sprayed once. The resident indicated she wasn't sure the medication had been dispensed. The DON then primed the bottle a couple times, and then repeated the medication administration. Interview with the DON after the observation, indicated she should have primed the bottle of fluticasone before administering. 2. On 12/1/21 at 10:02 a.m., QMA 1 was observed preparing medications to Resident 21. She prepared one tablet of of glyburide, 5 milligrams (mg), in addition to the other medications. A Physician's order, dated 8/27/21, indicated glyburide 5 mg, 2 tablets every morning. On 12/1/21 at 11:23 a.m., the DON confirmed the order and indicated the resident should have received 2 tablets of glyburide. 3.1-48 (c)(1)		**The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Residents will receive all medications as ordered by their physician at the scheduled time. All licensed and qualified nursing staff will be i-serviced over the following policy and procedures "Medication Errors, Administration Procedures for All Medications, and Nasal Administration". **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** ADON/Designee will observe 5 medication administrations at varying times weekly times 2 month, then every 2 weeks times 2 months, then monthly times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, IN 47944

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F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to 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;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to lack of hand hygiene during medication pass and not cleaning a pulse oximeter for 3 of 6 residents observed during medication pass, (Residents 5, 21 and 19),	F 0880	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Residents 5, 19, and 21 were not affected by this alleged deficient practice. Hand hygiene will be	12/25/2021

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	as well as improper eyewear worn by staff and lack of infection control surveillance which had the potential to affect all 34 residents in the facility. Findings include: 1. On 12/1/21 at 9:33 a.m., the Director of Nursing (DON) was observed during medication pass for Resident 5. The DON prepared the medications without performing hand hygiene. She then administered the medications to the resident, and performed hand hygiene after. Interview with the DON after the medication observation, she indicated she had forgot to perform hand hygiene before preparing the medications. 2. On 12/1 21 at 9:55 a.m., QMA 1 was observed giving medications to a resident in the dining room, She removed a pulse oximeter from her pocket and placed it on the resident's finger. She then put the oximeter back into her pocket without cleaning it either before or after use. At 10:02 a.m., the QMA was observed giving medications to Resident 21. She removed the oximeter from her pocket and placed it on the resident's finger. She then placed it back in her pocket. The oximeter had not been cleaned between the two residents. Interview with the QMA after Resident 21's medication administration, indicated she should have cleaned the oximeter between residents. 3. On 12/1/21 at 4:01 p.m., QMA 2 was observed preparing medications for Resident 19. The QMA did not perform hand hygiene prior to		performed when appropriate or indicated, shared equipment will be disinfected between use, proper eye wear will be worn when required, and infection control logs have been undated. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected. No other residents were affected by this alleged deficient practice. Hand hygiene will be performed when appropriate or indicated, shared equipment will be disinfected between use, proper eye wear will be worn when required, and infection control logs have been undated. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Hand hygiene will be performed when appropriate or indicated, shared equipment will be disinfected between use, proper eye wear will be worn when required, and infection control logs have been undated. All staff will be in-serviced over “how to don/doff PPE with return demonstration, proper hand hygiene with return demonstration, proper eye	

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	preparing the medications. Interview with the QMA after the medication observation, she indicated she had not performed hand hygiene before preparing the medications. The current policy, "Medication Administration", was received from the Administrator on 12/1/21 at 12:14 p.m., indicated, "...Wash hands with soap and water prior to beginning med pass...." and, "...Use alcohol gel or foam before between each resident unless using soap and water...."4. On 11/29/21 at 10:46 a.m., LPN 1 was observed at a medication cart. The nurse did not have protective eye wear on. The nurse indicated she was fully vaccinated and did not need to wear eye protection because the facility did not have any residents on TBP (transmission based precautions). She further indicated she was the only nurse working with all the residents that shift. On 12/1/21 at 9:46 a.m., QMA 1 was preparing medications. The QMA had on a face shield that had a gap at the top of the shield. The QMA indicated she was told the face shield was appropriate to wear. The local county COVID-19 Community Transmission was High per the CDC (Center for Disease Control) on 11/29/21 and 12/1/21. The Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities updated 11/22/21, indicated, "...For substantial or high community transmission, then eye protection should be used by all HCP for all residents within 6 feet when delivering essential direct care regardless of COVID-19 status..." "...Eye protection should be close to face with no		protection and when required to wear it, and infection control practices during medication administration. The facility LTC Infection Control Assessment has been completed (Attachment A). A Root Cause Analysis (RCA) (Attachment B) for the facility has been conducted. All staff will be in-serviced over CDC guidelines regarding proper eye protection and when it is required to be worn (Attachment C). **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** ADON/Designee will complete IP rounds during scheduled workdays daily for a minimum of 12 weeks, then weekly times 12 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	

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	gaps at top, bottom, or sides of eyes...." 5. The monthly Infection Control Surveillance Logs Binder was reviewed on 12/2/21 at 11:00 a.m. The binder lacked any documentation that infection control surveillance was completed for the months of October and November 2021. Interview with the Administrator on 12/2/21 at 11:30 a.m., indicated she could not find any documentation the monthly infection control surveillance was completed for the months of October and November 2021. The staff member who had been completing them no longer worked there and did not show anyone how to complete the line listing and the monthly surveillance before she left. An Infection Control Manual policy titled, "Surveillance" and received as current from the Assistant Director of Nursing on 12/2/21, indicated, "...Data Collection And Recording 4. MONTHLY: The IP/designee shall collect information from the surveillance logs and tabulate incidence of type(s) of infection. The data shall be summarized by nursing unit by site and by pathogen, using a facility map to visualize patterns/trends. 5. MONTHLY: The IP/designee shall compare incidence of current infections to the previous Month. If an increase is noted, conduct root cause analysis...." 3.1-18(a) 3.1-18(b)(1) 3.1-18(b)(2)			
F 9999 Bldg. 00	3.1-13 Administration and Management	F 9999	**What Corrective Action(s) Will**	12/25/2021

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	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an unusual occurrence was reported to the Indiana Department of Health (IDOH), related to a fall that required staples for 1 of 3 residents reviewed for accidents. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 11/30/21 at 12:11 p.m. Diagnoses included, but were not limited to, osteoarthritis, hypertension, and anxiety disorder. The resident was admitted to the facility on 9/30/21. The Admission Minimum Data Set (MDS) assessment, dated 10/7/21, indicated the resident		**Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 20 will not have any adverse effects related to this alleged deficient practice. Initial reports for all unusual occurrences will be reported in required timeframe. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. Initial reports for all unusual occurrences will be reported in required timeframe. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All staff, including Administrator will be in-serviced over Abuse/Neglect and ISDH Reportable Unusual Occurrence policy and procedures. Administrator/Designee will be responsible for filing timely reports and follow up reports if indicated. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator/Designee will	

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	had two or more falls since admission including one with major injury. A Fall Investigation, dated 10/1/21, indicated the resident fell in the doorway of her bathroom and hit her head on the foot board of her bed. She was found to have a 4-5 inch laceration to the back of her head with moderate bleeding and was sent to the emergency room for evaluation and treatment. A Progress Note, dated 10/1/21 at 9:31 p.m., indicated the resident was found in the doorway to her bathroom and was noted to have a large laceration to the back of her head. The resident was sent to the emergency room for evaluation. A Progress Note, dated 10/2/21 at 5:30 a.m., indicated the resident had returned from the emergency room with 11 staples to the back of her head. Interview with the Administrator on 12/1/21 at 12:23 p.m., indicated the fall had not been reported to IDOH. She was not aware the fall had resulted in the resident receiving staples. A facility policy, titled Indiana State Department of Health Division of Long Term Care Incident Reporting Policy, received as current from the Administrator, indicated "...C. Types of incidents reportable under State rules only...5. Major accidents-unexpected or unintentional events resulting in any fracture or other outcomes that require medical treatment beyond basic first aid or ER/physician evaluation..."		monitor Reportable/Unusual Occurrence Log weekly times 3 months, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QA Committee monthly for minimum of 6 months and plan adjusted accordingly.	