STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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 the Investigation of Complaints IN00380573, IN00381221, IN00381238, and IN00381251. Complaint IN00380573 - Unsubstantiated due to lack of evidence. Complaint IN00381221 - Substantiated. Federal/State deficiencies related to the allegations are cited at F800. Complaint IN00381238 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558, F609, F610, and F692. Complaint IN00381251 - Substantiated. Federal/State deficiencies related to the allegations are cited at F693. Unrelated deficiencies are cited. Survey dates: June 8 & 9, 2022 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 8 Medicaid: 71 Other: 12 Total: 91	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a facility Complaint Survey (IN00380573, IN0038122, IN00381238 , IN00381215) on 6/2/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/14/22.			
F 0558 SS=D Bldg. 00	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 meet residents' needs, related to a call light not placed within reach for 2 of 8 residents observed for call light placement. (Residents K and L) Findings include: 1. Resident K was interviewed on 6/8/22 at 8:58 a.m. She indicated the call light was moved away from her every time the staff came in and helped her with her care and she was unable to call for help when she needed assistance. At the time of the interview, the call light was observed lying in a bedside dresser drawer, which was not in reach of the resident. The call light was then given to the resident per her request. Resident K's record was reviewed on 6/8/22 at 3:29 p.m. The diagnoses included, but were not limited to, displaced fracture of medial malleolus of right tibia. An Annual Minimum Data Set (MDS) assessment, dated 5/1/22, indicated a moderately impaired cognitive status, required extensive assistance of	F 0558	**F558** **Reasonable Accommodations Needs/Preferences** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident K and L were not harmed by the alleged deficient practice. The DON/designee has reviewed resident K and L's care plans and observed resident's call light placement. Resident K and L's call lights are placed within	07/01/2022

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	two for bed mobility and transfers, and was dependent on two for toileting. A Care Plan, dated 5/26/21, indicated a deficit in self care for activities of daily living (ADL's). The interventions included, the call light was to be within reach and the resident was to be reminded to activate the call light is assistance was needed. 2. Resident L was observed on 6/8/22 at 9:01 a.m. He was lying in bed with his eyes closed. The call light was not in reach and was draped over the bedside dresser next to the bed. During an interview on 6/8/22 at 9:13 a.m., CNA 3 indicated if the resident needed assistance, he would activate his call light. CNA 3 then placed the call light on the resident's bed and within reach if needed. Resident L's record was reviewed on 6/8/22 at 3:39 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly MDS assessment, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility, transfers, and toileting, and had no falls. A Care Plan, dated 3/3/21, indicated a risk for falls. The interventions included, to ensure the call light was within reach. This Federal tag relates to Complaint IN00381238. 3.1-35(b)(1)		reach. 2. All residents have the potential to be affected by same alleged deficient practice. The Director of Nursing or designee completed a call light placement audit on all residents, and all call lights are within reach of each resident. 3. The Director of Nursing or designee educated nursing staff on the “Resident Rights” policy, with emphasis on “ensure call lights are within reach”. 4. DON/Designee will observe call light placement on 5 residents, 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, and weekly for 4 weeks to ensure that call light placement is within easy reach of the residents. 5. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 07/01/2022	
F 0609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations			

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for abuse. (Resident M) Finding includes:	F 0609	**F609** **Reporting of Alleged Violations** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of	07/01/2022

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	During an interview on 6/9/22 at 11:17 a.m., Resident M was sitting in a wheelchair in her room. She indicated she had been physically abused by a CNA and received a bruise to her right forearm from the CNA, "grabbing her". She had reported the abuse to the Social Service Director and was told by the Social Service Director the Director of Nursing had been notified. The Social Service Director and the Administrator were interviewed on 6/9/22 at 11:27 a.m. The Social Service Director indicated the resident had voiced the allegation on 5/31/22 and the allegation had been reported to the Director of Nursing and the Administrator. The resident indicated the abuse occurred on 5/30/22. She had not observed a bruise on the forearm. The Administrator indicated he had not been informed of the allegation, then indicated there had not been a bruise, so the allegation had not been reported. Resident M's record was reviewed on 6/9/22 at 11:47 a.m. The diagnoses included, but were not limited to anxiety. A Quarterly Minimum Data Set assessment, dated 4/16/22, indicated a moderately impaired cognitive status, required extensive assistance of two for bed mobility and transfers, extensive assistance of one for locomotion, dressing toileting, hygiene, and bathing. A facility Abuse Policy, dated 10/27/21 and received from the Director of Nursing as current, indicated each occurrence of alleged abuse will be reported to the Supervisor and investigated timely. The Supervisor or designee will notify the Director of Nursing and Executive Director (Administrator) immediately. Required notification of agencies, Physician, and Resident		Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident M was not harmed by the alleged deficient practice. The facility ED/designee has reported and investigated Resident M's allegations to Indiana Department of Health. 2. Any resident that sustains an injury requiring reporting to the Indiana Department of Health has the potential to be affected by the same alleged deficient practice. An Abuse audit has been conducted on all residents within the last 15 days, and any incidents/events requiring reporting to the Indiana Department of Health has been reported. 3. The Regional Director or Clinical Operations or designee will educate the ED and DON on the "Indiana Abuse & Neglect & Misappropriation of Property" policy with emphasis on "State Reporting", and "Allegation Investigation". 4. ED/Designee will review all resident reported incidents/events daily for one month, and after will	

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	Representative will be completed. All alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made. The Executive Director will report to the Adult Protective Services and the Division of Licensing and Regulation as required by state law and other regulatory agencies as required. This Federal tag relates to Complaint IN00381238. 3.1-28(c)		review resident abuse audit weekly for one month to ensure that any incidents requiring reporting to Indiana Department of Health are reported according to the policy and state guidelines. The abuse audit review will be audited for completion Monday-Friday as this is an on-going facility practice. 5. ED/Designee will report on audits monthly to the QAPI team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months. Date of completion: 07/01/2022	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the			

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	alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to investigate an allegation of physical abuse for 1 of 3 residents reviewed for abuse. (Resident M) Finding includes: During an interview on 6/9/22 at 11:17 a.m., Resident M was sitting in a wheelchair in her room. She indicated she had been physically abused by a CNA and received a bruise to her right forearm from the CNA "grabbing her". She indicated she had reported the abuse to the Social Service Director and was told by the Social Service Director the Director of Nursing had been notified. The Social Service Director and the Administrator were interviewed on 6/9/22 at 11:27 a.m. The Social Service Director indicated the resident had voiced the allegation on 5/31/22 and the allegation had been reported to the Director of Nursing and the Administrator. The resident indicated the abuse occurred on 5/30/22. She had not observed a bruise on the forearm. The Administrator indicated he had not been informed of the allegation, then indicated there had not been a bruise, so the allegation had not been reported. The Administrator was unable to provide an investigation of the abuse allegation. Resident M's record was reviewed on 6/9/22 at 11:47 a.m. The diagnoses included, but were not limited to, anxiety. There was no documentation in the record which	F 0610	**F610** **Investigate/Prevent/Correct Alleged Violation** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1.Resident M was not harmed by the alleged deficient practice. The facility ED/designee has reported and investigated Resident M's allegations to Indiana Department of Health. 1.Any resident that sustains an injury requiring reporting to the Indiana Department of Health has the potential to be affected by the same alleged deficient practice. An Abuse audit has been conducted on all residents within the last 30 days, and any incidents/events requiring reporting to the Indiana Department of Health has been reported.	07/01/2022

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	indicated the resident had been assessed for signs and symptoms of abuse, for the presence of a bruise, and that an investigation had been initiated after the allegation of abuse had been voiced. The facility Abuse Policy, dated 10/27/21 and received as current from the Director of Nursing , indicated the abuse allegations would be investigated by the Executive Leadership. Statements would be obtained from the resident or from the reported of the allegation in writing when possible. Statements would be obtained from the staff related to the allegation in writing. Findings/conclusions to the investigation were to be reported to the Physician, the Executive Director (Administrator), and the Resident Representative, and documented on the investigation form. The Investigation files were to be kept in the Executive Director's Office and would be accessible for follow-up and state or local police review of the investigation. This Federal tag relates to Complaint IN00381238. 3.1-28(d)		1.The Regional Director of Clinical Operations will educate the ED and DON on the “Indiana Abuse & Neglect & Misappropriation of Property” policy with emphasis on “State Reporting”, and “Allegation Investigation”. 1.ED/Designee will review all resident reported incidents daily for one month, and after will review resident abuse audit weekly for one month to ensure that any incidents requiring reporting to Indiana Department of Health are reported according to the policy and state guidelines. The abuse audit review will be audited for completion Monday-Friday as this is an on-going facility practice. 1.ED/Designee will report on audits monthly to the QAPI team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months. Date of completion: 07/01/2022	
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			

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	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 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 observation, record review, and interview, the facility failed to ensure dependent residents had fluids accessible to maintain proper hydration for 2 of 2 residents reviewed for hydration. (Residents B and J) Findings include: 1. On 6/8/22 at 8:50 a.m., Resident B was observed in her room eating breakfast. At 9:30 a.m., the resident was observed in her room in bed. There was a bedside table, there were no beverages available on the table or in the room. The resident was again observed at 11:08 and 12:16 p.m., there were no beverages available in the room. On 6/9/22 at 9:43 a.m. and 10:40 a.m.., the resident was seated in her room. There were no beverages available in the room. At 11:40 a.m., the resident was seated in the TV area with no beverage available.	F 0692	**F692** **Nutrition/Hydration Status Maintenance** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents B and J was not harmed by the alleged deficient practice. The DON/designee have reviewed resident B and J's ADL	07/01/2022

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	The resident's record was reviewed on 6/8/22 at 11:42 a.m. The resident was admitted on 1/31/22. Diagnoses included, but were not limited to, dementia, muscle weakness and hyperkalemia (elevated potassium).The resident was not on fluid restrictions. The Quarterly Minimum Data Set assessment, dated 5/18/22, indicated the resident was cognitively impaired and required extensive two person assistance for bed mobility, transfers and toileting assist. She needed extensive one person assist for eating. A Hydration Care Plan, dated 2/2/22, indicated the resident was at risk for dehydration related to a history of dehydration. An Activities of Daily Living (ADL) care plan, dated 4/25/22, indicated the resident required assistance with ADLs related to decline in functional status, weakness and confusion. Interventions included to observe and anticipate resident's needs for thirst, pain and toileting needs. 2. On 6/8/22 at 9:20 a.m., Resident J was observed in her bed. She had a beverage on her bed side table. She indicated sometimes the aides did not bring her water when asked. On 6/9/22 at 8:10 a.m., the resident was in bed with her eyes closed, there was no beverage available in her room. At 9:00 a.m., there was a breakfast tray on her bedside table, the resident's eyes were closed and she was not eating or drinking. At 10:40 a.m., and 11:40 a.m., the resident was in bed, there was no beverage available.		care plans and completed an observation on fluid placement in each resident's room, and fluid is placed appropriately. 2. All residents that are dependent on staff for hydration have the potential to be affected by same alleged deficient practice. The Director of Nursing or designee will complete an observation of placement of fluids on dependent residents and ensure available at bedside if MD order allows. 3. The Director of Nursing or designee will educate the nursing staff on the "General Hydration" policy with emphasis on "monitor and attend hydration needs", and ensuring that fluid is passed on each resident daily and as requested and per MD order. 4. DON/Designee will observe placement of fluids within easy reach for 5 dependent residents 5 x a week for 4 weeks, then 3 x week for 4 weeks, and weekly x 4 weeks. 5. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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	The resident's record was reviewed on 6/8/22 at 10:14 a.m. The resident was admitted on 5/11/22. Diagnoses included, but were not limited to, Multiple Sclerosis and functional quadriplegia. The resident was not on fluid restrictions. The Admission Minimum Data Set assessment, dated, 5/23/22, indicated the resident was cognitively intact. She required extensive assistance for bed mobility, transfers and eating. An ADL Care Plan, dated 5/13/22, indicated the resident required assistance with ADLs related to weakness, chronic pain and Multiple Sclerosis. Interventions included to observed and anticipate resident's needs for thirst, food, body positioning, pain and toileting. Interview with CNA 1 on 6/9/22 at 11:43 a.m., indicated she was going to give the residents beverages with lunch soon. They offered water every day, but residents would sometimes refuse. Interview with LPN 1 and QMA 1 on 6/9/22 at 11:44 a.m., indicated residents should have beverages available at all times. Interview with the Director of Nursing on 6/9/22 at 11:49 a.m., indicated residents should have beverages at all times, and if they refused, water should be left in the room anyway. This Federal tag relates to Complaint IN00381238. 3.1-46(b)		Date of completion: 07/01/2022	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy			

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	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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to provide proper feeding tube care as per professional standards related to feeding tube dressings/ treatments and water flushes not completed as ordered by the Physician, for 2 of 3 residents reviewed for feeding tubes. (Residents G and E) Findings include: 1. During an observation on 6/9/22 at 8:30 a.m., Resident G was lying in bed. The Wound Nurse exposed the feeding tube, which had an abdominal binder over the insertion site on the stomach. There was no dressing around the feeding tube at the insertion site and the site was pink. The Wound Nurse indicated the area around the feeding tube insertion site appeared excoriated	F 0693	**F693** **Tube Feeding Management/Restore Eating Skills** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.**	07/01/2022

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	155218	A. BUILDING 00 B. WING	06/09/2022

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	and acknowledged there was no dressing on the site. Resident G's record was reviewed on 6/8/22 at 2:11 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy. A Quarterly Minimum Data Set (MDS) assessment, dated 3/17/22, indicated a severely impaired cognitive status, required extensive assistance for eating, had a feeding tube and received 51% or higher of all nutrition from the feeding tube and 501 cubic centimeter or higher of her daily fluids through the feeding tube. A Physician's Order, dated 5/13/22, indicated an abdominal binder was to be used at all times to prevent the feeding tube from being pulled out. A Physician's Order, dated 6/25/21, indicated the feeding tube site was to be cleansed with soap and water, patted dry, and a gauze dressing was to be applied daily. A facility policy related to care of a gastrostomy tube site, received from the Director of Nursing as current on 6/9/22 at 10:50 a.m., indicated a dressing was not required unless ordered by a Physician. If a Physician's Order for a dressing was in place, the dressing was to be changed daily and more frequently if soiled, wet or not intact /loose. 2. The closed record for Resident E was reviewed on 6/8/22 at 10:04 a.m. Diagnoses included, but were not limited to, Parkinson's disease, schizoaffective disorder, and depressive disorder. The resident was admitted to the facility on 5/3/22 and discharged to the hospital on 5/18/22. The Admission MDS assessment, dated 5/11/22,		1. Resident's G and E were not harmed by the alleged deficient practice. The DON/designee has reviewed resident G's care plan and orders, and observed g-tube site. Any issues have been addressed according to resident's care plan and orders. Resident E no longer resides in facility. 2. Any resident that has a gastrostomy tube has the potential to be affected by same alleged deficient practice. The Director of Nursing or designee completed a gastrostomy tube order audit on all residents with gastrostomy tubes, and any order discrepancies have been addressed. 3. The Director of Nursing or designee will educate the licensed nurses on the "Care of Gastrostomy Tube Site" policy, and "Enteral Feeding Tube/G-Tube flushing" policy, with emphasis on following physician orders for flushing and care of gastrostomy tube site and dressing placement. 4. DON/Designee will observe dressing placement for 3 residents with physician orders for dressing to a gastrostomy tube site 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then	

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	indicated the resident was cognitively impaired and required an extensive assist of one with eating. A Care Plan indicated the resident had a PEG tube (percutaneous endoscopic gastrostomy, a tube passed into the stomach through the abdominal wall used as an alternate way to provide food, fluids, or medications) due to the diagnoses of paralytic ileus (slowing or stopping of intestinal movement), polyphagia (excessive eating), and dysphagia (difficulty swallowing). The hospital discharge paperwork, dated 5/3/22, indicated "Diet instructions: Regular. Jevity (tube feeding) was discontinued, continue water flushes every 6 hours 400 ml (milliliters) per orders." A Care Management Strategies Note, dated 5/5/22 at 9:18 a.m., indicated the resident was a new admission to the facility and had a PEG tube in place but received an oral diet. A Physician's Order, dated 5/14/22, indicated an order to flush the PEG tube with 30 ml of water every 8 hours. The Medication Treatment Record (MAR) and Treatment Administration Record (TAR), dated 5/2022, lacked any documentation of water flushes to the PEG tube until 5/14/22. Interview with the Director of Nursing (DON) on 6/9/22 at 11:15 a.m., indicated she was unable to find any documentation of water flushes prior to 5/14/22. The water flush orders on the hospital discharge paperwork had been missed. A current facility policy, titled "Enteral		weekly for 4 weeks, to ensure all gastrostomy sites with physician orders for dressing placement are in place and being followed. DON/Designee will verify that physician orders for water flushes are in place and completed for 3 residents with enteral feeding 5 x weekly x 4 weeks, 3 x weekly for 4 weeks, then weekly x 4 weeks, to ensure physician's orders for flushes are being followed. DON/designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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	Feeding/G-tube Flushing," indicated, "...Procedure: I. Flushing the tube. a. obtain and verify provider/physician flush order for solution, amount and frequency ...II. Documentation. a. Documentation to include but not limited to: i. the flush for liquid totals ...iii. Flush solution and amount ..." This Federal tag relates to Complaint IN00381251. 3.1-44(a)(2)			
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review, and interview, the facility failed to provide a resident with a nourishing and well-balanced diet, failed to provide special dietary needs, and failed to assess the resident's preferences for nutritional services, for 1 of 4 residents reviewed for nutritional services. (Resident C) Finding includes: During an interview on 6/8/22 at 10:46 a.m., Resident C indicated he cannot eat pork and the facility continued to serve him pork. He then produced pictures on his cell phone of bacon, a ham and cheese sandwich, and sausage gravy served on three different meal trays. He indicated he goes to sleep hungry and wakes up hungry. He has family who will bring food in for him. One morning he had not received a breakfast tray. The	F 0800	**F800** **Provided Diet Meets Needs of Each Resident** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident C was not harmed	07/01/2022

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	Registered Dietician and or the Dietary Manager had not been in to see him and talk to him about his dietary preferences. During an observation of the lunch meal, on 6/8/22 at 1:07 p.m., the menu indicated hot dogs were being served. The resident received a hamburger as a substitute for the hot dog. During an interview and observation on 6/9/22 at 8:49 a.m., a staff member brought the resident's breakfast tray into the room and left it on the bedside table per his request. Upon removal of the lid, there was one piece of dry toast on the plate. There was a carton of whole milk and a glass of orange juice on the tray. The tray card indicated he was to be served a cheese omelet and oatmeal. The Dietary Manager arrived to the room and acknowledged he was only served a piece of toast and had not received the cheese omelette and oatmeal. The resident informed the Dietary Manager that this had happened frequently and also indicated he received pork, even though he was unable to eat pork. He then showed the pictures on his cell phone to the Dietary Manager. The Dietary Manager indicated she was unaware of the concerns. He informed the Dietary Manager no one from the Dietary Department had been in to talk to him and if they had, he would have requested double portions to help heal his pressure ulcer. He stated he "rarely gets what is listed on his dietary card." During an interview on 6/9/22 at 9:40 a.m., the Dietary Manager indicated either she or the Registered Dietician (RD) usually visited the new residents and assessed their needs and preferences. She had not met with the resident. During an interview on 6/9/22 at 9:42 a.m., the RD		by the alleged deficient practice. Resident C no longer resides in facility. 2. All residents with oral diets that can express their diet preferences have the potential to be affected by same alleged deficient practice. A dietary preference review has been conducted on residents with oral diets, those resident's diet preferences have been documented appropriately. 3. The Dietary Manager/designee has been educated on the "HCSG Policy 004 Menus" policy, with emphasis on adjusting the individual meal plan to meet residents' request as appropriate. 4. ED/Designee will observe meal trays for 5 residents 5 x weekly for 4 weeks, and after will observe 5 residents 3 x weekly for 4 weeks, and then 5 residents weekly for 4weeks to ensure that residents have received a meal meeting the needs/wants of the resident. 5. ED/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6	

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	indicated she had not interviewed the resident for his needs and preferences and his needs had only been discussed during the Nutrition at Risk meetings. The Dietary Manager indicated someone should have met with him upon admission. Resident C's record was reviewed on 6/8/22 at 10:14 a.m. The diagnoses included, but were not limited to, pressure ulcer of the buttock with osteomyelitis. The admission date was 5/13/22. An Admission Minimum Data Set assessment, dated 5/20/22, indicated a moderately impaired cognitive status and required limited assistance with eating, The weight was 159 pounds with no significant weight gain or loss. There was a stage 4 (full thickness skin loss) pressure ulcer present on admission. A Care Plan, dated 5/16/22, indicated a pressure ulcer was present. The interventions included, the nutritional status would be monitored and diet would be served as ordered by the Physician. The weights were 158 pounds on 5/13/22 and 158 on 6/7/22. A Physician's Order, dated 5/14/22, indicated a regular diet. The Registered Dietician's (RD) Dietary Assessment, dated 5/25/22, indicated a regular diet was ordered, and the resident had been educated and agreed to the prescribed diet order. He did not eat pork, per the hospital records, had a pressure ulcer, and the usual body weight was 163-178 pounds. The RD would continue to monitor the resident including the diet order, intakes, weights, lab results, medications, and skin		months. Date of completion: 07/01/2022	

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	as needed. There was an increase in demand for protein (due to pressure ulcer). This Federal tag relates to Complaint IN00381221. 3.1-46			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 0880	**F 880**	07/01/2022

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	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 not placing a newly admitted resident on transmission based precautions (TBP) as ordered, not keeping a resident on TBP in the isolation room, and staff not wearing proper personal protective equipment (PPE) in a TBP room on 1 of 2 units observed (East unit). This had the potential to affect 24 residents who resided on the East unit. Findings include: 1. On 6/8/22 at 8:50 a.m., 9:30 a.m., and 11:08 a.m., Resident B was observed in her room. There was no isolation set up or signage on her door indicating she was on isolation. At 1:25 p.m., the resident was in her bed, and a staff member was seated next to her assisting her with lunch. The staff member was wearing a surgical mask and there was no signage on the door indicating the resident was on isolation precautions. On 6/8/22 at 2:25 p.m., there was an isolation set up at the resident's door and a sign on the door indicating the resident was on droplet precautions. Resident B's record was reviewed on 6/8/22 at 11:42 a.m. The resident had been readmitted to the facility after a hospital stay on 6/7/22. Diagnoses included, but were not limited to, dementia, hyperkalemia (elevated Potassium) and muscle weakness. There was no documentation the resident had received the COVID-19 vaccinations.		**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B was not harmed by the alleged deficient practice. The facility's Infection Preventionist reviewed resident B's care plan and physician's orders, signage has been posted at resident's door per facility policy **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: ·Ensure the resident/residents affected/potential affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented Policy: Criteria for Covid-19 Requirements and Resident Placement	

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	The Quarterly Minimum Data Set assessment, dated 5/18/22, indicated the resident had significant cognitive impairment, and required extensive two person assistance for bed mobility, transfers and toileting, and extensive one person assistance for eating. A Physician's Order, dated 6/7/22, indicated to place the resident on droplet precautions due to new admission protocol. 2. On 6/9/22 at 8:10 a.m., Resident B was observed seated in her wheelchair near the nurses' station. She was wearing a surgical mask around her chin, not over her mouth and nose. At 8:53 a.m., the resident was still seated near the nurses' station. Interview with an unidentified LPN at 8:53 a.m., indicated she was not aware if the resident was vaccinated. She indicated the resident was on TBP and should not be seated in the common area, then took the resident back to her room. On 6/9/22 at 11:40 a.m., the resident was observed seated in the TV area between two other residents approximately three feet apart from each other. The residents were wearing surgical masks. CNA 1 was present and seated near the residents. Interview with CNA 1 at 11:43 a.m., indicated the resident was a fall risk, so she had brought her to the common area. Interview with the Director of Nursing (DON) on 6/9/22 at 8:55 a.m., indicated she was not aware the resident was not placed on TBP until yesterday afternoon. The resident had not received the COVID-19 vaccinations and should not be seated in common areas. If the resident was		· Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy. Policy: USE OF PPE WHILE IN THE FACIITY Policy: Criteria for Covid-19 Requirements and Resident Placement CDC: PPE sequence / Job Aides Competency: AAPACN PPE **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified	

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	a fall risk, then other measures needed to be put into place. 3. On 6/9/22 at 9:43 a.m., CNA 2 was observed in Resident B's room providing care. The CNA was only wearing a surgical mask. There was an isolation set up on the door and a sign indicating the resident was on droplet precautions. Interview with the CNA upon exit of the room, indicated she was aware she was supposed to have full PPE on when in isolation rooms. The current policy, "Criteria for COVID-19 Requirements and Resident Placement", was received from the DON on 6/9/22 at 11:15 a.m., indicated, "... All new admissions/re-admissions who are NOT up to date with all recommended Covid-19 vaccine doses...Residents will be placed in a private room if available per state requirements. Appropriate signage is placed on or around the resident room door...Full PPE is required when entering a resident room. Full PPE consists of N95 mask, eye protection, gown, and gloves. Full PPE should be located at or near the entrance to resident room...." 3.1-18(b)		changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. ·Ensure all staff are aware of who is on isolation and appropriate signage implemented and PPE is available for each room · Ensure staff appropriately don and doff PPE	

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			2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. ·Ensure all staff are aware of who is on isolation and appropriate signage implemented · Ensure staff appropriately don and doff PPE **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	