STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(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 Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 11, 2021. This visit was in conjunction with the Investigation of Complaints IN00356566 and IN00357133. Complaint IN00356566 - Substantiated. Federal/State deficiencies related to the allegations are cited at F661. Complaint IN00357133 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697. Survey dates: August 3, 4, and 5, 2021 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 9 Medicaid: 60 Other: 1 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/9/21.	F 0000	Please reference the enclosed 2567 as “plan of correction” For the complaint and Annual survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on 8/17/ 2021 serves as our allegation of compliance. The provider respectfully request a desk review on or after August 7th 2021Should you have any questions or concerns	

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

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			regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 2 of 3 residents reviewed for skin conditions (non-pressure related). (Residents 6 and 7) Findings include: 1. On 8/3/21 at 12:10 p.m., Resident 6 was seated in her wheel chair in the dining room. Areas of scabbing were observed on the left side of her	F 0684	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible*	08/14/2021

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	forehead. The resident was wearing a long sleeve shirt and had geri sleeves in place to both arms. On 8/5/21 at 1:05 p.m., the areas of scabbing remained to the left side of the resident's forehead and areas of purple bruising and scabs were observed on the resident's bilateral shins. No bruises were observed on her arms. The record for Resident 6 was reviewed on 8/3/21 at 1:56 p.m. Diagnoses included, but were not limited to, anxiety disorder, anemia, atrial fibrillation, and obsessive compulsive disorder. The Admission Minimum Data Set (MDS) assessment, dated 7/10/21, indicated the resident had short and long term memory problems and she needed extensive assistance with bed mobility and transfers. A Physician's Order, dated 7/5/21, indicated bruising to the resident's bilateral arms was to be monitored each shift until resolved. The July 2021 Treatment Administration Record (TAR), indicated the bruising was not monitored on the day shift on 7/10, 7/20, 7/26, and 7/27/21. The bruising was not monitored on the evening shift on 7/10 and 7/24/21. The bruising was not monitored on the night shift on 7/10, 7/11, 7/12, 7/22, 7/23, 7/24, 7/25, and 7/28/21. The August 2021 TAR, indicated the bruising had been signed out as being monitored all three shifts 8/1-8/4/21. A skin evaluation, dated 7/31/21 at 11:21 a.m., indicated the resident had bruising to her left and right legs and scabs to her forehead.		*allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 684 Quality of Care** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R6 discoloration on the forehead is resolving. R6 remains within his baseline of functioning. No signs of distress noted. ·R7's discoloration on right elbow have been assessed, monitored and documented. R7 remains within his baseline of functioning. No signs of distress noted. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses were in serviced on proper skin assessment, monitoring of alterations in skin, and proper documentation of	

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	A Physician's Order, dated 8/2/21, indicated to monitor the red scabs to the left upper forehead, as well as the scabs and scattered discolorations to the lower extremities every shift. The Physician was to be notified of any changes. The order was not listed on the August 2021 TAR and there was no documentation of the scabs and bruising being monitored. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated documentation should have been completed on the July TAR related to the arm bruising. She also indicated the order to monitor the scabs and bruising to the resident's forehead and legs should have been transcribed onto the August TAR. 2. Resident 7's record was reviewed on 8/3/21 at 1:15 p.m. Diagnoses included, but were no limited to, dementia, high blood pressure and arthritis. An interview on 8/3/21 at 1:00 p.m. with Resident 7, indicated he had moved his television and hurt his right arm. A large dark red discoloration with a small scab on the back of the resident's right elbow was observed at the time of the interview. A skin assessment was completed on 7/21/21 and indicated discolorations to the right elbow measuring 7.0 cm (centimeters) X 4.5 cm, the right wrist 2.8 cm X 3.9 cm, and the left forearm 2.8 cm X 3.5 cm. The current Physician's Order Summary, indicated on 7/21/21 to monitor discolorations to the right wrist, elbow and left forearm every shift until resolved.		findings and treatment on the medical records. ·DON/designee will audit skin documentations of 16 random residents weekly for 4 weeks then 10 random residents for 6 months to ensure that any alteration in skin condition is being assessed, monitored, and properly documented Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: 8/14/21	

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	The July 2021 Treatment Administration Record (TAR), lacked documentation the bruises had been monitored during the night shift on 7/22, 7/23, 7/24, and 7/28/21. The bruising was not monitored on the day shift on 7/24 and 7/27 and the evening shift on 7/24/21. Interview with the Director of Nursing on 8/5/21 at 10:03 a.m., indicated there was a lack of documentation on the TAR by the nurses to monitor his bruises. This deficiency was cited on June 11, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure residents	F 0686	*Submission of this plan of correction does not constitute*	08/14/2021

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	with pressure ulcers received the necessary treatment and services to promote healing related to ensuring treatments were completed as ordered for 2 of 2 residents reviewed for pressure ulcers. (Residents 3 and 2) Findings include: 1. The record for Resident 3 was reviewed on 8/4/21 at 11:07 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavior disturbance, and pressure ulcers. The Significant Change Minimum Data Set (MDS) assessment, dated 6/28/21, indicated the resident was severely cognitively impaired for daily decision making and was extensive assist for bed mobility and totally dependent on staff for transfers and eating. The resident had a significant weight loss during the assessment reference period and she had 1 stage 4 pressure area, 2 unstageable pressure areas, and 5 deep tissue injuries. The Care Plan, dated 6/2 and revised on 7/23/21, indicated the resident was at risk for further impaired skin integrity related to very limited sensory perception, skin very moist, bedfast, very limited mobility, probably inadequate nutritional intake, and potential problem with friction/shearing. The resident presented with impairment to the left heel, left lateral foot, left distal medial foot, left lateral ankle, right lateral ankle, left upper medial shin, right medial knee, and left lateral thigh. The resident was currently receiving palliative end of life care as well as comfort care per facility staff. Interventions included, but were not limited to, administer treatments as ordered and monitor for		*admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F686 Treatment/Prevent/Heal Pressure Ulcer** Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: ·R3 receives wound treatment and wound care as ordered. R3's wounds are being assessed by the wound care MD weekly. R3's treatments are being documented properly on the eTAR. ·R2 receives wound treatment and wound care as ordered. R2's wounds are being assessed by the wound care MD weekly. R2's treatments are being documented properly on the eTAR. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same	

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	effectiveness. A Physician's Order, dated 5/4/21, indicated the resident's left medial heel pressure area was to have betadine (a topical antiseptic) applied daily and the area was to be left open to air. The July 2021 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 7/1, 7/14, 7/17, 7/23, and 7/28/21. A Physician's Order, dated 6/28/21, indicated the resident's left medial shin wound was to be cleansed with normal saline, patted dry, and a hydrocolloid (a transparent dressing for wounds) dressing was to be applied every day shift on Monday, Wednesday, and Friday. The July 2021 TAR indicated the treatment was not signed out as being completed on 7/14, 7/23, and 7/28/21. A Physician's Order, dated 7/17/21, indicated the left distal medial foot and the left lateral foot was to be cleansed with normal saline or wound cleanser, pat dry, apply betadine saturated gauze, apply abd pad, and cover with kerlix every day shift. The July 2021 TAR indicated the treatments to the left distal medial foot and the left lateral foot were not signed out as being completed on 7/17, 7/23, and 7/28/21. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated the treatments should have been signed out as ordered. 2. Resident 2 was observed in his room sitting in his wheelchair on 8/3/21 at 9:55 a.m. His left leg was crossed over		deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses were in serviced to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to ensuring treatments were completed as ordered ·DON/designee will audit wound treatment documentations of 10 random residents weekly for 4 weeks then 7 random residents weekly for 6 months to ensure residents with pressure ulcers treatments are done and signed out appropriately on the eTAR Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on	

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	onto his right leg and his dressing to his left ankle area was soiled and orange in color. Part of the dressing had come off. An interview at that time with the resident, indicated the nurse was in earlier to give him his medications and he did not let her know his dressing needed to be changed. On 8/3/21 at 10:15 a.m. a wound treatment cart was observed in front of Resident 2's room, LPN 2 indicated the resident's wound dressing was soiled, had partially come off and she was changing the dressing now. An observation of the resident's wound treatment with LPN 2 was completed on 8/3/21 at 10:15 a.m. LPN 2 gathered the wound care supplies and placed them on 3 paper towels on the resident's bed spread. The resident was laying on his back in his bed on top of the bed spread. LPN 2 washed her hands and gloved, removed the old soiled dressing (not dated) and discarded the dressing into a garbage bag. The left lower ankle was cleansed with Dakins Solution (wound cleanser to prevent infection). Iodosorb gel (medication to help wound heal) was placed on a sterile 4 X 4 gauze pad and placed on the resident's left lower ankle, an abdominal pad was placed over the gauze and secured with kerlix (a gauze wrapping). The LPN 2 dated and initialed the kerlix. Resident 2's record was reviewed on 8/3/21 at 11:20 a.m. Diagnoses included, but were not limited to, frost bite, stroke and diabetes mellitus. The Physician's Order Summary lacked an order to use Iodosorb gel to the wound. A Wound Evaluation and Management Summary, dated 7/30/21, indicated the treatment to the left		additional Months until Compliance is sustained. Dates when corrective action will be completed: 8/14/21	

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	lower ankle was to cleanse with Dakin's Solution and place a gauze island twice a day for 30 days. A Nurses' Note, dated 7/30/21 at 3:05 p.m., indicated the resident was assessed by the wound doctor and new orders were received to change the treatment to Dakins Solutions. Interview with LPN 2 on 8/3/21 at 11:35 a.m., indicated she had not rechecked the resident's wound order. She usually worked the other hall and the last order was to place the Iodosorb gel to the wound. This deficiency was cited on June 11, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-40(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 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;			

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	§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 record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents who were nutritionally at risk for 2 of 3 residents reviewed for nutrition. (Residents 3 and 5) Findings include: 1. The record for Resident 3 was reviewed on 8/4/21 at 11:07 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavior disturbance, and pressure ulcers. The Significant Change Minimum Data Set (MDS) assessment, dated 6/28/21, indicated the resident was severely cognitively impaired for daily decision making and was extensive assist for bed mobility and totally dependent on staff for transfers and eating. The resident had a significant weight loss during the assessment reference period and she had 1 stage 4 pressure area, 2 unstageable pressure areas, and 5 deep tissue injuries. A Care Plan, updated on 7/14/21, indicated the resident had a nutritional problem or potential nutritional problem due to mechanically altered diet, skin breakdown, and increased protein needs. The resident presented with a greater than 10% weight loss in 180 days with a continued decline expected related to end of life processes. The resident was receiving palliative care. Interventions included, but were not limited to, provide and serve diet as ordered. Monitor intake	F 0692	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F692 Nutrition/Hydration Status Maintenance** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R3's meal consumption log was reviewed and updated. R3 was assessed by the dietitian and nutritional interventions in place. ·R5's meal consumption log was reviewed and updated. R5 was assessed by the dietitian and nutritional interventions in place remains at his baseline of functioning. No distress noted. How the facility will identify other residents having the potential to	08/14/2021

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	and record every meal. A Physician's Order, dated 6/15/21, indicated the resident was to receive a regular diet, puree texture. House shake at all meals. Assist with feeding all meals. The food consumption logs for July and August 2021, indicated meals were not documented for the following dates and times: -No meals documented on 7/11 and 7/18/21. -Breakfast and lunch not documented on 7/10 and 7/17/21. -Dinner not documented on 7/7, 7/8, 7/15, 7/16, 7/19, 7/20, 7/24, 7/25, 7/28, 7/31, 8/1, and 8/2/21. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated the food consumption logs should have been completed for each meal. 2. The record for Resident 5 was reviewed on 8/3/21 at 2:54 p.m. Diagnoses included, but were not limited to, stroke, dementia without behavior disturbance, dysphagia (difficulty swallowing), adult failure to thrive, schizophrenia, hemiplegia (muscle weakness), and psychotic disorder with hallucinations. The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/21, indicated the resident was cognitively impaired for daily decision making and needed supervision with eating. She received a mechanically altered, therapeutic diet and had sustained a significant weight loss of 5% in one month or 10% in 6 months. The Care Plan, dated 5/17/21, indicated the resident had a potential nutritional problem. The resident received a mechanically altered diet and had variable intake. She was underweight as		be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses were in serviced to ensure that resident's meal consumption is monitored and properly recorded on the medical records. ·DON/designee will audit meal consumption documentations of 16 random residents weekly for 4 weeks then 10 random residents weekly for 6 months to ensure residents receives adequate nutritional status related to meal consumption. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility	

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	evidenced by a body mass index (BMI) below normal range of 18.5-24.9 related to energy intake less than energy expenditure. The resident also had a history weight loss. Interventions included, but were not limited to, provide and serve diet as ordered, monitor intake and record every meal. A Physician's Order, dated 5/25/21, indicated the resident was to receive a pureed diet with double meat portions, super cereal at breakfast and ice cream at lunch. The food consumption logs for July and August 2021, indicated meals were not documented for the following dates and times: -No meals documented on 7/10, 7/11 and 7/17/21. -Dinner not documented on 7/7, 7/9, 7/15, 7/16, 7/18, 7/19, 7/20, 7/24, 7/25, 7/28, 7/30, 8/1, 8/2, and 8/3/21. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated the food consumption logs should have been completed for each meal. This deficiency was cited on June 11, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-46(a)(1)		stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: 8/14/21	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	155653	A. BUILDING 00 B. WING	08/05/2021

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were held per blood pressure parameters for 1 of 3 residents reviewed for unnecessary medications. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 8/4/21 at 12:07 p.m. Diagnoses included, but were not limited to, hypotension (low blood pressure) and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 5/28/21, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 7/1/21, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 2.5 milligrams (mg) by mouth three times a day. The medication was to be held if the systolic (top number) blood pressure was greater than 90 or if the diastolic (bottom number) blood pressure was	F 0757	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F757 Drug Regimen is Free from Unnecessary Drugs** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R4's medication administration	08/14/2021

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	greater than 60. The July 2021 Medication Administration Record (MAR), indicated the medication was given when the resident's systolic blood pressure was greater than 90 on the following dates and times: A.M. dose: 7/2, 7/3, 7/5, 7/6, 7/7, 7/10, 7/16, 7/18, and 7/30/21 Midday dose: 7/2, 7/9, 7/10, and 7/15/21 P.M. dose: 7/1, 7/5, 7/6, 7/8, 7/9, 7/12, 7/15, 7/17, 7/20, and 7/29/21 Interview with the Director of Nursing on 8/5/21 at 10:30 a.m., indicated the resident's medication should have been held based on the blood pressure parameters. This deficiency was cited on June 11, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)		record has been reviewed. BP were checked and R4's blood pressure remains within baseline. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nurses were in serviced to ensure that blood pressure are checked prior to administering BP medications, parameters are followed per doctor's order and documented properly on the medical records . ·DON/designee will audit medication administration record of 16 random residents weekly for 4 weeks then 10 random residents weekly for 6 months to ensure that resident's blood pressure is checked prior to giving BP medications and parameters are followed per doctor's orders. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are	

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			achieved and are permanent. All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: 8/14/21	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	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 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			

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	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 hand hygiene not completed prior to donning personal protective equipment (PPE) and not wearing the correct PPE in transmission based precaution (TBP) rooms for 2 of 2 residents in transmission based precautions. (Residents 9 and 8) Findings include: 1. During a random observation, on 8/3/21 at 1:41 p.m., Resident 9 was observed in his room on all fours. Therapy Staff 1 and CNA 1 were observed donning personal protective equipment (PPE) outside of the resident's room. They donned a gown and gloves. They were wearing a face shield as well as a surgical mask. The Administrator also donned a gown and gloves. She was wearing a face shield and a surgical mask as well. The three of them entered the resident's room to provide care. Interview with the Administrator at 1:44 p.m., indicated the resident was in TBP due to being a new admission. He had not been vaccinated for COVID-19. She also indicated the CNA, therapist	F 0880	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* F880 Infection Control Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: ·There was no noted spread infection and communicable diseases.	08/14/2021

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	and herself should have been wearing an N95 mask instead of a surgical mask. 2. During a random observation, on 8/4/21 at 8:50 a.m., CNA 2 was observed to deliver Resident 8's breakfast tray. The CNA was wearing an N95 mask and no other PPE. The CNA was observed repositioning the resident and setting up her breakfast chair. There was an isolation set up outside of the resident's door and a sign on the door indicating she was in contact/droplet isolation. Interview with the CNA at the time, indicated she was not aware she had to put on full PPE to deliver meal trays. Interview with the Second Floor Unit Manager at the time, indicated the CNA should have donned a face shield, gown, and gloves prior to entering the resident's room. The record for Resident 8 was reviewed on 8/5/21 at 1:00 p.m. Diagnoses included, but were not limited to, stroke and congestive heart failure. A Physician's Order, dated 7/21/21, indicated the resident was in contact and droplet isolation related to new admission/re-admission. There was no order indicating when the isolation was to be discontinued. 3. During a random observation, on 8/4/21 at 8:58 a.m., RN 1 was observed donning PPE prior to entering Resident 9's room. The RN did not use hand sanitizer before donning her gown or her gloves. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated the RN should have used		How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Nursing staff has been in-serviced on the infection control policy including but not limited to: 1. Hand hygiene before and after donning and doffing of personal protective equipment (PPE) 2. Wearing of appropriate personal protective equipment (PPE) when rendering care of residents that are on TBP (transmission based precautions). ·DON/designee will do 7 random staff observations weekly for 4 weeks then 5 random staff weekly for 6 months to ensure that hand hygiene is completed during	

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	hand sanitizer before donning her gown and her gloves. 4. During a random observation, on 8/4/21 at 9:18 a.m., CNA 2 was observed donning PPE in the hallway prior to entering a TBP room. She sanitized her hands prior to donning her gown, however, she did not hand sanitize prior to donning her gloves. She repeated the same routine prior to entering another TBP room. Interview with the Director of Nursing on 8/5/21 at 10:15 a.m., indicated the CNA should have used hand sanitizer prior to applying her gloves. The COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated on 7/23/21, indicated the following: "Unknown COVID-19 status (Yellow): All residents in this category warrants (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed." "Glove Hygiene: Perform hand hygiene before use of non-sterile gloves upon entry into the resident room for direct care area." This deficiency was cited on June 11, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)		donning and doffing of personal protective equipment (PPE) and staff are wearing the correct PPE in rooms that are in transmission based precautions. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: 8/7/21 **2.Directed Plan of Correction** F880 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any	

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			admission of guilt or liability by the facility and is submitted only on response to the regulatory requirements. 3.Directed Plan of Correction F880 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only on response to the regulatory requirements. 1.Staff received education from Assurance with links to pertinent CDC guidance on Covid 19. The following links included: Clean Hands and PPE use- https://youtu.be/xmYMUly7qiE Lessons - https://youtu.be/YYTATw9yav4 1.The Infection Preventionist, Director of Nursing in conjunction with the Medical Director and senior leadership completed policies related to the development and implementation of the following: ·Develop and implemented Infection control training of staff including but not limited to proper hand hygiene and appropriate PPE use	

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			·Staff were re-educated on Covid19 infection prevention and procedures ·Screening of staff at the beginning and end of their shift for fever, respiratory symptoms. This includes actively measuring and recording staff temperatures and assessment of any covid signs and symptoms. ·Remind residents to practice social distancing and perform frequent hand hygiene. ·Educate and assist the resident to utilize an appropriate mask to reduce droplet spread. ·Coordinate with medical provider to obtain necessary testing as required. 1.Root Cause Analysis: Problem statement Staff failed to perform hand hygiene before and after donning of PPE and failed to utilize appropriate PPE prior to entering resident's rooms that are on transmission based precautions. Why? Staff fails to follow proper protocol of Hand Hygiene and PPE use protocol despite regular in services and education Why? Staff trying to rush through assignments Why? Staff wants to accomplish tasks faster	

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			Why? Staff lacks awareness of the importance of ensuring that proper HH and proper use of PPE is critical in providing care to residents to prevent spread of infection Root Cause(s) Staff needs more awareness of the proper infection control and prevention program and requires more education/training and supervised return observations. 1.Implemented system changes: ·Increase routine in-servicing of staff on Infection control prevention basics including but not limited to hand hygiene, mask, gloves, gown, utilizing proper PPE for transmission-based precautions. ·Increase routine return demonstration for hand hygiene and proper PPE use. ·Develop and implement infection signs and symptom tracking tool to monitor all residents and staff for communicable, respiratory infections. ·Staff involved were educated (with return demonstration) for hand washing and ABHS and have an understanding on when to perform HH, that handwashing	

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			with soap and water will be performed when hands are visibly soiled or the use of ABHS as appropriate. Hand hygiene practices, observation and return demonstration will be done with staff twice monthly at a minimum of 6 months and as needed until compliance is met. ·Staff will receive education on using PPE when entering and leaving rooms on transmission based precautions (TBP). Education will include demonstration and knowledge check testing. 1.Monitoring: Monitoring of approaches to ensure infections are controlled will include: ·The Facility will ensure adequate supplies of PPE are readily available to all staff ·The Infection Preventionist and/or the Director of Nursing or designee, each day Monday through Friday and more often as necessary, will monitor hand hygiene practices, observation and return demonstration with staff. Further monitoring will be performed twice monthly at a minimum of 6 months and as needed and will perform audits/observations and review of infection prevention tracking and trending. Any noted discrepancies will be corrected immediately. Any unexpected increases in infection will result in	

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			communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection. Such monitoring will continue until the facility has been infection free for at least six weeks. ·The Infection Preventionist, Director of Nursing and or designee and other leadership will conduct rounds throughout the facility to ensure staff are exercising appropriate use of PPE, proper hand hygiene practices, and to ensure infection control procedures are followed. ·The facility conducted RCA with the help of the Infection Preventionist. 1.The facility through QAPI program will review, update, and make changes to the DPOC as needed for substantial compliance for no less than 6 months. Completion date: August 14, 2021	
F 9999 Bldg. 00		F 9999	we cleared this tag???	08/05/2021