**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>IDENTIFICATION NUMBER</th>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY</th>
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<td>155670</td>
<td>A. BUILDING 00</td>
<td>B. WING</td>
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**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE OF NEWBURGH

**STREET ADDRESS, CITY, STATE, ZIP CODE**

5233 ROSEBUD LANE

NEWBURGH, IN 47630

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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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**PREPARATION AND/OR EXECUTION**

Preparation and/or execution of this plan of correction in general, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. The facility respectfully requests a paper compliance review.

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**483.20(k)(1)-(3)**

PASARR Screening for MD & ID

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k) (3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation 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 disclosed 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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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.
performed by a person or entity other than the State mental health authority, prior to admission,  

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and  

(B) If the individual requires such level of services, whether the individual requires specialized services; or  

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-  

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and  

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-  

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual—  

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
### Statement of Deficiencies

Based on observation, interview, and record review, the facility failed to ensure newly admitted residents had a preadmission screening for mental illness after admission to the facility for 2 of 3 residents reviewed. (Resident 23, Resident 32)

**Findings include:**

1. On 5/3/21 at 10:17 a.m., Resident 23 was observed sitting in his room talking and yelling aloud.

   The clinical record for Resident 23 was reviewed on 5/4/21 at 1:35 p.m. Diagnoses included, but were not limited to, schizophrenia, major depressive disorder, hallucinations, mental disorder, generalized anxiety disorder, and insomnia. Resident 23 had been admitted to the facility on 12/21/20. An admission MDS (Minimum Data Set) assessment, dated 12/28/20,

### Provider's Plan of Correction

1. **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?**
   - Residents #23 and #32 PASRR have been completed.

2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**
   - 100% Audit of residents admitted in the last 30 days has been completed ensure PASRR complete.

3. **What measures will be put into place and what systematic changes will be made to ensure**

indicated the resident had severe cognitive impairment. The MDS indicated Resident 23 had not been evaluated by Level II PASRR (Preadmission Screening and Resident Review) and determined to have a serious mental illness.

A Preadmission Screening and Resident Review, dated 2/26/21, provided by Social Service 1 on 5/4/21 at 1:31 p.m., included Resident 23 had a PASRR Level I completed. The report indicated a PASRR Level II evaluation should be conducted. The report indicated the PASRR level II had not been completed until 3/11/21 and the resident was approved for short term stay at the facility without specialized services.

On 5/6/21 at 8:53 a.m., Social Service 1 indicated the facility had not completed the PASRR in the 30 days of admission to the facility. SS 1 indicated the hospital had done the PASRR level 1 in the past but had not been doing them recently. She indicated she had not noticed the PASRR level 1 had not been completed when the resident had been admitted.

2. On 5/4/21 at 8:20 a.m., Resident 32 was observed to be laying in bed. His room door was shut. The resident indicated he had paralysis from the waist down and stayed in his room. He indicated he did not like to get out of bed.

The clinical record for Resident 32 was reviewed on 5/4/21 at 2:11 p.m. Diagnoses included, but was not limited to, traumatic brain injury, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). Resident 32 had been admitted to the facility on 3/22/21. An admission MDS (Minimum Data Set) assessment, dated 3/29/21, indicated the resident had slight cognitive impairment.

that the deficient practice does not recur?

· Social Service Director has been educated on the PASRR requirement and a tracking system has been put in place.

4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?

· SSD will monitor tracking log monthly x 3 and/or until QAPI team determines substantial compliance has been achieved. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. The review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance Committee.
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<tr>
<td>F 0656</td>
<td>SS=D</td>
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<td>The facility lacked documentation of a Preadmission Assessment and Record Review level I or level II for Resident 32.</td>
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<td>On 5/4/21 at 1:28 p.m., Social Services 1 indicated she had forgot to do a PASRR level I on Resident 32.</td>
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<td>On 5/6/21 at 8:53 a.m., Social Services 1 indicated she was working on the PASRR level 1 for Resident 32.</td>
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<td>The current facility policy, &quot;Pre-Admission Screening and Resident Review (PASRR),&quot; reviewed 8/1/18, provided by the Director of Nursing on 5/6/21 at 12:01 p.m., included but not limited to, &quot;All applicants to Medicaid-certified nursing facility, regardless of payment or known diagnoses, are given a preliminary assessment to determine whether they might have SMI (serious mental illness) or ID (intellectual disabilities). This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in determination of appropriate setting and a set of recommendations for services to inform the individual's plan of care. An individual is considered to have a serious mental illness if the individual meets the following requirements on diagnosis, level of impairment and duration of illness...&quot;</td>
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<td>Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered</td>
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care plan for each resident, consistent with
the resident rights set forth at §483.10(c)(2)
and §483.10(c)(3), that includes measurable
objectives and timeframes to meet a
resident's medical, nursing, and mental and
psychosocial needs that are identified in the
comprehensive assessment. The
comprehensive care plan must describe the
following -

(i) The services that are to be furnished to
attain or maintain the resident's highest
practicable physical, mental, and
psychosocial well-being as required under
§483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be
required under §483.24, §483.25 or §483.40
but are not provided due to the resident's
exercise of rights under §483.10, including
the right to refuse treatment under §483.10(c)
(6).

(iii) Any specialized services or specialized
rehabilitative services the nursing facility will
provide as a result of PASARR
recommendations. If a facility disagrees with
the findings of the PASARR, it must indicate
its rationale in the resident's medical record.

(iv) In consultation with the resident and the
resident's representative(s)-

(A) The resident's goals for admission and
desired outcomes.

(B) The resident's preference and potential for
future discharge. Facilities must document
whether the resident's desire to return to the
community was assessed and any referrals
to local contact agencies and/or other
appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive
care plan, as appropriate, in accordance with
the requirements set forth in paragraph (c) of
this section.
Based on observation, interview, and record review, the facility failed to develop a care plan for 1 of 2 residents reviewed for dental, follow the plan of care for 1 of 4 residents reviewed for nutrition. A resident with missing upper teeth did not have a care plan, a resident's physician orders and care plan were not followed. (Resident 23, Resident 149)

Findings include:

1. On 5/3/21 at 2:55 p.m., Resident 149 was observed sitting in her room in a wheelchair, a sling was observed on her right arm.

On 5/5/21 at 8:23 a.m., Resident 149 was sitting in her room in her wheelchair. Her right arm was observed in a sling. Resident 149 indicated she had eaten breakfast, but that some of it had fallen on the floor because she has a hard time eating by herself, staff were supposed to assist her to eat but had not. Food was observed on the floor.

On 5/5/21 at 9:20 a.m., a Styrofoam cup with a lid and straw, dated 5/4/21 was observed sitting on Resident 149's nightstand.

On 5/5/21 at 11:40 a.m., Resident 149 was observed sitting in her room in her wheelchair, she indicated she is supposed to be assisted with her meals because she is partially blind and her arm is in a sling. She further indicated she is not assisted to eat at any meal by staff. The cup of water was still at bedside.

On 5/5/21 from 12:15 p.m. to 12:50 p.m., a continuous observation was done. Resident 149 was observed in her room sitting in her wheelchair with her lunch tray in front of her eating. No staff were observed in her room. Staff were observed

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<td>F0656</td>
<td>1</td>
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<td>1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</td>
<td>05/21/2021</td>
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<td>· Resident #23 and Resident #149 care plans were reviewed and updated as appropriate.</td>
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<td>· Resident #23 fluid restriction was discontinued on 5/20/21.</td>
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<td>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</td>
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<td>· House-wide audit of all residents on fluid restriction was completed to ensure all had care plans in place.</td>
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<td>· House-wide audit of all resident eating status was completed to ensure all residents who require assistance with meals had care plans in place.</td>
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<td>· New dental observations for all residents were completed to ensure all residents with dental issues had care plans in place.</td>
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<td>· Care plans for residents identified with dental needs have been reviewed and updated as appropriate.</td>
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<td>· Care plans for residents with nutritional needs have been reviewed and updated as appropriate.</td>
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<td>3. What measures will be put into place and what systematic changes will be made to ensure</td>
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outside of Resident 149's room waiting on the next food cart to be delivered. At 12:43 p.m., Resident 149's tray was observed. It contained peas, mashed potatoes, mechanical altered chicken, a slice of bread in a bag, and a piece of cake covered with saran wrap. Bites of food were observed gone.

On 5/5/21 at 12:50 p.m., CNA 2 was observed to enter Resident 149's room and exit the room with the food tray. CNA 2 indicated she picks up the food tray if the resident says they are finished eating.

On 5/4/21 at 9:55 a.m., Resident 149's record was reviewed. She had diagnosis that included, but were not limited to, acute on chronic diastolic (congestive) heart failure (admission), dementia in other diseases elsewhere without behavioral disturbance, Parkinsons disease, Alzheimers disease, hypertension, dysphagia, oropharyngeal phase, right upper quadrant swelling, mass, and lump, unspecified cirrhosis of liver, need for assistance with personal care, unspecified fracture of upper end of right humerus, subsequent encounter for fracture with routine healing.

Physician orders for 5/1/21 to 5/6/21 were reviewed, and included, but were not limited to, diet type: NAS (no salt added), mechanical soft, fluids thin, divided plate all meals, requires assistance for all meals, ...no fluid at bedside, (sling to R) arm...

An admission MDS (Minimum Data Set), dated 4/21/21 indicated Resident 149's cognition was severely impaired, eating extensive with assist of one. Section K on the MDS, swallowing/nutritional status, was marked for loss of liquids/solids from mouth when eating or
Care plans were reviewed and include, but not limited to:

Nutritional status: start date of 4/16/21, resident is at nutrition and/or hydration risk as evidenced by:

- diagnosis including cirrhosis with ascites as well as CHF requiring fluid restriction with therapeutic diet.
- Mechanically altered diet related to chewing and swallowing problem with DX of dysphagia.
- Resident is right hand dominant and has a FX R) humerus.
- Pitting edema to BLE with temporary increase in diuretic resulting in fluid related weight loss.

Interventions included, but were not limited to:

- assistance provided with meals, start date of 4/29/21
- no fluids at bedside, start date of 4/19/21
- On 5/5/21 at 9:04 a.m. LPN 1 indicated he was unsure if Resident 149 was an assist with meals.
- On 5/5/21 at 12:55 p.m., CNA 1 indicated Resident 149 was a set up to eat and feeds herself, staff do not assist her to eat.
- On 5/6/21 at 11:36 a.m., the DON (Director of Nursing), indicated she did not know why the staff caring for Resident 149 did not know she was supposed to be assisted to eat, and it would be addressed.
- 2. On 5/3/21 at 9:05 a.m., Resident 23 was observed to be sitting in a chair in his room.
- Resident 23 indicated he only had 2 or 3 upper teeth and would like to see a dentist for dentures.
On 5/4/21 at 8:15 a.m., Resident 23 indicated he only used mouthwash for oral care.

The clinical record for Resident 23 was reviewed on 5/4/21 at 1:35 p.m. Diagnoses included, but were not limited to, schizophrenia, major depressive disorder, hallucinations, mental disorder, generalized anxiety disorder, and insomnia. An admission MDS (Minimum Data Set) assessment, dated 12/28/20, indicated the resident had severe cognitive impairment. The MDS indicated the resident had obvious or likely cavity or broken natural teeth.

An "self-care deficit" care plan, start date 12/28/20, included, but was not limited to, eating - supervision, set-up.

The clinical record lacked documentation of a care plan regarding the resident's dental status.

On 5/5/21 at 11:40 a.m., the Administrator indicated Resident 23 had missing teeth but had not been able to see a dentist due to his schizophrenia and behaviors.

On 5/6/21 at 10:37 a.m., the Director of Nursing indicated all nurses had access to care plans, but usually the MDS Coordinator would complete them. The facility should complete a care plan if a resident had dental issues.

The current facility policy, "Comprehensive Care Plans," revision date 7/19/18, provided by the Director of Nursing on 5/6/12 at 12:06 p.m., included, but was not limited to "A person-centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each
resident. The Comprehensive Care Plan will be person-centered to include the discharge plans to meet the resident's preferences and goals to address the resident's medical, physical, mental and psychosocial needs. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment... care plan interventions are implemented after considerations of the resident's problem areas and their causes. Interventions address the underlying source(s) of the problem area(s), rather than addressing only the symptom triggers. The interventions will reflect action, treatment, or procedure to meet the objectives toward achieving the resident goals... care plans are ongoing and revised as information about the resident and the resident's condition change. The nurse/interdisciplinary team is responsible for the review and updating of care plans. The care plan should reflect the current status of the resident and be updated with changes in the resident status.

On 5/6/21 at 12:06 p.m., the DON provided a document titled "Physician Orders At -A- Glance" The document had a revision date of 11/6/19. The document included, but was not limited to, following identification of root cause, individuals responsible for the error or omission will receive training to clarify proper procedure and must demonstrate (through verbal or written) competency

3.1-35(a)(e).

F 0695
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483.25(i) Respiratory/Tracheostomy Care and Suctioning
§ 483.25(i) Respiratory care, including...
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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- **Finding includes:**
  - On 5/3/21 at 10:13 a.m., Resident 27 was observed wearing oxygen per nasal cannula at 4 liters per minute via oxygen concentrator with no humidification.
  - On 5/4/21 at 9:14 a.m., Resident 27 was observed wearing oxygen per nasal cannula at 4 liters per minute via oxygen concentrator with no humidification.
  - On 5/4/21 at 9:55 a.m., the record for Resident 27 was reviewed. The record indicated, but was not limited to, oxygen therapy order, dated 3/4/21, which stated - oxygen via NC (nasal cannula) at 4 liters per minute to maintain oxygen saturation greater than 90% (percent).
  - On 5/5/21 at 3:08 a.m., Resident 27 was observed wearing oxygen per nasal cannula at 4 liters per minute via oxygen concentrator with no humidification.

- **1.** What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?
  - Resident #27 was provided humidification.

- **2.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?
  - House-wide audit of all residents on 4 liters of oxygen was completed to ensure all orders reflected to have humidification provided.
  - Residents who require 4 liters or more of oxygen care plans have been audited to ensure care plans are reflective of their needs.

- **3.** What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?
  - Nursing staff have been educated in relation to providing...
On 5/5/21 at 3:11 p.m., LPN 1 indicated they use humidification anytime there is oxygen. There should be humidification on oxygen, and Resident 27 should have humidification in place. He would get one (humidification bottle) and put it on.

On 5/6/21 at 12:06 p.m., the Director of Nursing provided the current facility policy, Oxygen Administration - Nasal Cannula Clinical Practice Guideline, last reviewed dated 10/23/2020. The Policy indicated, but was not limited to, "Humidification of oxygen is used for a flow rate of four liters per minute or greater, or if requested by a patient."

3.1-47(a)(6)

humidification to oxygen concentrators when oxygen is ordered at 4 liters or more.

- Ambassador Rounds have been updated to include oxygen administration and humidification needs.
- CNA Care Guides have also been reviewed and updated to include oxygen and humidification needs.

4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?

- The SDC or designee will conduct random audits of residents who require 4 liters or more of oxygen to ensure that humidification is in place per the policy and procedure weekly times 4 weeks, monthly times 4 months and then quarterly times 3 quarters. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance Committee.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Based on observation, interview, and record review, the facility failed to ensure medications were labeled with open dates upon opening and discard potentially outdated medications for 1 of 2 medication carts reviewed. (East Medication Cart 2, Resident 4, Resident 2, Resident 20, Resident 44, Resident 23, Resident 17)

Findings included:

On 5/4/21 at 11:26, Agency RN 1 was observed at the East Medication Cart 2. The East Medication Cart 2 was observed and contained:

F 0761

1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?
   · Residents #2, 4, 17, 20, 23 and 44 medications were labeled or discarded per policy.

2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?

05/21/2021
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<td>1. Open vial of Novolog (treats elevated blood sugar levels) insulin 100u/ml (units per milliliter), 10 units sq (subcutaneous) with meals, order after 4/16/21, with no open date, for Resident 4.</td>
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<td>A QA tool has been implemented to ensure all medications that should be labeled when opening or discarded upon date of expiration are being handled appropriately per facility policy and state regulations.</td>
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<td>2. Open vial of Lantus insulin (treats elevated blood sugar levels) U-100, inject 44 units sq daily, order after 4/1/21, with no open date, for Resident 2.</td>
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<td>Medication carts will be reviewed daily, Monday thru Friday to ensure all medication is labeled and or discarded appropriately.</td>
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<td>3. Open vial of Lantus insulin (treats elevated blood sugar levels) U-100, 100 unit/ml (milliliter) subcutaneous daily, order after 4/29/21, with no open date for Resident 20.</td>
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<td>3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?</td>
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<td>4. Open vial of Novolog insulin (treats elevated blood sugar levels) 100u/ml flexpen, subcutaneous daily before meals and at bedtime, order after 5/7/2, with no open date for Resident 44.</td>
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<td>Nursing staff have been educated in relation to the policy and procedure for dating of medications when opening and the discarding of medications upon expiration date.</td>
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<td>5. Open bottle of Durezol (medication to treat eye irritation and inflammation) 0.05% instill 1 drop in right eye daily, order after 3/31/21, with no open date for Resident 23.</td>
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<td>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?</td>
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<td>6. Open bottle of Timolol maleate (treats increased eye pressure) 0.5% 1 drop each eye twice daily, order after 4/11/21, with no open date for Resident 17.</td>
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<td>The ADON or designee will conduct random audits of medication carts to ensure medications that require a date when opened are dated and that all medications that are expired are disposed of according to facility policy, weekly times 4 weeks, monthly times 4 months and then quarterly times 3</td>
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<td>7. Open bottle of Dorzolamide (treats increased eye pressure) 2% 1 drop each eye daily, order after 5/14/21, with no open date for Resident 17.</td>
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<td>8. Open bottle of Dorzolamide -timolol (treats increased eye pressure) eye drops, instill 1 drop in right eye daily, pharmacist delivery date 3/21/21, with no open date for Resident 23.</td>
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<td>(Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
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9. Open bottle of Retaine pm (treats dry eyes) eye ointment, apply to affected eyes daily, order after 4/21/21, with no open date for Resident 23.

On 5/4/21 at 11:34 p.m., Agency RN 1 indicated Novolog was good for 30 days. All insulins and eye drops should have an open date.

On 5/6/21 at 12:06 p.m., the Director of Nursing provided the current facility policy, Medication Storage, Storage of Medication, dated 1/21. The Policy indicated, but was not limited to, "note the date on the label for insulin vials and pens when first used...outdated, contaminated, discontinued or deteriorated medications and this in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of...and reordered from the pharmacy..."

3.1-25(j)

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 quarters. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance Committee.
controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

$483.80(a)(2)$ Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be 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, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 and to ensure infection control practices were followed during resident care for 2 of 5 residents, and 5 of 5 residents observed for medication administration practices. Hand hygiene was not performed when indicated during medication administration, when entering rooms in isolation precautions, or when indicated during resident care. Surgical mask was not changed to N95 when entering yellow contact droplet precaution room. (Resident 199, Resident 17, Resident 42, Resident 47, Resident 15, Resident 24, Resident 34)

Findings included:

1. On 5/4/21 at 8:26 a.m., LPN 1 was observed to don full PPE (personal protective equipment) without performing hand hygiene, administer oral medications, removed (doffed) full PPE, and perform hand hygiene, for Resident 199 who was in droplet isolation (yellow zone room) related to being a new admission per guidelines.

The Transmission Based Precautions sign on yellow rooms indicated contact droplet and PPE

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What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

- Staff involved have been educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, eye protection and hand hygiene following facility policy and CDC guidance.

2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:

- AD HOC QAPI meeting conducted on 05/19/2021 and attended by Medical Director, Nurse Practitioner, CEO, DON, ADON, and Staff Development Coordinator. The Root Cause analysis determined to be agency staffing, staff non-compliance, and
required included N95 mask on Resident 199's room door.

2. On 5/4/21 at 8:47 a.m., Agency RN 1 was observed to prepare oral medications for Resident 17. Agency RN 1 obtained medication cards from the medication cart without performing hand hygiene, popped the medications in the medication cup, obtained applesauce and a glass of water, entered Resident 17's room and administered the medications. Agency RN 1 then handed Resident 17 the call light, returned to the medication cart, and failed to perform hand hygiene.

3. On 5/4/21 at 9:03 a.m., CNA 6 was observed to enter Resident 199's room, which was in yellow isolation precautions. CNA 6 was not observed to perform hand hygiene, applied isolation gown and gloves, entered Resident 199's room wearing a surgical mask, and failed to change into a N95 mask, to get Resident 199 for his appointment.

4. On 5/4/21 at 11:13 a.m., LPN 1 was observed to perform an accu check for Resident 42. LPN 1 gathered accu check supplies, went to Resident 42's bathroom for paper towel and laid the toweling and supplies on the bed side table. LPN 1 then applied gloves with no hand hygiene, set up the glucometer, applied alcohol to Resident 42's finger, performed finger stick, applied blood to the glucometer strip, obtained the results, and exited to place the disposable used items in the sharps container. LPN 1 removed his gloves, and no hand hygiene was observed. LPN 1 returned to Resident 42's room to obtain a clean pair of gloves and applied with no hand hygiene observed. LPN 1 then cleaned the glucometer and removed his gloves, no hand hygiene was observed. LPN 1 obtained an alcohol pad from the

lack of continuous education and more frequent compliance checks by facility leaders. It was identified that staff need to be re-educated and monitored for compliance more often.

· The LTC Infection Control Assessment was reviewed and applicable changes were made.
· Training initiated for all staff: Isolation, Handwashing and Cleaning and Disinfecting of Care Items policies, with return demonstration of donning and doffing PPE and handwashing.

3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:

· Education for all staff with return demonstration for hand hygiene, (handwashing and ABHS) and understand when to perform hand hygiene.
· Education of nursing staff on infection control practices during medication administration to prevent possible contamination of medication.
· Education of proper performance of ADL care including, but not limited to perineal care for male or female residents.
· Medication pass competencies will be performed with licensed nurses specific to
medication cart and indicated Resident 42 was going to receive Novolog per sliding scale and dialed up the dose on the flexpen. LPN 1 then applied gloves with no hand hygiene, applied the needle to the flexpen, applied alcohol to Resident 42's right arm, and injected the insulin. LPN then exited Resident 42's room, put the needle in the sharps container, removed his gloves and no hand hygiene was observed.

On 5/4/21 at 11:24 a.m., LPN 1 indicated hand hygiene should have been performed before the accu check and after the shot.

5. On 5/5/21 at 7:57 a.m., QMA 2 was observed to obtain medications for Resident 47. QMA 1 obtained a nasal spray and an inhaler, handed the inhaler to Resident 47 for use, administered the nasal spay to Resident 47 without applying gloves, and exited Resident 47's room with no hand hygiene, and returned the inhaler and nasal spray to the medication cart. No hand hygiene was observed.

On 5/5/21 at 8:07 a.m., QMA 2 indicated she should have performed hand hygiene between the inhaler and when finished.

6. On 5/5/21 at 8:13 a.m., QMA 1 was observed to obtain medications for Resident 15. QMA 1 entered Resident 15's room, no hand hygiene was observed, checked his blood pressure with automatic blood pressure cuff, returned to the medication cart and obtained a glass of water, no hand hygiene was observed. QMA 1 returned to Resident 15's room, handed Resident 15 the cup of oral medication and water, poured the left over water out in the resident bathroom and returned to the medication cart. No hand hygiene was observed.

- Staff will not be allowed to work prior to receiving the previous education.
- Facility has partnered with QSource-CMS services, who will be assisting the facility in achieving, and sustaining continued Infection Control compliance. QSource Advisor has assisted the facility in directed education and will be providing on-going facility consultation.

4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:

- The Infection Control Preventionist/Designee will complete daily infection control rounds as well as visual rounds throughout the facility to ensure staff are practicing appropriate infection control practices as they relate to donning/doffing PPE, and hand hygiene. The rounds will include monitoring for compliance with the solutions identified in the root cause analysis. These rounds will occur seven days a week for six weeks, then three times weekly for 6 weeks, then weekly for two quarters.
- Results of rounds will be submitted to QAPI for review to ensure increased compliance goals. QAPI Team will update and make changes to the DPOC as
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7. On 5/5/21 at 8:29 a.m., QMA 1 was observed to obtain medications for Resident 17. No hand hygiene was observed prior to popping the oral medications into the medication cup. Upon completion of administering oral medications to Resident 17, QMA 1 returned to the medication cart, discarded resident refused pill to the sharps container, and performed hand hygiene.

On 5/5/21 at 8:44 a.m., QMA 1 indicated he "messed up so bad". He was supposed to perform hand hygiene in between residents, anytime he used gloves, and when administering eye drops.

8. On 5/5/21 at 8:47 a.m., Resident 24 was observed to receive a shower. CNA 3 was observed to wash Resident 24's front peri area, rinsed the area, and carried the used washcloths to the soiled barrel in the shower room and place them inside. No change in gloves was observed or hand hygiene performed. CNA 3 then obtained a dry clean washcloth for Resident 24 to hold over her eyes and proceeded to wash Resident 24's hair...CNA 3 obtained towels and assisted Resident 24 to dry off, applied clean gown to cover resident, removed her gloves and performed hand hygiene....in Resident 24's room, CNA 3 was observed to wash Resident 24's rectal area, rinse and dry. CNA 3 then bagged the used washcloth, and gloves were not changed or hand hygiene performed. CNA 3 and CNA 5 applied a clean brief, applied lotion to Resident 24's legs...CNA 3 emptied and dried the bath basin, obtained the bags and transported them to the soiled utility, and sanitized her hands.

On 5/5/21 at 11:03 a.m., CNA 3 indicated she was to perform hand hygiene when she goes in, when hands are soiled, when changing gloves, and...
when you leave.

9. On 5/5/21 at 10:38 a.m., QMA 1 was observed handing a urinal to Resident 34 with a gloved hand. QMA 1 removed his gloves and left the room with no hand hygiene, walked up the hallway and spoke to RN 2, walked to the medication cart, and touched the computer. QMA 1 then performed hand hygiene.

On 5/5/21 at 11:01 a.m., QMA 1 indicated hand hygiene should be performed before entering a room, anytime you change gloves, when hands are visibly soiled, and when done.

On 5/6/21 at 12:06 p.m., the Director of Nursing provided the facilities current policy, Handwashing / Hand Hygiene, revised date August 2019, The Policy indicated, but was not limited to, "This facility considers hand hygiene the primary means to prevent the spread of infections...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...before and after direct contact with residents...before preparing or handling medications...before moving from a contaminated body site to a clean body side during resident care...after contact with blood or bodily fluids...after removing gloves...before and after entering isolation precaution settings..."

3.1-18(b)
3.1-18(f)