STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155843	A. BUILDING 00 B. WING	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS OF RICHMOND, THE	400 INDUSTRIES ROAD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00386195 and Complaint IN0390959. This visit included a State Residential Licensure Survey. Complaint IN00386195 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-684, F-686 and F-689. Complaint IN00390959 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-684 and F-686. Survey dates: September 25 through September 30, 2022 Facility number: 013635 Provider number: 155843 AIM number: 300026664 Census Bed Type: SNF/NF: 39 SNF:7 Residential: 11 Total: 57 Census Payor Type: Medicare: 30 Medicaid: 7 Other: 9 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 5, 2022	F 0000	The submission of this plan of correction does not indicate an admission that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Springs of Richmond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

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

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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, interview, and record review, the facility failed to provide fresh water daily and failed to assist a legally blind resident with meal set up, a divided plate and built up utensils. This affected 2 of 2 residents reviewed for dehydration. (Resident 31 and J) Findings include: 1. On 9/26/22, at 10:46 a.m., Resident 31 had no fluids in her room and she indicated normally they were good to provide fluids. She said they have not passed it today and she is unsure of the normal time to pass water. On 9/27/22, at 10:59 a.m., Resident 31 was sitting in her room in a recliner. She had no fluids in her room. She indicated they will bring something in the afternoon so she will have a drink during the night. Resident 31's record was reviewed on 9/28/22 at 10:13 a.m. and indicated Resident 31 had diagnoses that included, but were not limited to, dehydration, atrial fibrillation, hypertensive heart disease with heart failure, chronic congestive heart failure, and type 2 diabetes mellitus. An Admission Minimum Data Set assessment, dated 9/2/22, indicated Resident 31 was	F 0558	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Fresh ice water was given to Resident 31, 33 and Resident J. Meal set up assistance was provided to resident 33. Resident J was evaluated for the need of a divided plate and build up utensils. **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** All residents have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All residents were reviewed for the need of meal set up assistance and meal assistance devices. Nursing and dietary staff were educated on provided meal	11/01/2022

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	cognitively intact, required supervision and set up for eating, extensive assist of one for transfers and bed mobility, no impairment in range of motion, used a walker, had a problem condition of dehydration, and had no swallowing problems. Resident 31's diet orders included thin liquids. Resident 31 had an order for Spironolactone 25 milligrams every day and this medication is a diuretic that helps the body remove sodium and water. On 9/29/22 at 3:08 p.m., the Interim Director of Health Services indicated the Certified Resident Care Associates who pass water, at either the middle of the shift or the shift change, are responsible to ensure the resident has fluids in her room. 2.) During an interview and observation on 9/26/22 at 11:17 a.m., Resident J had a styrofoam cup with a small amount of water in it. The cup was dated 9/24/22. Resident J indicated she was on the facility to bring her some fresh ice water. During an observation on 9/26/22 at 1:16 p.m., Resident J had the styrofoam cup, dated 9/24/22, the resident indicated she went without fresh water frequently. During an interview on 9/26/22 at 1:21 p.m., Resident J indicated the staff to do not assist her with opening up her milk carton, cereal boxes', or assist her with any meal set up. The resident indicated it was hard for her to this on her own and would often spill her drinks on her food, attempting to get lids off. The resident indicated she use to eat in the dining room and enjoyed going to the dining room, but she stopped going because it was embarrassing to her spilling her		assistance and assistance devices for those who need them. All nurses and CNA's were educated on passing fresh ice water to all residents daily and per resident request. The Director of Nursing or Designee will conduct observations to ensure residents have been provided fresh water, meal assistance and adaptive equipment for all Residents 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	drinks in front of other residents. The resident indicated she was legally blind and required assistance with meal set up. During an observation on 9/28/22 at 11:53 a.m., Resident J was not in her room, her lunch tray was sitting on her bedside table covered up on a tray. The resident had a cup of water with a lid on it and ketchup with a lid on it. Certified Occupational Therapist Assistant (COTA) #19 brought the resident in her room in her wheelchair. The COTA indicated the resident had been in therapy working on hand strengthening exercises, the resident had arthritis. The resident attempted to get the lid off her water and ketchup several times and was unable to. The resident was able to remove the lid off of her food with little hand grip. There was no special utensils or divided plate. The resident indicated the facility did not provide fresh water enough and she had to get water from the faucet in her bathroom. The resident had a styrofoam cup that was half full dated 9/27/22 and was warm to touch. Review of the record of Resident J on 9/28/22 at 10:42 a.m., indicated the resident's diagnoses included, but were not limited to, encephalopathy, cardiac arrhythmia, depression, legally blind, insomnia, hypertensive heart disease with heart failure, osteoporosis, macular degeneration, pain, osteoarthritis, dysphagia and scoliosis. The Admission Minimum Data Set (MDS) assessment for Resident J, dated 9/3/22, indicated the resident had moderately impaired vision. The resident was cognitively intact for daily decision making, the resident was consistent and reliable. The resident required supervision and set up at meals.			

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	The plan of care for Resident 33, dated 8/31/22, indicated the resident was at risk for dehydration related to fluid imbalance. The goal was the resident would remain adequately hydrated. The plan of care for Resident 33, dated 8/31/22, indicated the resident had impairment in functional status in eating. The intervention included, but were not limited to, the resident required set up with eating. The plan of care for Resident 33, dated 9/1/22, indicated the resident had visual loss. The resident intervention included, but were not limited to, provide visual aid such as divided plate and built up utensils. During an interview with the Director Of Health Services on 9/29/22 at 2:45 p.m., indicated the facility protocol for passing fresh water to residents was the CNA normally would pass fresh water at the start of their shift and the end of their shift, also if the resident needed in between times. The CNA's and nurses were responsible to assist residents with meal set up when the resident receives their tray. The therapy department was responsible to provide Resident J with a divided plate and build up utensils. 3.1-3(v)(1)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility	F 0641	**1: What corrective action(s) will be accomplished for those residents found to have**	11/01/2022

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	failed to accurately document use of anticoagulants on the Mini mum Data Set (MDS) assessments for 2 of 2 residents reviewed for assessment accuracy. (Resident E and Resident 33) Findings include: An MDS assessment for Resident E with a review date of 9/5/2022 indicated that Resident E received anticoagulants for four of the last seven days. Review of the medication administration record for Resident E indicate she had not received any anticoagulants during the review period. An MDS assessment for Resident 33 with a review date of 9/3/2022 indicated that Resident 33 had received anticoagulants for four of the last seven days. Review of the medication administration record for Resident 33 indicate she had not received any anticoagulants during the review period. An interview with MDS nurse 17 on 9/28/2022 at 12:36 p.m. indicated she was not sure why anticoagulants were coded for the two assessments mentioned, but the residents did not receive anticoagulants during that review period. She indicated she would be entering modifications to the aforementioned assessments and that there is no specific policy for MDS accuracy, but it is their standards to code assessments to the "Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual" published by the Centers for Medicare and Medicaid Services.		**affected by the deficient practice** The MDS for resident #33 with an ARD 9/3/22 with inaccuracy of the MDS regarding anticoagulant medication was corrected and submitted per the MDS correction process in RAI. Resident had no ill effect noted from the alleged deficient practice. The MDS for resident #E with an ARD 9/15/22 with inaccuracy of the MDS regarding anticoagulant medication was corrected and submitted per the MDS correction process in RAI. Resident had no ill effect noted from the alleged deficient practice. **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** Current residents with Comprehensive MDS's would be at risk. All were reviewed for the accuracy of coding on the MDS per RAI guidelines. All MDSs were modified to be in compliance. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The MDS Coordinator was re-educated on 10/25/22 on coding Section" N" Medications. The MDS Coordinator or designee will	

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			review residents with new ARDs with Diagnosis and Medications. Audits will be conducted 3 days per week times 4 weeks, bi-weekly times 2 months, weekly times 3 months and then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** For quality assurance, the DHS or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure one dependent resident received showers, and failed to provide	F 0677	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient**	11/01/2022

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	nail care to one resident. This affected 2 of 3 residents reviewed for activities of daily living. (Residents K and 15) Findings include: 1. During an interview, on 9/26/22 at 11:08 a.m., Resident K's family member indicated Resident K has only had 3 showers since she has been here and the resident agreed. Resident K's record was reviewed on 9/27/22, at 2:30 p.m., and indicated Resident K had diagnoses that included, but were not limited to, right femur fracture, congestive heart failure, osteoarthritis, and osteoporosis. An Admission Minimum Data Set assessment, dated 8/27/22, indicated Resident K had moderate impairment in cognitive skills for daily decision making, it was very important for her to choose between a tub bath, bed bath, shower or sponge bath, required extensive assist of one for transfers, dressing, toileting, personal hygiene, balance was unsteady, only able to stabilize with staff assistance, had impairment on one side of lower extremity in functional limitation in range of motion, used a wheelchair, is at risk for developing pressure ulcers, had no pressure areas, had an incision, had pressure reducing device for bed, surgical wound care, did not use oxygen. A life enrichment assessment dated 8/26/22 indicated she prefers showers as her bathing type. On 9/29/22, at 2:30 p.m., Resident K's family member indicated staff offered her a shower last night at 9:30 p.m. and she said didn't want it that late. She said at home Resident K showers in the		**practice** Resident K was provided with a shower. Resident 15 was provided nail care. **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** All residents have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All residents shower preferences were obtained, and their care plans were updated. All nursing staff were educated on the Guidelines for Bathing Preferences Policy, to provide showers per resident preferences and to provide nail care during bathing and per resident request. The Director of Nursing or Designee will conduct audits and observations to ensure residents have been provided with showers and nail care for all Residents 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months.	

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	morning. On 9/28/22, at 11:34 a.m., Resident K sat in the recliner in her room, and a family member sat with her. The family member said Resident K hasn't had a shower since last Friday (September 23) and her shower schedule is every Tuesday, Thursday and Saturday in the afternoon. A physician's order, dated 9/27/22, indicated: "Nursing please ensure we are assisting resident with AM routine (brushing teeth/dentures, bathing, changing clothes, etc.)...." A care plan, dated 8/24/22, indicated a Profile Care Guide with interventions that included, but were not limited to, "Showers: T/Th/Sat Evenings". Review of shower documentation indicated Resident K had a shower on 9/3, 9/5, 9/8, 9/12, 9/13, 9/14, and 9/17/22. Resident K would have had 12 showers in September 2022 if she had received them according to her shower schedule. On 9/30/22 at 1:00 p.m., LPN 6 indicated Resident K's family gives her sponge baths that she didn't think she wanted showers, and her Certified Resident Care Associates (CRCA) tell her no showers. On 9/30/22 at 1:45 p.m., CRCA 14 indicated Resident K gets showered in the evening and she has given her a shower. CRCA 14 said the resident couldn't help much with the shower. 2. The clinical record for Resident 15 was reviewed on 9/26/2022 at 2:11 p.m. The medical diagnoses included, but were not limited to, stoke and muscle weakness. A Minimum Data Set Assessment, dated		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	7/27/2022, indicated that Resident 15 needed extensive assistance of one staff member for hygiene and physical assistants with bathing tasks. A care plan, dated 3/23/2022, indicated that Resident 15 was to receive shows on Tuesday, Thursday, and Saturday evenings. An interview and observations with Resident 15 on 9/26/2022 at 2:11 p.m. indicated that he had long unclean fingernails. He indicated that the staff here do not assist him with trimming his fingernails and he does not like to have long nails. An interview with Regional MDS on 9/29/2022 at 2:35 p.m. indicated that nail care is expected to be completed with bathing/showering per the resident's preference, but there is no specific policy for nail care. A policy entitled "Guidelines for Bathing Preferences", was provided by the Executive Director on 9/29/2022 at 9:15 a.m. The policy indicated, " ...PURPOSE To established personal preference bathing routine ...1. The resident will be advised of [Corporation's] guidelines for residents to self-determine their plan of care and schedule during their stay in the campus. 2. The resident shall determine their preference for bathing upon admission ...c. Type of bathing - tub bath, bed bath, or shower. 3. If the resident is unable to communicate their preference this information shall be obtained from the resident's repetitive based on known history. 4. Bathing shall occur at least twice a week unless resident preferences states otherwise." 3.1-38(a)(2)(A) 3.1-38(a)(3)(A)			

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	3.1-38(a)(3)(E) 3.1-38(b)(2)			
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, interview, and record review, the facility failed to ensure a dependent resident received care and services to prevent the development of skin alterations and have orders for a treatment observed in place (Resident C), not applying ace wraps per physician orders (Resident F), and not conducting a complete assessment of a wound upon admission and follow-up afterwards (Resident H), for 3 of 5 reviewed for skin integrity. Findings include: 1. The clinical record for Resident C was reviewed on 9/27/22 at 2:41 p.m. The diagnoses included, but were not limited to, dementia, macular degeneration, hearing loss, and unsteadiness on feet. A Quarterly Minimum Data Set (MDS) assessment, dated 9/18/22, noted Resident C with severe cognitive impairment, the need for extensive assistance of 2 staff members for bed mobility, and the need for extensive assistance of 1 staff person for personal hygiene and toilet use.	F 0684	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** MD was notified and a treatment order was obtained for Resident C. Resident E's ace wrap was applied per MD orders. Resident H's area was assessed, and the bacitracin order was clarified to include which finger it should be applied to. **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** All residents at risk for skin breakdown have the potential to be affected. **3: What measures will be put into place or what systemic**	11/01/2022

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	A care plan for skin integrity, dated 12/20/21, indicated Resident C was at risk for skin breakdown related to decreased mobility and incontinence. An approach was listed to encourage and assist Resident C to turn and reposition for comfort and as needed. There were no indications that Resident C refused to be turned and/or repositioned while in bed. The following observations were conducted of Resident C lying in bed on her back: 9/25/22 at 4:04 p.m., 9/26/22 at 10:52 a.m., 9/26/22 at 1:39 p.m., 9/27/22 at 9:05 a.m., 9/27/22 at 2:09 p.m., 9/27/22 at 3:15 p.m., & 9/28/22 at 9:13 a.m. An observation was conducted of Resident C's skin on 9/28/22 at 12:00 p.m. with Certified Resident Care Associate (CRCA) 2. CRCA 2 proceeded to perform perineal care for Resident C and there was a white adhesive bandage to her coccyx area. CRCA 2 indicated she was used to seeing a pink adhesive foam dressing to Resident C's coccyx area as a preventative treatment but not a dressing like the white one observed. CRCA 2 removed the white dressing and there was redness surrounding a pea sized open area to the coccyx area. There was a drop of a red substance on the white dressing removed by CRCA 2. After perineal care Qualified Medical Assistant (QMA) 10 was interviewed and indicated she didn't place any dressing to Resident C's coccyx area. There were no previous physician orders for Resident C to have a dressing placed to her		**changes will be made to ensure that the deficient practice does not recur?** A skin sweep was conducted on all residents. MD was notified of all identified areas, and treatment orders were obtained. All Nurses and CNA's were educated on turning and repositioning residents who are at risk for skin breakdown. All nurses were educated on the Guidelines for General Wound and Skin Care Policy. The Director of Nursing or Designee will conduct observations to ensure residents at risk for skin breakdown are being turned and repositioned, and conduct audits to ensure all skin areas have an appropriate assessments and treatments, 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for	

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	155843	A. BUILDING 00 B. WING	09/30/2022

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	buttocks and/or coccyx area. A progress note dated 9/28/22 at 1:15 p.m., by the Director of Health Services (DHS) indicated the following, " ...Nursing staff report dressing in place to left buttock that wasn't there yesterday. This nurse noted 2x2x0 [centimeters] abraded [scrape or wear away by friction or erosion] area to left upper buttock. Skin around area blanches upon palpation. No redness or drainage observed ...." 2. The clinical record for Resident F was reviewed on 9/27/2022 at 11:00 a.m. The medical diagnoses included, but were not limited to, diabetes and sepsis. No Minimum Data Set Assessment had been completed due to recent admission. A physician order, dated 9/23/2022, indicated for Resident E to have ACE wraps from toe to knee on in the morning and off in the evening. An interview and observation on 9/26/2022 at 11:16 a.m. indicated that Resident E had an ACE wrap to the right leg from toes to mid-calf at this time. Resident E indicated when she was at home, she used ACE wraps to both legs all the back to the knee due to swelling and the staff here had not unwrapped her leg since 9/24/2022. An interview and observation on 9/27/2022 at 11:39 a.m. indicated that Resident E had an ACE wrap to the right leg from toes to the mid-calf. Resident E indicated they had no unwrapped or redressed her leg on 9/26/2022. A skin integrity event, dated 9/23/2022, indicated that Resident E had a skin tear to the right foot on the 5th toe.		two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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A hospital wound care progress not, dated 9/21/2022, indicated that Resident E had an unhealed diabetic ulcer to the right lateral foot.

An interview with the Director of Health Services on 9/29/2022 at 2:35 p.m. indicated that the Resident had a diabetic wound to the right foot that she was followed by podiatry/wound care for prior to admission and that Resident E has a follow up appointment for 10/5/2022.

3. The clinical record for Resident H was reviewed on 9/27/2022 at 3:39 p.m. The medical diagnoses included, but were not limited to, Alzheimer's disease and an unspecified superficial injury to unspecified finger.

A physician fax, dated for 8/24/2022, indicated that Resident H had a " ...small wound to the finger ..." No measurements, description, or further location provided.

A physician order, dated 8/24/2022, indicated for Resident H to have bacitracin (an antibiotic ointment) to finger three times a day. No indicated for which hand or finger indicated.

An interview with the Director of Health Services (DHS) on 9/27/2022 at 3:39 p.m., indicated that Resident H did not have a wound to her finger but that the resident reported it is a wart and the resident self-reported a history of warts to the hands.

A policy entitled, "Guidelines for General Wound and Skin Care", was provide by the Executive Director on 9/29/2022 at 9:15 a.m. The policy indicated, " ...Turn/Reposition residents who are immobile according to their care plan requirements

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	...Dress chronic wounds in a clean technique ...Document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly ..." This Federal tag relates to Complaints IN00390959 and IN00386195.			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview, and record review, the facility failed to ensure hearing aids were placed per plan of care for a resident who was hard of hearing. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/27/22 at 2:41 p.m. The diagnoses included, but were not limited to, dementia, macular degeneration, hearing loss, and unsteadiness on feet. A Quarterly Minimum Data Set (MDS)	F 0685	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident C was provided with her hearing aid. **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** All residents with hearing aids has the potential to be affected.	11/01/2022

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	assessment, dated 9/18/22, noted Resident C with severe cognitive impairment, moderate difficulty with hearing, and the use of a hearing aid. A care plan for hearing loss, dated 12/30/21, indicated the approach for hearing aids as indicated. There were no care plans indicating Resident C refusing to wear hearing aid. There were no physician orders for the application of a hearing aid. The following observations were conducted to where Resident C didn't have her hearing aid in place and showed inability to communicate: 9/25/22 at 4:04 p.m., 9/26/22 at 10:52 a.m., 9/26/22 at 1:39 p.m., 9/27/22 at 9:05 a.m., 9/27/22 at 2:09 p.m., 9/27/22 at 3:15 p.m., & 9/28/22 at 9:13 a.m. An observation/interview conducted with Certified Registered Care Associate (CRCA) 2 on 9/28/22 at 12:00 p.m. There was a hearing aid on a charging station located on the dresser underneath the television. CRCA 2 was having difficulty communicating the Resident C and couldn't communicate with Resident C even after raising her voice. CRCA 2 indicated Resident C was very hard of hearing and does wear a hearing aid. CRCA 2 proceeded to take the hearing aid from the charging station and place it in Resident C's right ear. CRCA was able to speak to Resident C and then be understood. An interview conducted with the Director of Health Services (DHS) on 9/29/22 at 10:30 a.m. She		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Residents with hearing aids were identified, and orders were placed in the EHR to remind staff to place hearing aids. All nursing staff were educated to place hearing aids, for the residents that need them, daily per orders in EHR. Nurses were educated on documentation if a resident wishes to not wear their hearing aids. The Director of Nursing or Designee will conduct observations to ensure residents with hearing aids have them in place 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two	

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	indicated she would check to see if there were orders for staff to place a hearing aid, but she believed that Resident C would pull it out at times. She wasn't sure about Resident C's history of refusing to wear her hearing aid. An interview conducted with Clinical Support on 9/29/22 at 1:50 p.m. indicated there was no policy regarding hearing aids. The expectations are for staff to follow physician orders and the plan of care.		quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	
F 0686 SS=E 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, interview and record review the facility failed to implement pressure relieving devices and failed to follow the physician order and accurately assess unstageable pressure ulcer for 4 of 4 residents reviewed for pressure ulcers (Resident E, Resident F, Resident G and Resident K). Findings include:	F 0686	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident E was provided with additional pillows and her heels were elevated off of the bed and the pressure relieving boots were placed. Residents F's wounds	11/01/2022

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	1.) During an observation on 9/26/22 at 11:25 a.m., Resident E was laying in bed, the right foot and heel were bandaged, the resident's heels were not elevated off bed. During an observation on 9/27/22 at 10:51 a.m., Resident E was laying in bed, the resident's heels were not elevated off bed. During an observation 9/27/22 at 3:15 p.m., Resident E was laying in bed, the resident's heels were not elevated off the bed. Review of the Record of Resident E on 9/28/22 at 2:17 p.m., indicated the resident's diagnoses included, but were not limited to, sepsis, urinary tract infection, acute kidney failure, dysphagia, morbid obesity, hypertensive heart disease, chronic heart failure, diabetes, panic disorder, anxiety disorder, obstructive sleep apnea, legal blindness, difficulty walking, pain, malaise, pulmonary embolism, adult failure to thrive, obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and major depression disorder. The Admission Minimum Data Set (MDS) for Resident 35, dated 8/21/22, indicated the resident required extensive assistance of two people for bed mobility and transfers. The resident was at risk for pressure ulcers. The physician recapitulation for Resident E, dated September 2022, indicated the resident was ordered to float heals while in bed. The resident was to wear a right heel protector boot. Bilateral heel boots on at all times, except for when being transferred. The wound management report for Resident E,		have been assessed and her treatment orders were clarified. Md was notified of Resident G's refusals and the heel boots were discontinued. Resident G continues to be provided with pillows per his preference. Resident K's heels have been properly staged and documented. **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** All residents at risk for skin breakdown, and current residents with wounds have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A skin sweep was conducted on all residents. MD was notified of all identified areas, and treatment orders were obtained. All open areas were assessed, staged and documented. All Nurses and CNA's were educated on turning and repositioning residents who are at risk for skin breakdown, elevating bony prominences, and providing additional preventative measures per MD orders.	

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	dated 9/29/22, indicated the resident had a pressure ulcer on the right heel measuring 2.5 centimeter (cm) by 3 cm. During an interview with the Director Of Health Services (DHS) on 9/29/22 at 2:45 p.m., the nurses were responsible to ensure Resident E had pressure relieving boots in place. 2. The clinical record for Resident F was reviewed on 9/27/2022 at 11:00 a.m. The medical diagnoses included, but were not limited to, diabetes and sepsis. No Minimum Data Set Assessment had been completed. A skin integrity event, recorded on 9/26/2022 was dated for 9/23/2022. The event descriptions read "ADM[Admission]-left buttock" with physical observation of location left buttock with measurements documented as 3.0 centimeters (cm) by 1.5 cm with no depth. No additional wounds documented under physical observation. A physician order, dated 9/24/2022, indicated for Resident F to have hydrofera blue, pad, and secure every other date to the left buttocks. This order was discontinued on 9/27/2022. A physician order, dated 9/27/2022, indicated to cleanse Resident F's bilateral buttocks wounds, apply skin prep, and cover with foam dressings. Prior to 9/27/2022, no dressing order for the right buttocks was indicated for Resident F. A nursing observation documented on 9/27/2022 identified a pressure wound, stage 2, to the right buttocks of Resident F that was present on admission. Measurements for this wound were 1		All nurses were educated on the Guidelines for General Wound and Skin Care Policy, and the Pressure/Stasis/Arterial/Diabetic Wound Guidelines. The Director of Nursing or Designee will conduct observations to ensure residents at risk for skin breakdown are being turned and repositioned, preventative measures are in place, and conduct audits to ensure all skin areas have an appropriate assessments and treatments, 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	cm by 1 cm with a depth of 0.1 cm. A nursing observation documented on 9/27/2022 identified a pressure wound, without staging indicated, to the left buttocks of Resident H that was present on admission. Measurements for this wound were 3 cm by 2 cm with a depth of 0.1 cm. An observation on 9/27/2022 at 11:39 a.m. indicated Resident F was laying in bed. CRCA 17 (clinical resident care assistant) assisted Resident F to roll to her left side and observation of her buttocks were made. Resident F had a foam dressing to the right buttocks that was partially rolled, dated 9/24/2022, covering a wound. A foam dressing was to the left buttocks, loos on the medial aspect. CRCA 17 told Resident F her wounds are "looking better". When asked, CRCA 17 indicated to her knowledge Resident F admitted with both wounds to her buttocks. An interview with RN 11 on 9/27/2022 at 11:43 a.m., indicated that Resident F admitted with two shearing areas to her buttocks and a diabetic wound to her right 5th toe. The staff were doing treatments every other date to the toe and foam dressing to the buttocks. 3. The clinical record for Resident G was reviewed on 9/26/2022 at 2:42 p.m. The medical diagnoses included, but were not limited to, stroke and rhabdomyolysis. No Minimum Data Set Assessment had been completed. A physician order, dated 9/15/2022, indicated for Resident G to utilize bilateral heel boots at all times.			

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	A wound center visit note indicated that Resident G had pressure injuries of deep tissues to the right and left heels. At that time, the left heel wound measured 5 cm by 2 cm with a 0.5 cm depth and the right heel wound measured 1.2 cm by 1 cm with a 0.3 cm depth. An observation and interview with Resident G on 9/26/2022 at 2:21 p.m., indicated Resident G was sitting in his wheelchair with his feet on a pillow on the floor. Resident G indicated that he does not wear his heels boots because they are too tight on his feet and cause him discomfort. He indicated the staff brought him heels boots roughly two weeks ago, but he only tried them for the first two days but has refused them since that time. An observation on 9/26/2022 at 3:57 p.m., indicated Resident G sitting in his wheelchair without heel boots on. A treatment administration record for Resident G indicated that on 9/26/2022 evening heels boots were applied. An interview with Resident G on 9/27/2022 at 11:09 a.m. indicated that he still was refusing his boots due to them causing him discomfort and he had not worn them on 9/26/2022. An interview with CRCA 17 on 9/27/2022 at 11:22 a.m. indicated that Resident G does not wear his heels boots, it is his preference to have a pillow under her feet when he is sitting in his wheelchair. An interview with RN 11 on 9/27/2022 at 11:49 a.m. indicated that Resident G intermittently refuses dressing changes, but he always refuses to wear his heel boots.			

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	A policy entitled, "Guidelines for General Wound and Skin Care", was provide by the Executive Director on 9/29/2022 at 9:15 a.m. The policy indicated, " ...Turn/Reposition residents who are immobile according to their care plan requirements ...Dress chronic wounds in a clean technique ...Document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly ..." A policy entitled, "Pressure/Stasis/Arterial/Diabetic Wound Guidelines", approved by the Executive Director on 9/29/2022 at 9:15 a.m. the policy indicated, " ...Complete event for each impaired areas ..."4. On 9/26/22, at 11:14 a.m., Resident K's family member said Resident K developed areas on both heels after admission. They weren't raising her heels off the bed, or any other interventions, but now she has heel guards and her heels are raised off the bed when she is in it. They don't turn her side to side when she is in bed, and she can raise or lower the head of her bed, but she can't turn herself. Resident K's record was reviewed on 9/27/22, at 2:30 p.m., and indicated Resident K had diagnoses that included, but were not limited to, right femur fracture, congestive heart failure, osteoarthritis, and osteoporosis. An Admission Minimum Data Set assessment, dated 8/27/22, indicated Resident K had moderate impairment in cognitive skills for daily decision making, required extensive assist of one for transfers, dressing, toileting and personal hygiene, had impairment on one side of lower extremity in functional limitation in range of motion, is at risk for developing pressure ulcers, had no pressure areas, had an incision, and had a			

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	pressure reducing device for her bed. Current physician's orders included: Skin prep to right and left heel twice a day, started 9/27/22. Nursing to inspect bilateral heels every shift. Notify MD of changes, started 8/30/22. An order for betadine, started on 8/30/22 was in place prior to the skin prep order. An initial care plan, dated 8/24/22, indicated a problem for skin integrity, at risk for skin breakdown due to decreased mobility and recent hip surgery. The goal was "Resident's skin will remain intact." Approaches included, but were not limited to, "avoid shearing skin during positioning, turning, and transferring conduct weekly skin assessment. Pay particular attention to bony prominences. Encourage and assist to turn and reposition for comfort and as needed. Float heels as needed...Pressure reducing mattress to bed. Use lifting device as needed for bed mobility (e.g. lift sheet etc.)." A care plan, dated 8/30/2022, indicated Resident K had pressure ulcers to both heels and the pressure ulcers will heal without complications. Interventions included, but were not limited to, give pain relieving medication, assess and record the condition of the skin around the pressure ulcer, observe and report signs of infection and pain, treatment according the physician's order, pressure reducing mattress, and "weekly skin assessment, measurement, and observation of the pressure ulcer and record." Progress notes indicated: On 8/29/2022, at 2:39 p.m., "Upon measuring for Ted hose, pressure ulcer noted to right and left heel- unstageable. Skin prep BID (twice a day) to right heel and Betadine BID to left heel. Heels			

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	floated and cushion heel guards in place. MD and daughter aware." 8/30/2022, at 2:25 p.m., "Bilat[eral] heels remain pink with skin intact. Denies pain or (discomfort) to area. Tx. completed per order. Tolerated well." 8/30/2022, at 5:13 p.m., "Admission assessment (see observation): Resident admitted to facility s/p (after) hip replacement...Res [with] surgical incision to R hip and areas of pressure to bilat (both) heels, although skin intact; tx. in place...fortified shake with lunch and dinner d/t (due to) underweight status and to support skin integrity...." 9/06/2022, at 3:46 p.m., "Wounds to bilateral heels stable. Skin remains intact. Treatment orders and interventions reviewed and appropriate. Continue as ordered. Resident at risk for skin breakdown secondary to decreased mobility, weakness, recent hip surgery, fragile skin and chronic disease process. Nursing to monitor wounds weekly and notify MD of changes. MD, resident and daughter updated on progression of wounds...." 9/13/2022, at 1:59 p.m., "[Recorded as Late Entry on 09/15/2022 05:00 PM] Wounds to bilateral heels stable. Skin remains intact. Treatment orders and interventions reviewed and appropriate. Continue as ordered. Resident at risk for skin breakdown secondary to decreased mobility, weakness, recent hip surgery, fragile skin and chronic disease process. Nursing to monitor wounds weekly and notify MD of changes. MD, resident and daughter updated on progression of wounds...." "Wound Management Detail Reports" indicated			

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	the left heel wound was first observed on 8/29/22 at 4:36 p.m. and was described as a deep tissue injury. The initial measurements were 1.6 cm by 2 cm and was described as a dark red discoloration on the left heel. Subsequent observations and measurements by the facility staff failed to stage this wound. The right heel wound was first observed on 8/29/22 at 4:28 p.m. and was described as an unspecified ulcer. Further observations and measurements by the facility staff failed to stage this wound. On 09/29/22, at 2:30 p.m., Resident K's daughter indicated she came in after the resident had been here four days to see her, and her heels looked like they do now. On 9/29/22, at 2:42 p.m., observed both heels with RN 3. The right leg and foot ace wrap was removed and the area on the right heel was observed to be larger than a half dollar and was dark red/black. She removed the ace wrap on the left leg and foot, and the left heel was observed to have a half dollar sized area that was dark red/black and had peeling skin. On 9/30/22, at 1:10 p.m., both heels were observed with LPN 6 and the Director of Health Services (DHS). The left heel was red/black and measured 3 centimeters (cm) by 2.5 cm and the right heel was red/black and measured 3.5 cm by 4 cm. The DHS indicated both heels were unstageable and they had developed when she was in bed, and the left heel had started as a blister. This Federal tag relates to Complaints IN00390959 and IN00386195. 3.1-40(a)(2)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were implemented per the plan of care for 2 of 5 residents reviewed for accidents. (Resident B and Resident J). Findings include: The clinical record for Resident B was reviewed on 9/27/22 at 2:45 p.m. The diagnoses included, but were not limited to, history of surgical amputation, sepsis, cerebral ischemia, spinal stenosis, and acquired absence of right leg above knee. A 5-day Minimum Data Set (MDS) assessment, dated 7/15/22, indicated Resident B was cognitively intact, needed extensive assistance with one staff person for locomotion, dressing, toilet use, and personal hygiene. A fall care plan, revised 9/11/22, indicated Resident B was at risk for falling related to decreased mobility, history of falls, and use of antidepressant medication. An approach was noted to keep call light within reach.	F 0689	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident B's call light was placed within reach. Dycem was placed in Resident J's recliner. **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** All residents at risk for falls have the potential to be affected. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Residents with falls in the last 90 days were observed to ensure that their fall interventions were in place.	11/01/2022

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	The following observations were conducted to where Resident B was observed sitting in his wheelchair at the foot of his bed with his call light attached to the left side rail and not in reach: 9/25/22 at 3:28 p.m., 9/26/22 at 1:38 p.m., 9/27/22 at 2:09 p.m., & 9/28/22 at 9:14 a.m. An observation and interview conducted with the Director of Health Services (DHS) on 9/29/22 at 10:35 a.m., noted Resident B being propelled in wheelchair by staff back in his room and placed at the foot of his bed. His call light was still attached to the left side rail on his bed and not in reach. When asked about him being able to utilize his wheelchair to get to his call light Resident B indicated he could hardly move his wheelchair over the mat the was located on the left side of his bed to get to his call light. A policy titled "Guidelines for Answering Call Lights", revised 5/11/16, was provided by Clinical Support on 9/29/22 at 1:50 p.m. The policy indicated the following, " ...2. Ensure the call light in plugged in securely to the outlet and in reach of the resident ...." A policy titled "Fall Management Program Guidelines", revised 5/31/17, was provided by the DHS on 9/30/22 at 1:50 p.m. The policy indicated the following, " ...4. Any orders received from the physician should be noted and carried out ...5. The resident care plan should be updated to reflect any new or change in interventions ...." 2.) During an interview with Resident J on 9/26/22 at 1:40 p.m., indicated she had feel twice since being at the facility.		All nursing staff were educated on the Fall Management Program Guidelines Policy. The Director of Nursing or Designee will conduct observations to ensure fall interventions were implemented and are in place 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	Review of the record of Resident J on 9/28/22 at 10:42 a.m., indicated the resident's diagnoses included, but were not limited to, encephalopathy, cardiac arrhythmia, depression, legally blind, insomnia, hypertensive heart disease with heart failure, osteoporosis, macular degeneration, pain, osteoarthritis, dysphagia and scoliosis. The Admission Minimum Data Set (MDS) assessment for Resident J, dated 9/3/22, indicated the resident had moderately impaired vision. The resident was cognitively intact for daily decision making, the resident was consistent and reliable. The resident had a fall in the last month. The fall risk assessment for Resident J, dated 8/30/22, indicated the resident was at moderate risk for falls. The plan of care for Resident J, dated 8/31/22, indicated the resident was at risk for falling related to urinary tract infection, hypertension, decreased mobility, osteoporosis, scoliosis, macular degeneration, emphysema and tachycardia. The intervention included, but were not limited to, dycem in the recliner (9/21/22). The Interdisciplinary Team (IDT) progress note for Resident J, dated 9/22/22 at 10:11 a.m., indicated the resident reported she slipped when trying to get out of the recliner and fell to the floor. Treatment initiated for a skin tear. The fall care plan reviewed and updated with new intervention. During an observation and interview on 9/28/22 at 11:25 a.m., CNA 14 lifted up the blanket on Resident J's recliner and verified there was no dycem in her recliner.			

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	During an interview with the Director Of Health Services on 9/29/22 at 2:45 p.m., indicated the MDS Coordinator was responsible to implement fall interventions and the nurses were to ensure they were in place. This Federal tag relates to Complaint IN00386195. 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview, observation, and record review, the facility failed to maintain a urinary catheter bag free of contact with the floor for 1 of 1 reviewed for urinary catheter use. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 9/26/2022 at 2:11 p.m. The medical diagnoses included, but were not limited to, stoke and muscle weakness. A Minimum Data Set Assessment, dated 7/27/2022, indicated that Resident 15 utilized a urinary device (such as a catheter) and needed extensive assistance of one staff member for toileting and hygiene tasks. A physician order, dated 3/22/2022, indicated for Resident 15 to have an indwelling urinary catheter for retention. An observation on 09/27/22 at 11:38 a.m. indicated Resident 15 sitting in his wheelchair at the table in the dining room during lunch time. His urinary catheter bag was contacting the floor. An observation on 9/28/2022 at 12:50 p.m., indicated Resident 15 sitting in his wheelchair in his room. His urinary catheter bad was contacting the floor with a moderate amount of urine noted in	F 0690	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident 15's catheter drainage bag was readjusted from having contact with the floor. Resident suffered no adverse effects from deficient practice. **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** All Residents with Catheters were observed to ensure Foley Catheter drainage systems were not in contact with the floor. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff have been educated on the Urinary Catheter Care Policy. The Director of Nursing or Designee will conduct observations of all residents with urinary catheters, to ensure the	11/01/2022

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	the bag and tubing. An interview with CRCA 17 (certified resident care aide) on 9/28/2022 at 1:01 p.m. indicated that Resident 15 urinary catheter bag should be kept off the ground. A policy entitled, "Urinary Catheter Care", was provided but the Executive Director on 9/29/2022 at 9:15 a.m. The policy indicated, " ...Be sure the catheter tubing and drainage bag are kept off the floor ..." 3.1-41(a)(2)		drainage bags and tubing were not in contact with the floor, 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 0695	**1: What corrective action(s) will**	11/01/2022

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	Based on observation, interview, and record review, the facility failed to ensure oxygen was in place per physician orders, a humidifier bottle had water for use, and the utilization of a CPAP (continuous positive airway pressure) device for a resident with sleep apnea for 3 of 3 residents reviewed for oxygen use. (Resident C , Resident E and Resident K). Findings include: 1 The clinical record for Resident C was reviewed on 9/27/22 at 2:41 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, and dependence on supplemental oxygen. A physician order, dated 12/27/21, was noted for 2 liters of oxygen per nasal cannula continuous. An observation conducted on 9/25/22 at 4:04 p.m., of Resident C's nasal cannula on the floor and not in place. An observation conducted on 9/26/22 at 10:52 a.m., of Resident C's nasal cannula on the floor and not in place. An observation conducted on 9/26/22 at 1:39 p.m., of Resident C's nasal cannula on the floor and not in place. An observation conducted on 9/27/22 at 9:05 a.m., of Resident C's nasal cannula not in place and noted underneath the sheets of her bed. No water was noted in the humidifier bottle. An observation conducted on 9/27/22 at 3:15 p.m., of Resident C's nasal cannula in place but no		**be accomplished for those residents found to have affected by the deficient practice** Resident C's nasal cannula, oxygen tubing and humidity bottle were replaced. The nasal cannula was placed on the resident. Orders for Resident E's C-Pap were documented in EHR and implemented. Resident K's oxygen tubing was replaced and dated. Residents suffered no adverse effects from deficient practice. **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** All Residents on oxygen therapy, and with respiratory equipment, were reviewed to ensure that orders are in place, and that tubing and humidity bottles are changed and dated per policy. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff were educated on the policy of Administration of Oxygen. The Director of Nursing or designee will observe every Resident with oxygen orders, and respiratory equipment, to ensure	

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	water in the humidifier bottle. An observation conducted on 9/28/22 at 9:13 a.m., of Resident C's nasal cannula in place but no water in the humidifier bottle. An observation conducted on 9/29/22 at 10:30 a.m., of Resident C's nasal cannula hanging from the right side of her bed and not in place. There was no water in the humidifier bottle for her oxygen. An interview conducted with the Director of Health Services (DHS), on 9/29/22 at 10:30 a.m., indicated she would address the oxygen situation involving the humidifier bottle. She reapplied Resident C's nasal cannula and Resident C kept the oxygen in place while the DHS was in the room. Resident C's care plans didn't reflect any history of refusal to wear oxygen upon review on 9/27/22 at 2:41 p.m. A care plan, dated 12/30/21, indicated the potential for shortness of breath while lying flat related to chronic obstructive pulmonary disease. An approach was listed to administer oxygen per physician orders and as needed. An interview conducted with Clinical Support, on 9/29/22 at 1:50 p.m., indicated the expectations were staff to follow physician orders and the plan of care for residents. A policy titled "Administration of Oxygen", revised 5/2018, was provided by Clinical Support on 9/29/22 at 9:15 a.m. The policy indicated the following, " ...1. Verify physician's order for the procedure ...14. Date the tubing for the date it was initiated ...20. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order		the tubing and humidity bottles have been changed per policy and that MD orders are being followed 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	and are enough that the water bubbles as oxygen flows through ...a. Constant flow of oxygen can cause drying and thickening of normal secretions, resulting in laryngeal ulceration ...." 2.) During an observation on 9/26/22 at 11:25 a.m., Resident E was laying in bed with her eyes closed. The resident had C-Pap machine on her bedside table. Review of the Record of Resident E on 9/28/22 at 2:17 p.m., indicated the resident's diagnoses included, but were not limited to, sepsis, urinary tract infection, acute kidney failure, dysphagia, morbid obesity, hypertensive heart disease, chronic heart failure, diabetes, panic disorder, anxiety disorder, obstructive sleep apnea, legal blindness, difficulty walking, pain, malaise, pulmonary embolism, adult failure to thrive, obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and major depression disorder. The face sheet for Resident E, dated 9/1/22, indicated the resident was dependent on device/machine of a C-Pap. The nursing telephone report from the local hospital for Resident E, dated 9/1/22, indicated the resident was to have a C-Pap at night. During an interview with the Director Of Health Services (DHS) on 9/29/22 at 2:45 p.m., indicated she was unsure how Resident E's C-Pap did not get implemented. The resident reported that she had used it at the facility a couple times. The DHS was unsure if the resident's daughter had brought the machine in from home. The resident now has orders for the C-Pap. 3. During an observation, on 9/26/22 at 11:23 a.m., the oxygen tubing for Resident K was not dated.			

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	Resident K's record was reviewed on 9/27/22, at 2:30 p.m., and indicated diagnoses that included, but were not limited to, right femur fracture, pneumonia, and congestive heart failure. An Admission Minimum Data Set assessment, dated 8/27/22, indicated Resident K had moderate impairment in cognitive skills for daily decision making, and did not use oxygen. Current physician's orders included, but were not limited to, oxygen at 2-3 liters per nasal cannula continuous, may wean from oxygen, change oxygen tubing monthly, monitor oxygen saturation every shift. During an observation, on 9/29/22 at 2:30 p.m., Resident K's oxygen tubing did not have a date on it. On 9/29/22, at 2:50 p.m., the oxygen tubing was observed with RN 3, who said there is a bag that is dated that they put the tubing in if she were to take it off. She looked in the bedside table drawers and could not locate a bag. RN 3 said the water bottle had been replaced on 9/28/22 and the water bottle was dated. The oxygen tubing was not dated at this time. 3.1-47(a)(6)			
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			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(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 ensure infection control practices were maintained during a dressing change, Resident E, and cleaning a vital signs machine in-between use of residents during a medication administration observation for Resident 246. Findings include: An observation of medication administration was conducted on 9/27/22 at 8:50 a.m. with Registered Nurse (RN) 4. She prepared medications for Resident 246 and took the vital signs machine into her room. After medication administration and	F 0880	**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** RN 4 has been educated disinfecting reusable medical equipment before use on another resident. LPN 6 has been educated on the Hand Hygiene 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**	11/01/2022

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	obtaining vital signs RN 4 left the room with the machine and went back to the hallway. RN 4 proceeded to take the vital signs machine without cleaning it and indicated she was going to the assisted living hallway to obtain vital signs on the residents over there. An observation of a dressing change for Resident E was conducted on 9/29/22 at 10:32 a.m. with Licensed Practical Nurse (LPN) 6 and Qualified Medication Assistant (QMA) 10. LPN 6 donned gloves and removed the old dressing to Resident E's left heel. LPN 6 applied betadine to the left heel with her right hand, covered with an abdominal pad, and wrapped with rolled gauze utilizing both hands. LPN 6 then removed her right glove to tape to secure the rolled gauze. She then removed her gloves and turned to get the items for the wound dressing to the right buttocks. LPN 6 indicated she had left the saline outside. She left the room and went to the treatment cart in the hallway. LPN 6 returned with a gauze soaked in saline. LPN 6 donned gloves and removed the dressing with her right hand. She then cleansed the area using her right hand with the saline soaked gauze. She then used her right hand and scissors to cut a piece of xeroform from the package. LPN 6 then applied the xeroform with her right hand and then applied the foam dressing with both hands. Resident E was repositioned on her back and asked by LPN 6 if she wanted a drink. LPN 6 removed her gloves and threw the old dressing into the trash can in the room. LPN 6 then assisted Resident E to take a few sips of water without performing hand hygiene. LPN 6 was interviewed at the time of the observation and indicated she believed she performed enough hand hygiene. A policy titled "Guideline for Handwashing/Hand Hygiene", revised 2/9/17, was provided by Clinical		An AD HOC QAPI meeting was held on 10/25 and was attended by ED, DHS and Interdisciplinary team. Root Cause determined that RN 4 and LPN 6 needed to be re-educated, competency performed and monitored for compliance more frequently. Root Cause also determined to be the disinfecting wipes not placed in a convenient location. The LTC Infection Control self-assessment was reviewed, and applicable changes were made. Training was completed for RN 4 and LPN 6 with return demonstration to ensure competency. Disinfecting wipes were placed in a more convenient location. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Training was initiated for all licensed nurses on infection control practices regarding wound care, to include handwashing during dressing changes. Training was initiated with all staff to ensure all reusable resident care items are properly sanitized with the EPA appropriate cleaner.	

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	Support on 9/29/22 at 1:50 p.m. The policy indicated the following, " ...3. Health Care Workers shall use hand hygiene at times such as ...b. Before/after preparing/serving meals, drinks, tube feedings, etc. ...c. Before/after having direct physical contact with residents ...d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. ...." A policy titled "Standard Precautions Guidelines", revised 5/11/16, was provided by Regional Minimum Data Set (MDS) on 9/29/22 at 2:10 p.m. The policy indicated to wear gloves for handling soiled equipment, and properly clean and disinfect reusable equipment before use on another resident.		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The IP Nurse/DON/Designee will complete daily infection control rounds, as well as visual rounds, throughout the campus to ensure staff are practicing appropriate infection control practices. The rounds will include monitoring for compliance with the solutions identified in the root cause analysis. The rounds will occur 5 days a week for six weeks, then 3 days a week for four weeks, then weekly for two quarters. Results of rounds will be submitted to QAPI for review to ensure increased compliance goals. QAPI Committee will update and make changes to DPOC as needed to sustain substantial compliance for no less than six months. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of complaints IN00386195 and IN00390959.. Complaint IN00386195 - Substantiated.	R 0000	The submission of this plan of correction does not indicate an admission that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	

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	Federal/State deficiencies related to the allegations are cited at F-684, F-686 and F-689. Complaint IN00390959 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-684 and F-686. Survey dates: September 25 through September 30, 2022 Facility number: 013635 Residential Census: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 5, 2022		living environment provided to the residents of The Springs of Richmond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record	R 0407	**1: What corrective action(s) will be accomplished for those**	11/01/2022

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	review, the facility failed to ensure that a vital signs machine was cleaned in-between use for 5 residents observed during medication administration. (Residents R2, R3, R4, R8, and R9) Findings include: An observation of medication administration was conducted with Registered Nurse (RN) 4 on 9/27/22 at 9:08 a.m. The vital signs machine was utilized on Resident R8 during medication administration. RN 4 didn't clean the machine after utilizing it. RN 4 proceeded to prepare and administer medications to Resident R9 and utilize the vital signs machine as well. RN 4 didn't clean the machine after utilizing it on Resident R9. RN 4 then proceeded to prepare and administer medications to Resident R3 and utilize the vital signs machine. RN 4 didn't clean the machine after utilizing it. RN 4 then proceed to prepare and administer medications to Resident R2 and utilize the vital signs machine. RN 4 didn't clean and machine after utilizing it. RN 4 then went to obtain vital signs for Resident R4 with the same vital signs machine that wasn't cleaned during medication administration. An interview conducted with the Director of Health Services (DHS) on 9/29/22 at 10:35 a.m., indicating the nursing staff will be educated on the use of the vital signs machine. A policy titled "Standard Precautions Guidelines", revised 5/11/16, was provided by the Regional Minimum Data Set (MDS) on 9/29/22 at 2:10 p.m. The policy indicated to properly clean and disinfect reusable equipment before use on another resident.		**residents found to have affected by the deficient practice** RN 4 has been educated disinfecting reusable medical equipment before use on another resident. **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** An AD HOC QAPI meeting was held on 10/25 and was attended by ED, DHS/IP and Interdisciplinary team. Root Cause determined that RN 4 needed to be re-educated, competency performed and monitored for compliance more frequently. Root Cause also determined to be the disinfecting wipes not placed in a convenient location. The LTC Infection Control self-assessment was reviewed, and applicable changes were made. Training was completed for RN 4 and with return demonstration to ensure competency. Disinfecting wipes were placed in a more convenient location. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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			Training was initiated with all staff to ensure all reusable resident care items are properly sanitized with the EPA appropriate cleaner. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The IP Nurse/DON/Designee will complete daily infection control rounds, as well as visual rounds, throughout the campus to ensure staff are practicing appropriate infection control practices. The rounds will include monitoring for compliance with the solutions identified in the root cause analysis. The rounds will occur 5 days a week for six weeks, then 3 days a week for four weeks, then weekly for two quarters. Results of rounds will be submitted to QAPI for review to ensure increased compliance goals. QAPI Committee will update and make changes to DPOC as needed to sustain substantial compliance for no less than six months. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	