STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 00 B. WING	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00438940, IN00438234, IN00438150, IN00437780, IN00437783, IN00437462, IN00436746, IN00435654, and IN00432231. Complaint IN00438940- Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00438150- No deficiencies related to the allegations are cited. Complaint IN00437783- Federal/state deficiences related to the allegations are cited at F925. Complaint IN00437780- Federal/state deficiencies related to the allegations are cited at F925. Compalint IN00437462- Federal/state deficiencies related to the allegations are cited at F925. Complaint IN00438234- No deficiencies related to the allegations are cited. Complaint IN00432231- Federal/state deficiencies related to the allegation are cited at F689. Complaint IN00435654- No deficiencies related to the allegations are cited. Complaint IN00436746- No deficiencies related to the allegations are cited. Survey dates: July 17, 18, and 19, 2024 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 5 Medicaid: 80	F 0000	Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusions set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs and to provide the best possible care to our residents as possible. The facility respectfully requests a desk review for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Administrator	08/14/2024

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

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	Other: 15 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2024.			
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 services for effective assessment, skin care, and monitoring were provided in a timely manner to a resident that complained of not feeling well for 1 of 3 residents reviewed for quality of care. (Resident G) Findings include: On 7/18/24 at 10:25 a.m., Resident G's medical record was reviewed. She was admitted on 10/19/23 for Rehab with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) exacerbation, and on 2/21/24 she was moved to Long-Term Care (LTC). Resident G's nursing progress notes were reviewed and lacked documentation of any new areas to her abdomen, back, thighs and/or peri-area. The progress notes lacked	F 0684	F684 1-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident G no longer resides in the facility. Other residents with Ostomy care have been reviewed by the DON/Designee for skin integrity and supportive documentation. 2-How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?	08/14/2024

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	documentation of any refusals to be cleaned, bathed or repositioned. The progress notes lacked documentation of any behaviors for picking at, removing, or refusing care for her ileostomy. The progress notes lacked documentation of any behaviors for making false allegations, delusion and/or incompetency in her decision making related to her needs for care and preferences. Resident G had one care plan, initiated on 10/20/23 and revised 10/24/23, which indicated she had an alteration in gastro-intestinal status related to an ileostomy in her right left quadrant. All 6 of 6 interventions were initiated on 10/20/23. The interventions included, "change colostomy appliance and ouch/bag per physician orders and as needed if damaged and/or requires disposal ...Colostomy care and training with resident ....Empty and document each shift/as needed ....GI consult as ordered and/or as needed ...Observe for any unusual discharge in colostomy such as blood, pus, clay like stool, etc. intervene and notify the M.D ...Observe stoma site and peristomal skin for any irritation, itching, burning bruising, redness, weeping, breaks in skin, etc. intervene and notify MD." The ileostomy care plan lacked documentation of revisions for behaviors related to picking at the area, removing the dressings, refusing dressings and/or other treatments as needed. The plan of care lacked documentation or revision to include education and/or intervention to maintain her ileostomy care, risks/benefits of self-care, risks/complications of infection ...etc. Resident G's comprehensive care plans lacked documentation of a history of refusing care or picking at/removing her ileostomy treatment. A nursing progress note, dated 7/12/24 at 6:28		The IDT team will review Monday through Friday any change of conditions that have occurred and ensure that appropriate documentation has been completed. Nursing staff have had education on Ostomy/Skin care, Peri Care, Assessments and Documentation. 3-What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? DON/Designee will audit resident skin assessments 3 times a week for 4 weeks and then weekly for 4 weeks. DON/Designee will audit all residents with Ostomy Care 5 times a week for 4 weeks and then 3 times a week for 4 weeks and then weekly for 4 weeks. The IDT team will review change of conditions Monday thru Friday to ensure all documentation is complete. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed and reported to the IDT in QAPI.	

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	a.m., indicated Resident G alerted the Certified Nursing Aide (CNA), who told the nurse, Resident G did not feel well and needed to go to the hospital. The nurse checked the resident's vital signs which were within normal limits. The MD was notified, and the nurse waited for a response. On 7/12/24 at 12:02 p.m., the Nurse Practitioner (NP) visited Resident G and indicated she was seen for a Chief Complaint of, " ...feeling poorly ... Called to bedside by nursing due to daughter's request. Patient was seen resting in bed on baseline oxygen. Calm and confused. Daughter reports patient has chest pain, shortness of breath, cough, and dysuria, [burning with urination]. Daughter was concerned about pneumonia and UTI. Patient endorses chest pain, congested cough, increased shortness of breath. Lungs are diminished. Baseline cardiac irregularity and murmur. On chronic oxygen for chronic hypoxic respiratory failure. Ileostomy with liquid brown stool. Urine is foul and concentrated ... Daughter wants patient sent to [Hospital] for further evaluation ..." Resident G arrived at Hospital #1 on 7/12/24 at 2:32 p.m. An Emergency Department (ER) note indicated, " ...presents to the emergency department ... upon examination of patient, she has erythema to nearly her entire backside ... Has ostomy bag present, but it is nonadherent to skin ... The back has a large area of skin break down, it appears to cover the entire back, bleeding on the buttocks. Bleeding on the coccyx. Skin breakdown on the groin and the area of the chest and groin. The left knee has a bandage and has a large area of skin breakdown. Bruising to the left arms. Legs have areas of skin breakdown. The Patient arrives drenched in urine with a foul odor, The ostomy is not stuck to the skin ...." Several attempts were		Determination of ongoing monitoring will be completed within the QAPI process.	

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	made to place an IV but they were unable to obtain access, and Resident G required transfer to a second hospital. Resident G required the placement of a urethral catheter, " ... Indication for Insertion: Acute anatomic or functional urinary retention or bladder outlet obstruction ...." Resident G arrived at Hospital #2 on 7/12/24 at 8:01 p.m. An ER note indicated she was transferred due to " ...urosepsis and need for central line access ... she presented for a chief complaint of a cough ... upon arrival to the ED arrival she was found covered in urine, feces with ostomy bag present but not adhered to skin, and severely erythematous mostly dependent positions on her back and buttock region with other wounds and skin breakdown. Workup included labs significant for a white blood cell count (WBC) [elevated WBC count is significant evidence of infection], procalcitonin [a protein that the body produces as a biomarker in response to bacterial infections or systemic inflammation.].... IV access was unable to be obtained ... multiple attempts were made at central venous access ... Central line was placed in the right IJ site by the ER physician here ...." Resident G received Ostomy Therapy at Hospital #2 which indicated, "...right lower quadrant pouch removed and changed. Fungal rash seen throughout torso ..." Hospital #2 Wound Consultation note, dated 7/15/24, indicated she had scattered Moisture Associated Skin Damage (MASD) to her " ...left and right, upper, and lower, anterior, and Posterior sides. Wound Care Instructions involved, coccyx, sacrum, buttocks, cleft, groin, abdomen, back chest, etc ...Fungal rash throughout torso ... New patient seen for wound care evaluation. Patient from facility, admitted 3 days ago			

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	...Recommendations: Please keep coccyx, sacrum, buttocks, cleft, perirectal, perineum, groin, abdomen, back, torso clean and dry!!! Please give morning care on a daily basis. Apply antifungal ointment to rash non-fold areas and antifungal powder to folds....." During an interview on 7/18/24 at 2:35 p.m., Resident G's family member indicated on 7/12/24, Resident G had called very early, close to 4:00 a.m., and said she did not feel well and wanted to go to the hospital. The family member advised her to put her light on and let the nurse know. The nurse told Resident G, they didn't send people out just for "not feeling well," but the nurse would put in a request for the resident to be seen by the Nurse Practitioner (NP) later that day. The family member called back around 10:30 a.m. to check in. Resident G informed the family member that she was feeling worse and still had not been seen by the NP. Around 11:30 a.m., Resident G called her family member again and the resident said she felt worse, and nothing had been done. The family member indicated she was concerned and went over to check on her. She arrived shortly after 12:00 p.m. When she arrived, Resident G's family member found her "drenched with urine and the room smelled awful." When the nurse came in she told them to wait just a minute but then returned with the NP. The NP indicated she would put in orders to run lab work STAT (immediately) but the family member indicated, "that should have been done hours ago," and demanded that Resident G be sent to the hospital immediately. The NP said they needed to get someone to "clean her up before they sent her out," but the aides were busy. When Resident G was rolled over to start cleaning her up and the family member was shocked at the condition of her skin, "her whole entire backside was red, and her buttocks was			

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	bloody. It appeared some of her skin was sloughing off." The family member asked the for care to be stopped and send her out immediately, because she did not want to clean or wipe Resident G without pain medication and appropriate infection control precautions because her skin was so degraded. During an interview on 7/19/24 at 10:15 a.m., Registered Nurse (RN) 16 indicated he had only worked with Resident G once or twice before and the only reason his name was on the Nursing Progress Note for transfer to the hospital was because he helped a "new nurse" with her documentation. He did not see Resident G or assist in the discharge upon the NP's order. He only assisted the nurse in completing paperwork. During an interview on 7/19/24 at 10:23 a.m., Licensed Practical Nurse (LPN) 17 indicated she was a new nurse at that facility and had only worked with Resident G a few times. Until the day of her discharge, she had not noticed any acute concerns. LPN 17 administered medications and applied the treatment to her knee without complications or refusals. On the morning of her discharge, LPN 17 indicated the CNA came and told her a family member was there and very upset with her condition. LPN 17 informed the NP of the family's concerns and Resident G's recent reports of not feeling well, and the NP went in to see her. During a confidential interview, it was indicated, a CNA worked the evening shift on 7/11/24 and noticed Resident G was not acting right, and when she asked, Resident G indicated she wasn't feeling great. The CNA notified the nurse on duty and left for the night. They returned the following morning and found Resident G was still feeling poorly and had refused to eat or drink at breakfast. Because she felt so bad, she also			

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	refused to be cleaned up and told the aide she wanted to go to the hospital. This was unusual for Resident G, so the CNA reported it a second time to the nurse. When the CNA brought Resident G her lunch, she still refused to eat or drink and complained she felt worse. The CNA informed the nurse for a third time but by then the family member arrived and was furious at Resident G's condition. Resident G was alert and oriented. She was always pleasant and cooperative. It was unlike her to refuse care, treatments and/or meals. During an interview on 7/19/24 at 11:35 a.m., the Assistant Director of Nursing (ADON) indicated she was unaware of skin integrity concerns which may have been present at the time of her discharge. The ADON indicated Resident G was a "heavy wetter" and picked at her ostomy which caused it to leak and irritate the surrounding skin. She indicated, Resident G refused to get out of bed, or allow routine hygiene tasks to be completed "as scheduled," but preferred they were "completed on her time." By the end of the survey exit on 7/19/24, no additional documentation or evidence was provided by the ADON, DON, or Executive Director (ED) to support a pattern of Resident G's alleged refusal of care/treatment and/or services. On 7/19/24 at 1:20 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Care Planning Process," dated 1/29/19. The policy indicated the Interdisciplinary Team (IDT) "need to go into the care plans for that resident and create or modify the residents care plan. This process will occur every quarter." On 7/19/24 at 12:40 p.m., the ADON provided a copy of current facility policy titled, "Colostomy			

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	and Ileostomy Care- General," revised 6/2020. The policy indicated, "Purpose: To maintain resident hygiene, control odor, prevent skin irritation or breakdown, and provide supportive care to the resident ... Stoma and surrounding skin will be monitored for irritation with routine care and as a part of licensed nurses' weekly assessments ... inspect stoma for color and surrounding skin for irritations. Notify the Attending Physician if there is a change in stoma size, appearance, pain or skin rash, irritation, or open areas. Apply an ostomy bag. Apply and secure dressing for stoma bag as ordered ...." On 7/19/24 at 1:20 p.m., the ED provided a copy of current facility policy titled, "Perineal Care," revised 6/2020. The policy indicated, "Purpose: To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown ... Perineal care is provided as part of a resident's hygiene program, a minimum of once daily and per resident need...." On 7/19/24 at 1:20 p.m., the ED provided a copy of current facility policy titled, "Change of Condition Notification," revised 6/2020. The policy indicated, "To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner ... an acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. 'Clinically important' means a deviation that, without intervention, may result in complications or death. Members of the IDT are expected to report and document signs and symptoms that might represent an ACOC. The facility will promptly inform the resident, consult with the resident's attending physician, and notify the resident's			

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	legal representative when ... significant change in their condition cause by, but not limited to ... a decision to transfer or discharge the resident from the facility ...." This Federal Tag is related to Complaint IN00438940. 3.1-37(a)			
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 provide supervision for a resident while taking a shower resulting in a fall for 1 of 3 residents reviewed for falls (Resident C). Findings include: On 7/17/24 at 10:32 a.m., a record review was completed for Resident C. He had the following diagnoses which included but were not limited to C2-C7 cervical fracture, essential hypertension, Alzheimer's disease, cardiomegaly (enlarged heart), type 2 diabetes mellitus, unspecified dementia, chronic embolism and thrombosis of unspecified deep veins of left lower extremity (blood clots in the left lower leg), muscle weakness, repeated falls, need for assistance with	F 0689	F689' 1-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in the facility. 2-How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken? All residents have the potential to be affected.	08/14/2024

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	personal care, and adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol). Resident C admitted to the facility on 3/6/24. He was prescribed a blood thinner called Eliquis 5 mg (milligrams) by mouth two times daily. Other medications included, but were not limited to, hydrocodone 5/325 mg give 1 tablet by mouth every 6 hours as needed for pain, melatonin 10 mg (used to treat insomnia) by mouth every 24 hours for sleep, Troujeo (an insulin) 300 unit/ml give 80 units subcutaneously at bedtime and Tresiba solution 100unit/ml (an insulin) inject subcutaneously at bedtime. Resident C's admission assessment was completed on 3/6/24. The assessment indicated Resident C needed partial assistance from another person to complete activities of self-care such as bathing, dressing, using the toilet, or eating. Resident C needed partial to moderate assistance for showers and/or bathing. Resident C's mobility was coded as needing supervision or touching assistance. Tub shower transfer (the ability to get in and out of a tub/shower was coded as Resident C needing substantial to maximal assistance. Resident C's walking was coded as needing substantial to maximum assistance. His neurological status upon admission on 3/6/24 was intact, he had no cognitive impairment, he had reported some pain in his neck and wore an Aspen collar (the structure of the collar is engineered to provide substantial motion restriction without producing painful pressure points that can lead to skin breakdown or poor patient compliance). His fall screen upon		Staff education on fall interventions and documentation has been provided. Staff education on shower room procedures has been provided to Nurses and Certified Nursing Assistants. 3-What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Staff education on fall interventions and documentation has been provided. Staff education on shower room procedures has been provided to Nurses and Certified Nursing Assistants. Random weekly shower room procedure audits will be completed by the DON/Designee 5 times a week for 4 weeks and then 3 times a week for 4 weeks and then weekly for 4 weeks. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed	

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	admission indicated he scored an "8" indicating he was a low risk for potential falls. His baseline care plan indicated he had a vision impairment, and he wore a vision appliance. The baseline care plan indicated he required partial to moderate assistance with shower/bathe self (the ability to bathe self, including washing, rinsing and drying. The care plan indicated he could transfer independently to the tub/shower. His baseline care plan indicated he had a history of falls. An Occupation Therapy (OT) notes, dated 3/7/24 through 3/22/24, indicated tub/shower transfer was supervision to touching assistance, he required supervision or touching assistance. An OT note, dated 3/7/24 through 5/5/24, indicated he required supervision or touching assistance with bathing. An OT note, dated 3/15/24, indicated Resident C was instructed in functional ambulation using a standard cane. Resident C's Minimum Data Set (MDS) assessment, dated 3/15/24, indicated he required partial/moderate assistance with his shower/bathe. He had a progress note, dated 3/22/24 at 4:45 p.m., indicating he was showering independently after telling the Certified Nursing Assistant (CNA 12) he would like to shower without assistance. The Registered Nurse (RN 21) heard Resident C yelling out and found him on the floor. A situation, background, assessment, and recommendation (SBAR) was completed on		within the QAPI process.	

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	3/22/24 and indicated he had a fall with a change in his neurological status and was sent out 911 to a local hospital. A care plan was present and updated on 3/22/24 indicating he was at risk for falls related to impaired mobility, resident used a cane and ambulated independently at baseline, had a cervical fracture with cervical collar in place, had atrial fibrillation (irregular heartbeat), and resident had a preference to shower independently. The care plan goal indicated his risks and injury potential will be minimized through the next review. Interventions included encouraging him to allow staff to supervise, anticipate his needs, be sure the call light was within reach and encourage the resident to use it for assistance as needed, therapy evaluation and treatment. Resident C had a total of 4 showers during his stay. On 3/11/24, he had a shower and did not want staff to stay with him. He had a shower on 3/14/24 with no concerns, 3/18/24 he refused to allow staff to stay with him, and on 3/22/24 he showered without staff supervision and fell. A hospital note, dated 3/22/24, indicated he was having a shower at his extended care facility (ECF) when the aide turned around and heard the patient fall. Emergency Medical Services (EMS) called for transport. He was admitted to the hospital related to a right hemispheric subdural hemorrhage (blood is leaking out of a torn blood vessel and below the space of the brain and skull) with extension into right parafalcine region and falx (sections of the brain), acute epidural (the area between the outermost layer of tissue and the inside surface of bone) hemorrhagic component along the right orbital frontal convexity (area of brain), multiple adjacent subarachnoid			

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	hemorrhages (bleeding in the space between your brain and the membrane that covers it) in the right cerebral suld (section of the brain), approximately 1.4cm (centimeters) midline shift towards left with entrapment of left lateral ventricle and a large left parieto-occipital subgaleal hemorrhage with nondisplaced acute oblique fracture extending from left parietal calvarium crossing the midline into right occipital calvarium. He was transferred to comfort measures and passed away on 3/23/24 at 3:04 a.m. On 7/17/24 at 2:04 p.m., the shower room was observed. Upon entering the shower room, there was a sink and toilet to the left, a linen cart to the right side, and two shower stalls. The left one was cluttered with equipment, the right side had grab bars, a shower curtain and a call light connected by a long, thin, black string. On 7/17/24 at 2:05 p.m., Occupational Therapist (OT) 22 was interviewed. The Director of Rehabilitation was present with her. Resident C's cognition was pretty good. He didn't act like he had dementia. He was very uncertain of getting into the shower with the neck collar and the wet floors. He was nervous. The OT indicated he was not independent. He was never independent and was to shower with contact guard assistance (CGA). He still required supervision upon his discharge from therapy on 3/22/24. On 7/17/24 at 3:22 p.m., the daughter was interviewed. She did not want him home due to safety. She indicated she had a specific conversation with the facility related to him not going home, and not being able to make decisions independently. She told Social Services (SS) he was at risk for falls. She told the nursing home and the resident that he cannot independently			

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	shower on his own. On a condition for him returning home, he would have to accept care by a home health aide. They were aware that he was not to shower without assistance. They were aware of the dementia diagnosis. On 7/18/24 at 10:30 a.m., CNA 12 was interviewed with the Assistant Director of Nursing (ADON) present. She indicated the resident showered alone all the time. He asked her to leave the shower room and she did not want to upset him so she left him alone in the shower. She was not comfortable leaving him alone because he was a fall risk. She was not aware he had a neck fracture, Alzheimer's disease, or dementia. She indicated he acted alright on the way to the shower; he did not act like he had Alzheimer's or dementia. She indicated she wasn't supposed to shower him because it was not his shower day. She indicated she could have stood on the other side of the shower curtain instead of leaving the room, but she did not think of it. After leaving the shower room, she informed the agency, RN 21 that he wanted to shower alone. RN 21 went to the shower room and talked with the resident. She could hear them talking but did not know what they said. The CNA indicated she remained outside the shower door. After RN 21 left the shower room, the resident fell approximately 3 to 5 minutes later. The resident was screaming for help. When she opened the door, she saw the resident on the floor and the shower curtain pulled down. He was continuously calling for help. Other staff rushed into the shower room. On 7/18/24 at 10:45 a.m., the ADON indicated she observed the resident on the floor of the right-sided shower room. The shower curtain was hanging on the right side, on him. The water was still running and had spilled out onto the floor of			

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	the shower room, and she was trying to soak it up with a bath blanket. RN 21 was with the resident, assessing him. She and other staff were moving the resident trying to get the bath blanket underneath him. The resident was awake and alert, he was clearly in pain. He indicated his head hurt, and she observed facial grimacing. RN 21 was assessing him. The ADON indicated she had completed vital signs (VS), blood sugar (BS) check, and assessed his neurological status (neuro checks). She indicated his blood pressure was high and his pupils were "ok." Someone in the room indicated they would call 911. The ADON indicated calling 911 was appropriate for someone who had fallen on a hard surface and was on anticoagulants. The ADON indicated the residents should not have been left alone in the shower room. On 7/19/24 at 10:02 a.m., attempted to obtain a statement from RN 21 but was unable to reach him for comment. A policy titled, "Fall Management Program," without a revision date was provided by the Administrator on 7/17/24 at 3:35 p.m., It indicated, " ... to position call bell within reach and keep walkways obstruction and spill free ...". A policy titled, "Showering a Resident," without a revision date was provided by the Administrator on 7/18/24 at 9:51 a.m. It indicated, " ... Assist the resident into the shower and assist to bathe as needed ...". This Federal Tag relates to Complaint IN00432231. 3.1-45(a)			

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F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure the pest control program, throughout the building, was effective for 3 of 3 days of observation which had the potential to affect 100 of 100 residents residing in the building. Findings include: During a conversation, on 7/17/24 at 11:58 a.m., the Maintenance Supervisor (MS) indicated he had used Drop Dead insect spray on the baseboards and in the air. Also, he used chemicals used to treat the drains in the kitchen, resident restrooms, and pantries. The facility used a local pest company. He would provide the pest control company documents, his efforts to control the pests, and the Material Safety Data Sheets for the chemicals he used in this building. During a conversation, on 7/17/24 at 1:49 p.m., the Administrator (Admin) indicated the facility did have gnats. On 7/17/24 at 9:50 a.m., the first wooden door in the dining room was opened, the door was used for window food service access, and at least a dozen flying insects were observed flying together in the air (swarming). The Assistant Dietary Manager (ADM) observed the flying insects as well, she indicated we are trying to keep the bugs out. They had tried using drain cleaner and drop dead (bug) spray. The kitchen tour, on 7/17/24 was started at 9:51	F 0925	F925 1-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Facility Pest Control Service came into the facility on July 30, 2024 and applied an Enzyme Cleaner to all drains in Kitchen and Dish room as well as treated resident rooms. The Pest Control Service visits have been increased to twice a month and as needed. On June 18, 2024 the kitchen, dining areas were "bombed" with a Gnat Repellent to rid the building of pests. Resident rooms were also individually sprayed to elevate any pest concerns. 2-How are other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken? Environmental Services Director/Designee have continued to treat the kitchen and dining room area at least weekly for pest concerns as well as resident rooms.	08/14/2024

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	a.m., with the ADM. At 9:54 a.m., several flying insects were observed inside and outside of the juice machine dispenser. At 9:55 a.m., bananas with brown spots were observed on the condiment cart next to the Air Cooler refrigerator. At 9:56 a.m., the ADM indicated the Air Cooler (AC) refrigerator leaked due to condensation. A white towel was observed on a tray at the bottom of the AC. The ADM indicated the towel was placed in there this morning. It was observed to be completely saturated and sitting in water. The ADM indicated the towel was changed every day or every other day. At 9:57 a.m., a flying insect was observed flying through the air in the kitchen. At 10:02 a.m., in the small dry storage room, two lemonade decanters, used this morning for breakfast, were observed on a cart. Two flying insects were observed flying around them. At 10:04 a.m., a flying insect was observed in the large dry storage room. At 10:06 a.m., the janitor door was observed to be propped open with a bucket. The ADM indicated the janitor's room door should have been kept closed. The janitor's sink and floor were observed to be dirty. A flying insect was observed in the janitor's room. The ADM indicated it was the kitchen staff's responsibility to keep the janitor's room clean. At 10:08 a.m., the outside door to the kitchen was observed to be dirty. The ADM indicated the		On June 23, 2024 the main sewer pump was drained and treated for pest concerns. 3-What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? Facility staff have been educated on pest control. Environmental Services Director/Dietary Director/Designee will perform audits of the dining room and kitchen for pest concerns for 5 times a week for 4 weeks and the 3 times a week for 4 weeks and then weekly thereafter. 4-How will the corrective actions be monitored to ensure the deficient practice will not reoccur? All audit results will be reviewed and reported to the IDT in QAPI. Determination of ongoing monitoring will be completed within the QAPI process.	

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	door should have been cleaned. During an interview, on 7/17/24 at 10:09 a.m., Dietary Aide 8 indicated he had seen a few flying insects in the dish room. At 10:10 a.m., in the dish room, water was observed on the floor and dripping from the counters. The wall behind the dish machine was observed to the dirty, the drain under the dish machine was covered with a gray film, on, around and in it. Under the stainless steel counter in the dish room, 40-50 flying insects were observed on the wall. The ADM observed them as well, and indicated that was a problem area. Above the "problem area" was an open window to the cart room. In the cart room, no staff were observed and the used trash can was observed uncovered and about a dozen flying insects were observed flying in the air. On 7/17/24 at 11:37 a.m., the kitchen cart room was observed again, four flying insects were observed in the air. During an interview in her room, on 7/17/24 at 11:51 a.m., Resident J indicated she observed gnats when she received her meals. They would land on her food. One flying insect was observed on the domed light. During an interview in her room, on 7/17/24 at 11:53 a.m., Resident K indicated the gnats were all over the place, especially in bathroom. The gnats were really bad, especially around her food when she tried to eat. They were everywhere. During an interview in the dining room, on 7/17/24 at 12:01 p.m., Resident L indicated he had seen gnats in the building, just flying around. They			

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	were especially bad around food. They dived at your food. These gnats were determined. He indicated they were also in his room. During an interview in the dining room, on 7/17/24 at 12:04 p.m., Resident M indicated she had seen gnats in the dining room and a lot in her restroom. She indicated she had to swat them away while eating. It had been going on for a couple of months. During an interview in the dining room, on 7/17/24 at 12:06 p.m., Resident N indicated she saw gnats every time she ate. They tried to get on the food and you have to wave at them to get them away from you while eating. During an interview in the dining room, on 7/17/24 at 12:10 p.m. Resident O indicated see had seen lots of gnats, especially while eating. They were such a nuisance. She also had them in her room. During an interview in the dining room, on 7/17/24 at 12:12 p.m., Resident Q indicated she saw gnats, mostly in the dining room but also in her room. During an interview in the dining room, on 7/17/24 at 12:14 p.m., Resident D indicated gnats were all over the place. On 7/17/24 at 12:38 p.m., lunch service was observed in the kitchen. The ADM prepared lunch trays to be served to the residents in the dining room. A flying insect was observed in the air around the steam tray. On 7/17/24 at 12:43 p.m., flying insects observed in dish room under and around the stainless steel table. A used trash can, with food debris inside, was observed uncovered in the dish room.			

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	During an interview, on 7/17/24 at 12:47 p.m., Resident P indicated she had flying insects in her room. On 7/17/24 at 12:52 p.m., a flying insect was observed flying in the air in the dining room. On 7/17/24 at 12:54 p.m., Resident D was observed to swat flying insects away while eating lunch. During an interview, on 7/17/24 at 12:57 p.m., Resident M indicated she had to swat a gnat away from her food while trying to eat lunch. On 7/17/24 at 2:40 p.m., two flying insects were observed, in the kitchen, around a large uncovered bowl of fruit salad and about 12 uncovered individual bowls of fruit salad were observed on the counter. No kitchen staff were observed attending to the fruit salad. On 7/17/24 at 2:43 p.m., a used trash can, lid partially open, was observed with a flying insect flying in and out of it. The ADM entered the kitchen and indicated should have covered the bowl and individual servings of fruit salad before leaving to get a sharpie. She was gone longer that she anticipated. She was observed covering the fruit salad bowl, putting lids on the individual servings and dated them. She put the bowl and servings into the walk-in refrigerator. During an interview, on 7/17/24 at 2:40 p.m., Dietary Aide (DA) 8 indicated the Dietary Manager (DM) had not asked him to clean the dish room. One flying insect was observed flying in the dish room and about a dozen flying insects were observed on the wall in the dish room. Dirt and debris were observed on the floor in dish			

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	room. During an interview, on 7/17/24 at 2:45 p.m., the ADM indicated the Maintenance Supervisor (MS) cleaned the drains under prep table, ice machine, and two drains in dish room. She indicated she was part-time and did not know how or when the drains were cleaned. On 7/17/24 at 1:45 p.m., the Admin provided documentation of the facility efforts to remove the flying insects. She indicated as far as she knew these documents were inclusive of all events to remove the insects. During an interview, on 7/18/24 at 10:12 a.m., the DM indicated the kitchen staff were doing extra cleaning in the kitchen to help control the gnat problem. The main problem, in the kitchen, was the standing water. The kitchen staff used Drop Dead insect spray in the mornings, especially under the dish machine avoiding use in the food areas. The Air Cooler was leaking and she asked the MS to look at it. The kitchen staff scrubbed out the area under the stainless steel table in the dish room. The kitchen staff swept and mopped the floor every night. Insect foggers were used in the kitchen overnight, she was unsure of the date. She indicated the kitchen staff took everything out that they could. After the foggers, everything was wiped down, all the dishes were rewashed and the floor scrubber was used. The MS used chemicals with special enzymes to clean out the drains. The ice machines and dish machine were serviced quarterly by Care Safe. In the dining room, the MS was responsible for controlling the flying insects while the residents ate. On 7/18/24 at 10:25 a.m., observations with the DM included an uncovered used trash can in the			

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	dish room and more than a dozen flying insects on the wall under the stainless steel table, by the garbage disposal. The DM indicated they sprayed Drop Dead insect spray in that area this morning. She did not know why the insects were there again. During a conversation, on 7/19/24 at 10:06 a.m., MS indicated 6 insect foggers were used in the kitchen on 6/18/24. When he would treat resident rooms for flying insects; he would enter, preferably when the resident was out of the room, and spray the surfaces of all walls. The rooms that were worse than the others were residents who soiled themselves more often because the gnats would gravitate to that room. Items that would help would be to take out the trash more often and limit the food in resident rooms, but the main problem was the cleanliness of the kitchen. The facility needed to have a clean kitchen. The issue with the gnats started at the beginning of June. The drains have tied-in pipes and he used drain cleaner in the sinks to get to the pipes. He indicated he could only do so much, the kitchen needed to keep things clean. The juice and food attracted the gnats. Treating areas was not enough, the kitchen had to be clean because it continued to attract the gnats. The kitchen needed to clean an area first and then spray for gnats. They washed dishes all day so they needed to repeatedly clean and spray. The kitchen dealt with a lot of sugary stuff attracting the gnats. More can be attracted overnight. The Drop Dead insect spray was ok to use if the kitchen was not preparing food. On 7/19/24 at 10:44 a.m., the label for the drain cleaner, titled, "Foaming Free Flow Aerosol Drain Cleaner and Odor Eliminator," indicated it eliminated odors with expanding foam and breaks			

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	down fats, oils and greases, and contained multiple strains of non-pathogenic beneficial bacteria that produced enzymes necessary for degradation of fats, oils, and grease inside drain lines. Thick, rich foam expands into areas otherwise impossible to reach. The 24" tube allowed the used to apply deep into drains and pipes where build-up occurs, reducing odors and organic materials. This product can also be used after treatment with drain openers to prevent future clogging and residual odors. For use in restaurants, kitchens, and bathrooms. Re-apply the product periodically to maintain and keep the drain pipe and (garbage) disposal clean and odor free. During an interview, on 7/19/24 at 1:11 p.m., the local pest technician (Pest Tech) who serviced the facility indicated he had been servicing the facility pest control needs. He came once a month. He had talked with the MS about the gnat issue. He informed the MS about the grout was getting washed out and the tiles were lifting in the kitchen, especially in the dish room. On 6/18/24, he came out for the routine pest maintenance and provided 6 foggers for the kitchen as a temporary fix for the gnats in the air. The cleanliness of the kitchen was a problem with getting rid of the gnats. They lifted the floor mats in the kitchen and dish room and there was a distinct odor of a sewer. He indicated the pest control company had products available to them that were more effective than foggers. He was at the facility only one time in June, on 6/18/24, and had not been back to the facility as of 7/19/24. He indicated on 6/18/24, he requested the kitchen to be cleaned and to keep it dry. They had a lot of water issues. He indicated he had not provided any products for the drains. He indicated a thin gray film was probably a biofilm (thin, slimy film of bacteria). He			

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	155215	A. BUILDING 00 B. WING	07/19/2024

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	indicated he treated under the kitchen counters, floor equipment, and tiles. He indicated he remembered he did a gnat treatment previously to try and get everyone on pace and he thought the facility gnat issue was improving. He indicated insect foggers were a temporary fix and they needed to get to the root cause of the gnat problem. During an interview, on 7/19/24 at 11:30 a.m., the Admin indicated the facility had worked diligently every day to manage the gnat situation. She indicated she would round on her own to assess for insects and other things. The MS would go around with the pest control company to assess the building. She did not provide dates for these assessments. During an interview, on 7/19/24 at 11:51 a.m., the DM indicated the MS looked at the Air Cooler leak and would be buying a new seal. The white towel, on the bottom of the Air Cooler, was observed to be saturated with water. The Air Cooler door was standing open because lunch was being served. She indicated the three trash cans in the kitchen were cleaned weekly with bleach or comet. Flying insects were observed on the wall, under the stainless steel table, near the garbage disposal. She indicated they had already sprayed that area with Drop Dead insect spray twice this morning. She indicated the leaking device attached to the faucet on the three compartment sink was a divider. She was observed to try and turn the water off and it continued to leak. A flying insect was observed flying around the drain under the three compartment sink. The dish machine was cleaned after every meal; the racks were spray with hot water and the outside was cleaned daily.			

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	A current policy, titled, "Pest Control, dated 8/2020, was provided by the Admin, on 7/17/24 at 3:33 p.m. A reviews of the policy indicated, " ...Purpose: To ensure the Facility is free of insects ...The Facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects ...The Maintenance Department assists, when appropriate and necessary, with pest control services ...The Administrator arranges for a pest control company ("Company") to visit and inspect the Facility at least once a year ...The company representative will inspect the Facility and grounds for insects ...Submit a written report to the Administrator detailing its findings ...The inspection report will be filed in the Maintenance Director [sic] ...Submit a site-specific work plan for each area/department with recommendations on how to keep the Facility pest-free ...Department and area staff are responsible for carrying out these recommendations to prevent pests in their respective area ...As authorized by the Administrator, the Company will carry out any pest control actions needed to rid the Facility and its grounds of any environmental pests ...After exterminating or spraying for insects, as the situation warrants, the Facility will once again get inspected by the Company to ensure that all environmental pests were removed from the premises ...Facility Staff will report to the Housekeeping Supervisor any signs of rodents or insects, including ants, in the Facility ...The Housekeeping Supervisor takes immediate action to remove the pests ...." A current policy, titled, "Cleaning Schedule, dated 12/2020, was provided by the Admin, on 7/17/24 at 3:33 p.m. A reviews of the policy indicated, " ...The nutrition services staff will maintain a sanitary environment in the nutrition services			

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	department by complying with the routine cleaning schedule developed by the Nutrition services manager ...The Nutrition services manger monitors the cleaning schedule to ensure compliance ...." A current policy, titled, "Ice Machine, dated 12/2020, was provided by the Admin, on 7/19/24 at 9:20 a.m. A reviews of the policy indicated, " ...The ice machine will be cleaned routinely ...On no less than a monthly basis, remove the ice to wash the inside of the machine ...Sanitize the inside of the machine using a sanitizing solution and a clean cloth ...." This Federal Tag relates to Complaints IN00437783, IN00437780, and IN00437462. 3.1-19(f)(4)			