STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 21, 22, 23, 24 and 27, 2022. Facility number: 000291 Provider number: 155404 AIM number: 100286710 Census Bed Type: SNF/NF: 25 Total: 25 Census Payor Type: Medicare: 3 Medicaid: 22 Total: 25 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 7, 2022.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life,			

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

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	recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observations, interview, and record review, the facility failed to ensure a resident maintained her dignity by not providing incontinent care in a timely manner or providing her a shower as she requested after an incontinent episode for 1 of 1 residents randomly reviewed for dignity (Resident 6). Findings include: On 6/22/22 at 11:13 a.m., Resident 6 was observed.	F 0550	It is the standard of this facility to ensure that residents maintain dignity by providing incontinent care and showers as requested. **-What corrective action is to be accomplished for those residents found to have been affected by the deficient practice?** Resident 6's needs will be met in a timely manner.	07/27/2022

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	She was sitting up but reclined slightly in her Broda chair. A blanket covered her face, but she pulled it down to answer questions. Resident 6 indicated her brief was wet, and she wanted a shower. "It's embarrassing and I stink!" During a continuous dining observation on 6/22/22 from 12:00 p.m., until 12:42 p.m., the following was observed: At 12:08 p.m., Housekeeping Aide 18, who was helping pass lunch trays, entered Resident 6's room. She set her lunch tray on an overbed table in front of Resident 6. Resident 6 indicated, "I'm wet, and my legs are soaking, I need a shower." Housekeeping Aide 18 indicated to Resident 6, "OK, I'll go tell them, but it will probably need to be after lunch." Resident 6 asked who the Certified Nurse Assistant (CNA) was, and Housekeeping Aide 18 indicated, "CNA 11." Resident 6 indicated, "I've been wet all morning, and I want CNA 11 to give me a shower today. Housekeeping Aide 18 indicated she would let CNA 11 know, but Resident 6 needed to go ahead and try to eat her lunch. At 12:22 p.m., Resident 6 was observed to have finished her lunch. She called out for help. The Maintenance Director entered her room and asked what was wrong. Resident 6 indicated she was still wet and wanted to get a shower. The Maintenance Director indicated CNA 11 was there and they would probably be able to get her a shower before the CNA left. At 12:32 p.m., Resident 6 was heard from the nurses' station as she called out, "someone! Someone!" At 12:34 p.m., Resident 6 was observed. She remained in her Broda chair and called out for		**-How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents requiring assistance with incontinence care are at risk to be affected by this alleged deficient practice. No other resident was affected by this alleged deficient practice. **-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?** All staff will be inserviced on 7/26/2022 regarding resident rights, call light placement, reporting resident concerns to the appropriate staff, and incontinence care and bathing requests. **-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?** An audit tool has been created that monitors incontinent residents every two to three hours to ensure timely incontinence care. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 3 months, and weekly for the next 2 months. Results will be shared monthly with the facility QAPI committee for additional recommendations. **-By what date with the systemic changes for each deficiency be completed?**	

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	help. Her call light chord was draped over the bed, but it was behind Resident 6's line of sight and out of reach. At this time, Resident 6 indicated she was still soaking wet and wanted a shower. At 12:39 p.m., CNA 11 entered the room and asked what was wrong. Resident 6 began to cry and said her legs hurt and she wanted a shower. CNA 11 indicated she could try to give her a shower later but, but for now to help her legs she could rub some lotion on them. Resident 6 agreed. During an interview on 6/22/22 at 12:42 p.m., CNA 11 indicated she was the only CNA at that time, and she was trying to get to everyone as fast as she could, but she was running short and was not sure if she could get a shower done. If Resident 6 said she was wet, or had an accident, CNA 11 believed her because she was very alert and oriented. She would get the Regional Nurse Consultant to come help with the Hoyer lift to put Resident 6 in bed and get her changed. CNA 11 indicated, a resident should not have to eat lunch with a wet brief, but CNA had not been able to get to her since the facility was short staffed. The following morning on 6/23/22 at 9:27 a.m., Resident 6 indicated she had not been able to have a shower yesterday as requested, but she had gotten one earlier that morning. On 6/23/22 at 8:49 a.m., Resident 6's medical record was reviewed. She had diagnoses which included, but were not limited to, Parkinson's disease, torticollis (a rare condition in which the neck muscles contract, causing the head to twist to one side), bipolar disorder with severe psychotic features and anxiety. The most recent Minimum Data Set (MDS)		07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	assessment was a quarterly assessment dated 3/21/22. The MDS indicated Resident 6 was totally dependent on staff for activities of daily living (ADLs) which included, but were not limited to, bathing, transfers, and bed mobility. She had a comprehensive care plan, initiated 6/24/21, which indicated Resident 6 required extensive to total assistance with all ADL care. Interventions for this plan of care included but were not limited to, " ...bathing: the resident is totally dependent on 1-2 staff to provide a bath 2 times per week and as necessary ... toilet use: the resident is provided incontinent care approximately every 2 hours and as needed by up to 2 staff with extensive to total assistance ...." A second comprehensive care plan, dated 6/25/21, indicated Resident 6 was totally incontinent of bowel and bladder and she was not a candidate for a bladder program. Interventions for this plan of care included, but were not limited to staff to provide incontinent care approximately every 2 hours and as needed. CNA charting for ADLs and the Shower Sheet Binder was reviewed and indicated Resident 6 had not been provided a shower on 6/22/22 as she requested, but a shower had been documented the following day on 6/23/22 at 9:26 a.m. On 6/24/22 at 10:00 a.m., the Regional Nurse Consultant indicated Residents should be given showers according to their preferences and schedule, and of course as needed if requested. At this time, she provided a copy of current facility policy titled, "Dignity," dated, 8/2009. The Policy indicated, "...Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality...'treated			

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	with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth ... residents shall be groomed as they wish to be groomed ... Staff shall promote dignity and assist residents as needed by ...promptly responding to the resident's request for toileting assistance ...." Cross Reference F725. 3.1-3(a)			
F 0641 SS=B 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 observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for 3 of 13 residents reviewed for MDS assessments (Residents 3, 15, and 21). Findings include: On 6/21/22 at 11:10 a.m., following the entrance conference the Regional Director of Clinical Operations (RDCS) provided a handwritten resident matrix. A Minimum Data Set (MDS) assessment generated printed matrix was requested at that time. On 6/22/22 at 9:00 a.m., the RDCS provided the printed matrix generated from the MDS assessment reports. A comparison of the two reports indicated several differences. a. Resident 3 was coded excessive weight loss on the handwritten matrix, he was not coded for weight loss on the printed matrix. b. Resident 15 was not coded for an indwelling urinary catheter on the handwritten matrix, the	F 0641	It is the standard of this facility to complete assessments that accurately reflect the resident's status. **-What corrective action to be accomplished for those residents found to have been affected by the deficient practice?** After the survey team identified the concerns about the MDS assessments for residents 3, 15, and 21, they were corrected and resubmitted. **-How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice.	07/27/2022

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	printed matrix indicated the presence of an indwelling catheter. c. Resident 21 was coded for dialysis on the handwritten matrix, but not on the printed one. 1. On 6/22/22 at 11:45 a.m., during an observation and interview, Resident 3 was observed coming in from outside in his electric wheelchair. He indicated he had recently had some surgeries and had lost a lot of weight. He was trying to get back on track. On 6/22/22 at 11:57 a.m., Resident 3's medical record was reviewed. The diagnoses included, but were not limited to spinal cord injury, pressure ulcers, heart disease, diabetes, rectal cancer and dementia. Resident 3 had a recent hospital stay from 3/9/22 to 3/26/22. On 6/7/2022 at 2:33 p.m., a Dietary note indicated "Resident reviewed due to sig.[significant] wt. [weight] loss of 13.8 lbs./10.7% in 3 mo.[months] and 20.2 lbs [pounds]/15% in 6 mo. BMI is now 17.9 underweight and resident meets clinical characteristics for Malnutrition dx [diagnosis]. He continues to have multiple pressure sores (refer to NN [nurse note] 6/6/2022) He has declined peg tube placement and continues with poor intakes of food and adequate fluid intake. Interventions continue- Magic cup each meal. Chocolate Milk L/D, Proheal protein supple., Ascorbic acid, vit. C, vit. D, thiamine. Suggest increase Proheal protein supple. to 30 ml tid [three times a day] and discontinue thiamine [supplement]. Current orders are for weekly wt. monitoring - follow MD orders." A care plan revised 8/1/21 indicated Resident 3 was at risk for nutritional deficit related to the resident preferring snack food over his meals, behavior of hoarding food, and was at risk of		**-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?** DON, MDS Coordinator(interim), Activity director, Dietary Supervisor, and SSD will be inserviced on 7/26/2022 over MDS policy and procedure with focus on checking accuracy of assessment before signing their responsible MDS section. **-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?** DON or designee will audit all resident's comprehensive MDS assessments for the next 4 months to ensure compliance. Results will be shared monthly with the facility QAPI committee for additional recommendations. **-By what date will the systemic changes for each deficiency be completed?** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adopted we will obtain and maintain continued compliance.	

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	weight loss, diuretic use, continued hypo albuminemia, risk for further abnormal lab results, dx of Adult Failure To Thrive, Hepatitis C, back and leg pain, Diabetes Mellitus type 2, leg pain secondary to neuropathy, hx (history) of significant weight loss, recurrent stasis and pressure ulcers r/t fragile skin and paraplegia. Resident states he has an allergy to chocolate) Recent cancer of rectum added 8/1/21. The goal indicated the resident's weight loss will slow to less than significant change through next review date. A review of Resident 3's weights in pounds (lb) for the past year indicated: a. On 6/16/2022, 114.4 Lbs. (after hospital stay) b. On 3/3/2022, 128.4 Lbs. c. On 1/6/2022, 140.6 Lbs. d. On 12/1/2021, 134.8 Lbs. e. On 10/4/2021, 137.2 Lbs. f. On 8/1/2021,153.6 Lbs. g. On 6/8/2021, 160.0 Lbs. Resident 3's significant change MDS assessment, dated 4/1/22, indicated weight was 128, height 67 inches. Weight loss indicated "No (0)" 2. On 06/22/22 at 2:48 p.m., Resident 15's medical record was reviewed. The diagnoses included, but were not limited to anemia, ulcerative colitis and depression. The quarterly MDS assessment, dated 4/29/22, indicated Resident 15 had an indwelling catheter. A review of the physician's orders did not indicate the resident had an indwelling urinary catheter. On 6/22/22 at 2:57 p.m., during an observation and interview, Resident 15 indicated he did not have an indwelling urinary catheter.			

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	3. On 6/22/22 at 12:25 p.m., during an observation and interview, Resident 21 was in room seated in a wheelchair. She indicated she had no concerns at that time. She was still receiving dialysis. On 06/23/22 at 11:57 a.m., the medical record was reviewed for Resident 21. The diagnoses included but were not limited to diabetes and end stage renal disease. The annual MDS assessment, dated 5/24/22, under special treatments, procedures and programs, indicated Resident 21 did not receive dialysis. A physician order, dated 4/4/22, indicated "Dialysis - Resident receives dialysis at (Name of Dialysis Center) on Mon, Wed, Fri routinely. Days may vary based on holidays and dialysis center schedule." On 6/23/22 at 11:39 a.m., during an interview, the RDCS indicated Licensed Practical Nurse 14 had been doing the MDS assessments. She was sent once a week, from the corporate office to help, since the previous MDS coordinator had resigned in April. She (RDCS) kept a pencil copy of the MDS assessments that was always current. The printed MDS (in the electronic system) was not current. Some of the indications on the pencil copy, such as falls for some residents, had recently occurred and they had not had a new MDS completed to capture them. In some instances, the MDS was coded wrong, such as Resident 21's dialysis. On 6/27/22 at 12:02 p.m., the RDCS provided a current policy, dated as revised December 2006, titled "Certifying Accuracy of the Resident Assessment." This policy indicated "All personnel who complete any portion of the Resident Assessment (MDS 3.0) must sign and			

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	certify the accuracy of that portion of the assessment...." On 6/27/22 at 12:02 p.m., the RDCS provided a current policy, dated as revised December 2006, titled "Electronic Transmission of the MDS." This policy indicated " All MDS assessments (e.g. admission, annual, significant change, quarterly review, etc.) and discharge and re-entry records will be completed and electronically encoded into our facility's computer MDS informational system and transmitted to the state database in accordance with current OBRA regulations governing the transmission of MDS data...." 3.1-31(c)(5) 3.1-31(c)(6) 3.1-31(i)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these			

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	changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient			

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	assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on record review and interview, the facility failed to ensure an adequate discharge planning process was in place to anticipate the resident's needs and goals for 1 of 1 reviewed for discharge (Resident 25). Findings include: On 6/23/22 at 9:52 a.m., Resident 25's record was reviewed. She was admitted to the facility on 10/27/21. A nursing progress note dated 10/27/21 at 5:32 p.m., indicated, Resident 25 admitted to the facility with diagnoses that included, but were not limited to Huntington's Disease, bipolar and confusion. At that time, she was alert and oriented to her name, but confused to place and time. The progress note did not indicate the type of stay Resident 25 anticipated.	F 0660	It is the standard of this facility to ensure that residents have a proper care plan that includes a discharge plan. **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 25 had the potential to be affected but was not affected by this alleged deficient practice. 25 was able to discharge safely to the place of her choosing with the appropriate resources. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And**	07/27/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	Upon her admission there was no baseline care plan to indicate her anticipated type of stay, or discharge goals. Both her Level of Care and Level I Pre-Admission Assessment and Resident Screenings indicated Resident 25 had been approved for short term stay. Resident 25 had a comprehensive care plan for her advance directive wishes to remain a full code status, that care plan also indicated, Resident 25 was " ... most likely long-term placement ...." However, the record lacked documentation that a comprehensive care plan had been created to anticipate Resident 25's specific, person-centered discharge planning goals, or intentions to stay long term care. The record lacked documentation of any IDT (interdisciplinary team) discussion and/or planning for Resident 25's discharge planning. A social service progress note, dated 3/21/22 at 11:30 a.m., indicated, Resident 25 came to the Social Service Director's (SSD) office and requested to discharge to her boyfriend's house that day. The SSD and nursing team got an order from the medical doctor, and she would discharge later that day. A nursing progress note, dated 3/21/22 at 4:17 p.m., indicated Resident 25 had been cleared and given an order to discharge to the community. She left the facility with her friend after she packed her belonging and was "happy to be going home with her friend." During an interview on 6/24/22 at 10:57 a.m., the SSD indicated, it was usually her or the Minimum		**What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. All resident's care plans were reviewed and updated as warranted for baseline care plans, comprehensive care plans, and discharge planning **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** SSD and Interim MDS Coordinator in-serviced on the need for Baseline care plans, comprehensive care plans, & discharge planning policy/procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Interim MDS Coordinator/Designee will audit all new admissions every week to ensure Baseline Careplans, Comprehensive Careplans & Discharge Planning are initiated and completed for 6 months. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly.	

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	Data Set Coordinator (MDSC) who initiated the discharge planning process. However, since there was no longer an MDSC, the SSD was not sure if Resident 25's discharge planning process had been started. Usually, the Discharge planning process started upon admission when the IDT team reviewed and discussed the resident's goals and wishes, whether they were there for short-term rehabilitation, or if they would be staying long-term. Because Resident 25 was so confused when she first came, everyone just assumed she would stay long-term. She had left the facility several times for LOA (leave of absence) to stay with her friends, so it was not a surprise that she wanted to leave. She came to the SSD office one day and said she wanted to leave with her boyfriend, and she left later that same day. The SSD reviewed Resident 25's electronic medical record and indicated she could not find any information regarding Resident 25's wishes to stay long-term, or discharge back to the community. During an interview on 6/24/22at 11:32 a.m., the Regional Nurse Consultant indicated she had double checked Resident 25's medical record and could not find documentation for any discharge planning. It appeared that there had been no definitive discharge planning process, the facility assumed she was going to stay long term. There was no care plan for her to stay long term, or plan for discharge. Her status had been undetermined until the day she decided to discharge on 3/21/22. On 6/24/22 at 11:45 a.m., the Regional Nurse Consultant provided a copy of current facility policy titled, "Discharge Summary and Plan," dated 11/2014. The policy indicated, " ...When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be		**Date of Completion:** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	developed to assist the resident to adjust to his/her new living environment... 3. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain as a minimum... e. a description of how the resident and family need to prepare for the discharge. 4. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge plan can be developed. 5. The social Service Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place...." 3.1-12(a)(18) 3.1-12(a)(19) 3.1-12(a)(21)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident's	F 0686	It is the standard of this facility to adhere to infection control	07/27/2022

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	pressure ulcer treatment was done as ordered and with infection control techniques to prevent wound infections for 1 of 1 residents reviewed for pressure ulcer dressing changes (Resident 3). Finding include: On 6/24/22 at 7:37 p.m., Licensed Practical Nurse (LPN) 12 indicated Resident 3 did not eat well. He received liquid protein. On 6/24/22 at 7:48 a.m., LPN 12 was observed bringing a sheet-covered wound treatment cart in Resident 3's room. She removed the sheet and laid it in the corner of the resident's room on top of a stack of the resident's clothes and his foam boot. On 6/24/22 at 7:50 a.m., Resident 3's chuck (fabric pad under patient) was observed to be soiled. Resident 3 indicated he spilled chocolate milk on it yesterday. It was not changed before the dressing change. On 6/24/22 at 7:52 a.m., LPN 12 changed Resident 3's full ostomy bag. She wore gloves and changed them throughout, she did not wash her hands during any part of the process. When she was finished, she removed her gloves, gelled her hands, and put on clean gloves to reposition the resident to remove his dressings. On 6/24/22 at 7:59 a.m., LPN 12 and Certified Nursing Aide (CNA) 8 repositioned Resident 3 for his dressing change. He was turned on his right side. LPN 12 removed his large coccyx dressing. She described the coccyx wound as, "red and meaty." It was macerated (soft, wet, or soggy) on the right lateral side. She left five calcium alginate (moisture absorbing) dressings in place with no covering.		standards while giving wound care. **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 3 will not be affected by this alleged deficient practice. Resident 3's wound/pressure ulcer treatment will be done as ordered using the proper infection prevention techniques. **How 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 by this alleged deficient practice. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All licensed/qualified nursing staff to be in-serviced on Hand Hygiene as it related to Wound/Pressure Ulcer Care & Infection control standards for dressing changes. All licensed/qualified nursing staff to be in-serviced on following treatment orders for wound/pressure ulcers. **How The Corrective Action(s)**	

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	LPN 12 removed her gloves, laid out a plastic bag on the bed. She did not use hand gel or wash her hands before she put on new gloves. Back at the treatment cart, she opened a calcium alginate dressing and with uncleaned scissors that were laying on the cart, she was cutting-out multiple wound size shapes. She did not clean the scissors prior to use. She went back to the resident and removed his soiled disposable brief. Removed her gloves, gelled, and put on new gloves. Resident 3's large coccyx wound was open to the air, and five smaller wounds were only covered with calcium alginate. LPN 12 indicated to CNA 8 to cover his wounds because she needed to leave the room for supplies. CNA 8 used the soiled sheet and blanket from the resident's bed to cover him up. At 8:10 a.m., LPN 12 returned to Resident 3's room. She was holding paper measuring tapes in her bare hand. She gelled and put on new gloves. She laid several paper measuring tapes directly on the resident's soiled chuck. She tucked part of a clean brief under the resident's left hip. LPN 12 indicated she needed normal saline (NS) to moisten the calcium alginate in the resident's wounds to remove them. She indicated as she removed the calcium alginate dressings, they were also removing slough (dead skin). The calcium alginate was bloody. Five calcium alginate dressings were removed. She removed her gloves, gelled her hands, and put on new gloves. She did not wash her hands according to facility policy.		**Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will randomly observe 2 wound treatments weekly for 2 months, bi weekly for 2 months and monthly for 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly. **Date of Completion:** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	LPN 12 laid gauze squares on the bed, and partially on the disposable brief, and plastic bag. She squirted NS onto the wounds, one at a time, and used the gauze square to catch any NS overflow. She did not wipe the wound to remove any additional slough. LPN 12 indicated one wound was spreading into another wound and she would measure them together. She removed her gloves, used hand gel, and put on new gloves. The coccyx wound measured 10 centimeters (cm) by (x) 7.4. cm x 1.2 cm with undermining from 7 o'clock to 1 o'clock. The undermining measured 1.0 cm. The right buttocks wound measured 2.8 cm x 1.4.cm x 0.1 cm. At 8:22 a.m., LPN 12 left the room again to get more supplies. She removed her gloves and gelled her hands. Upon returning to the room, she donned clean gloves and measured the right gluteal fold at 1.8 cm x 3.2 cm x 0.3 cm. The right lower buttock measured at 1.0 cm x 0.3 cm x 0.1 cm. LPN 12 was observed to lay the unclean paper measuring tape directly on the resident's impaired and intact skin. The left buttock measured at 1.8 cm x 0.3 cm x 0.1 cm. At 8:26 a.m., LPN 12 was observed to put Dakin's solution (antiseptic used to clean infected wounds) on a gauze square. She squeezed out the Dakin's over the trash can and spread the gauze square in one layer over the coccyx wound. She did not put any dressing in the undermined			

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	portions of the wound. LPN 12 went back to the treatment cart. She cut an adhesive dressing cover-all first, then the foam dressing, and the sterile calcium alginate last for five wounds with the uncleaned scissors. She indicated his dressings were changed daily. She placed one calcium alginate on the left buttock and gluteal fold. She removed her gloves, gelled, and put on new gloves. She brought the cutting adhesive dressing cover-all and laid it on the bed. She cut more calcium alginate for the right buttock. She removed her gloves, gelled, and put on new gloves. She put a foam dressing on the coccyx wound and asked CNA 8 to hold it in position. CNA 8 had been assisting Resident 3 with positioning by touching his bare skin with her gloved hands. She did not change gloves, wash her hands, or replace her gloves before assisting LPN 12 with holding the resident's coccyx dressing in place. LPN 12 was observed cutting additional foam with the uncleaned scissors. She indicated the scissors were dull. She removed her gloves, did not gel or wash her hands, and put on new gloves. She opened another sterile package of calcium alginate because it fell off of the resident's right lower buttock wound. Then, she placed more adhesive dressing cover-all to hold the dressing in place. She removed the trash from the resident's bed and told him they were done it that area. On 6/24/22 at 8:43 a.m., LPN 12 indicated Resident 3 had a pressure ulcer on his right outer foot. She changed gloves, gelled, and put on new gloves. She did not wash her hand after changing gloves or between the coccyx and multiple buttocks wounds before she started the right outer foot			

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	wound. At 8:44 a.m., LPN 12 asked CNA 8 to leave Resident 3's side and retrieve additional supplies. Resident 3 was holding a positioning bar for stability. At 8:46 a.m., CNA 8 returned. She gelled and put on new gloves. LPN 12 removed the right outer foot dressing and indicated it had serosanguineous (pink watery fluid) drainage. She did not change her gloves or wash her hands after removing the dressing. She cleaned it with NS and gauze. Then, she changed her gloves, gelled, and put on new gloves. She indicated the wound measured 0.8 cm x 1.4 cm x 0.2 cm. She did not change gloves or wash her hands after measuring the wound. She put Medi-Honey (pulls moisture from wound and dehydrates bacteria) on a gauze square and placed it on the open wound. She covered it with an adherent dressing cover-all. She removed her gloves, gelled, and put on new gloves. She did not wash her hands before moving to the next open wound. At 8:50 a.m., LPN 12 removed the dressing on Resident 3's open right lateral malleolus. She sprayed skin prep on a gauze square and replaced the foam boot. She removed her gloves, gelled, and put on new gloves. She did not wash her hands before moving to the next open wound. At 8:52 a.m., LPN 12 removed the dressing on Resident 3's right knee wound. It had serosanguineous drainage. She placed a dry gauze on the knee and used adherent dressing cover-all. She indicated his right knee wound chronically opened. It measured 0.6 cm x 0.4 cm x			

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	0.1 cm. At 8:57 a.m., LPN 12 removed her gloves, gelled, and put on new gloves. She indicated to CNA 8 we should get this, "dirty pad," out from under him. There were two pads under the resident, only one pad was removed. At 9:00 a.m., LPN 12 bagged up the treatment cart scissors to cleanse them. She recovered the treatment cart with the soiled sheet. It was removed from the corner of the resident's room where she laid it. It had been lying on his foam boot and stacks of his clothes. At 9:06 a.m., LPN 12 was observed in the "hopper," (janitor's) room to clean the treatment scissors with super sani-cloths (disinfecting wipes). After the scissors were clean, she laid them on an unwiped countertop. The hopper room was not observed to be clean. On 6/27/22 at 12:05 p.m., Resident 3 record was reviewed. His diagnoses included, but were not limited to, protein-calorie malnutrition, carcinoma (cancer) and traumatic amputation of the left lower leg. His wound dressing physician's orders were followed for the most part. The orders did not include the coccyx packing or undermined areas of the coccyx. His wound care plan, dated 5/12/22, indicated the resident had actual impairment to his skin integrity. An intervention indicated to document the size, characteristics, and any treatment changes weekly. Another wound care plan, dated 5/12/22, indicated			

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	he was at risk for further skin impairment. He had multiple types of ulcers including diabetic, arterial, and pressure. An intervention indicated to follow the facility policies and procedures for the prevention and treatment of skin breakdown. On 6/27/22 at 9:29 a.m., the IDON provided the, "Weekly Skin Condition Report," dated 6/24/22. It indicated Resident 3's right lower buttock wound was a pressure ulcer and was facility acquired on 10/7/21, and his right outer foot wound was a pressure ulcer and was facility acquired on 10/7/21. During an interview, on 6/27/22 at 10:25 a.m., the Interim Director of Nursing (IDON) indicated the nurse should have washed her hands after removing her gloves according to the dressing change policy. The sheet covering the treatment cart should not have been laid on the resident's foam boot and clothes stacked in the corner and not put back on the cart. The treatment cart scissors should have been cleaned prior to resident use. A clean area should have been created for the dressing and not laid on the resident's bed. The soiled chuck should not have been used for the dressings. She should not have put the paper measuring tool on the resident skin and wound. The dressing for the large coccyx wound with undermining should have been Dakin's-soaked gauze and should have been tucked in the undermined part of the wound. The gauze should have filled the remainder of the wound so all areas would have been covered and filled. After cleaning the treatment cart scissors, they should not have been laid on the dirty hopper counter and should have been placed in a clean place. A current policy, titled, "Handwashing/Hand			

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	Hygiene," dated August 2015, was provided by the IDON, on 6/24/22 at 11:11 a.m. A review of the policy indicated, " ...The facility considers hand hygiene the primary means to prevent the spread of infections ...." A current policy, titled, "Dressings, Soiled/Contaminated," dated August 2009, was provided by the IDON, on 6/24/22 at 11:11 a.m. A review of the policy indicated, " ...All soiled/contaminated dressings must be handled in a safe and sanitary manner ...." A current policy, titled, "Dressings, Dry/Clean," dated September 2013, was provided by the IDON, on 6/24/22 at 11:11 a.m. A review of the policy indicated, " ...Establish a clean field. Place the clean equipment on the clean field. Arrange the supplies so they can be easily reach ...Wash and dry your hands thoroughly. Put on clean gloves. Loosen tape and removed soiled dressing ...Wash and dry your hands thoroughly ...Label tape or dressing with date, time and initials. Place on clean field. Using clean technique, open other products (i.e., prescribed dressing; dry, clean gauze). Wash and dry your hands thoroughly. Put on clean gloves...Cleanse the wound ...Apply the ordered dressing ...Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly ...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services			

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	to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview, and record review, the facility failed to ensure an adequate amount of licensed nursing staff and nursing assistants were available to ensure sufficient daily assignments were completed according to the most recent Facility Assessment. These deficient practices had the potential to effect 25 of 25 residents who resided in the facility and required skilled nursing services. Findings include: On 6/24/22 at 9:25 a.m., one month of nursing schedules were reviewed for nursing coverage. From June 1st through June 30th the 24 hour	F 0725	It is the standard of this facility to be adequately staffed. **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 6 now receives incontinent care in a timely manner. Resident 3, 15, and 21 MDS were corrected and resubmitted. **How Other Residents Having The Potential To Be Affected By The Same Deficient**	07/27/2022

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ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	schedule listed 3 Licensed Practical Nurses (LPN), 2 Registered Nurses (RN), 1 Regional Director of Clinical Operations (RDCO), and 5 Certified Nursing Assistants (CNA), total to make the daily assignments complete. Each day one LPN was scheduled from 6:00 a.m. to 6:00 p.m. and one LPN or RN was scheduled 6:00 p.m. to 6:00 a.m.; CNA 8 worked 6:00 a.m. to 2:00 p.m. (day shift), CNA 11 alternated shifts (day/evening), CNA 20 worked 2:00 p.m. to 10:00 p.m. (evening) and CNA 13 was scheduled to work alternating shifts but was off sick for 5 days of the schedule. CNA 21 worked nights shift 10:00 p.m. to 6:00 a.m. 1. The schedule showed an agency CNA had worked one double shift, on 6/19/22 from 2:00 p.m. to 6:10 a.m. CNA hours scheduled and worked, in a 24 hour period, per the schedule were: 6/1/22 16 hours 6/2/22 32 hours 6/3/22 32 hours 6/4/22 16 hours 6/5/22 24 hours 6/6/24 32 hours 6/7/22 32 hours 6/8/22 32 hours 6/9/22 32 hours 6/10/22 24 hours 6/11/22 24 hours 6/12/22 24 hours 6/13/22 24 hours 6/14/22 32 hours 6/15/22 16 hours 6/16/22 32 hours 6/17/22 24 hours 6/18/22 24 hours		**Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Facility will ensure adequate staff are scheduled each day to meet resident's needs and ensure accurate assessments are completed. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor the nursing schedule for 6 months to ensure the adequate number of staff are scheduled each day for each shift. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly. **Date of Completion:** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain	

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	6/19/22 24 hours 6/20/22 26 hours 6/21/22 24 hours 6/22/22 24 hours 6/23/22 32 hours 6/24/22 32 hours The Facility Assessment, dated 3/2/22 and reviewed with QAPI (Quality Assurance and Performance Improvement) on 3/14/22, indicated the scheduling of Certified Nursing Assistants providing direct care was listed as: Two CNAs from 6:00 a.m. to 2:30 p.m. Two CNAs from 2:00 p.m. to 10:30 p.m. One CNA from 10:30 p.m. to 6:30 a.m. The facility failed to ensure a resident maintained her dignity by not providing incontinent care in a timely manner or providing her a shower as she requested after an incontinent episode for 1 of 1 residents randomly reviewed for dignity (Resident 6). During an interview on 6/22/22 at 12:42 p.m., CNA 11 indicated she was the only CNA at that time, and she was trying to get to everyone as fast as she could, but she was running short and was not sure if she could get a shower done. If Resident 6 said she was wet, or had an accident, CNA 11 believed her because she was very alert and oriented. She would get the Regional Nurse Consultant to come help with the Hoyer lift to put Resident 6 in bed and get her changed. CNA 11 indicated a resident should not have to eat lunch with a wet brief, but CNA had not been able to get to her since the facility was short staffed. Cross referenced F550. 2. On 6/24/22 at 9:15 a.m., during an interview, LPN		and maintain continued compliance.	

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	12 indicated LPN 19 had called off all week. LPN 12 came in to cover for LPN 19's shifts and her own. Normally she worked 3 or 4 12 hour shifts a week. A review of the nursing schedule indicated LPN 19 was marked off the schedule on 6/17/22, 6/22/22, 6/23/22 and 6/24/22. LPN 12 was scheduled 6/17/22, 6/20/22, 6/21/22, 6/22/22 and had the weekend that followed 6/25/22 and 6/26/22. All shifts were 12 hours, 6 a.m. to 6 p.m. On 6/24/22 at 12:42 p.m., during an interview LPN 12 indicated she "felt like crying, she was so tired." The Facility Assessment, dated 3/2/22 and reviewed with QAPI (Quality Assurance and Performance Improvement) on 3/14/22, indicated the average daily census was 26 residents and 77% occupancy. The staffing plan, included, but was not limited to: One Full Time Equivalent (FTE) RN for DNS, Licensed nurses who provided direct care: Licensed Practical Nurses (LPNs) or RNs for 24 hours per 24-hour period Other nursing personnel with administrative duties: 1 MDS/Medical Records FTE Nurse aids for 40 hours per 24 hour period. The Facility Assessment, dated 3/2/22 and reviewed with QAPI (Quality Assurance and Performance Improvement) on 3/14/22, indicated the scheduling of Licensed Nurses providing direct care was listed as: One LPN or RN from 6:00 a.m. to 2:30 p.m. One LPN or RN from 2:00 p.m. to 10:30 p.m. One LPN or RN from 10:30 p.m.-6:30 a.m. At least one RN for a minimum of 8 hours per day. One FTE for Medical Records and MDS (Nurse			

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	with Administrative Duties) The facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for 3 of 13 residents reviewed for MDS assessments (Residents 3, 15, and 21). On 6/22/22 at 9:00 a.m., the RDCS provided the printed matrix generated from the MDS assessment reports. A comparison of the two reports indicated several differences: a. Resident 3 was coded as excessive weight loss on the handwritten matrix, but he was not coded for weight loss on the printed matrix. b. Resident 15 was not coded for an indwelling urinary catheter on the handwritten matrix, but the printed matrix indicated the presence of an indwelling catheter. c. Resident 21 was coded for dialysis on the handwritten matrix, but not on the printed one. Cross Reference F641. The facility failed to ensure they had employed Registered Nurses RNs) to meet minimum requirements to perform required resident assessments and ensure comprehensive assessments were complete and accurate. On 6/24/22 at 9:25 a.m., one month of nursing schedules were reviewed for RN coverage. On 6/3/22, 6/17/22, 6/18/22 there was no RN coverage on the schedule. There was no RN coverage scheduled for the upcoming days of 6/28/22 and 6/22/22. On 6/24/22 at 9:27 a.m., during an interview, the Administrator indicated to his knowledge the schedule provided was correct. The Director of Nursing Services (DNS) and the Minimum Data Set (MDS) Coordinator positions were both open. The facility used the RDCS to support their RN			

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	coverage, Monday through Friday. She did not work weekends, so they had not had an RN in the building on Saturday 6/18/22. She was not on the schedule for Friday 6/17/22. To his knowledge the schedule provided was correct. The DNS and the MDS Coordinator positions were both open. He indicated RN 16, who was listed on the IDOH records had been gone "quite a while." She left before he became Administrator. They had another DNS since then, who was now gone also. He had not reported any change in DNS status to the state. He thought corporate would do that. The MDS Coordinator had left at the beginning of April. On 6/27/22 at 11:33 a.m., during an interview, the Administrator indicated he was trying to hire a DNS and MDS, but no one was applying. He did not know why it was so hard to get staff. He recently switched the nurse schedules (RN/LPN) to 12 hour shifts, requiring 2 nurses per day from 8 hours which required 3 nurses per day, to try and maximize time. He had agency do some shifts over the weekend to give staff a "little break." On 6/24/22 at 11:13 a.m., during an interview, the RDCO indicated she possibly was the acting DNS, but she was not sure. They did not have a DNS. She did not think her license was displayed in the facility. It would be up to the Administrator to notify the Health Department of DNS changes. Cross Reference F727. On 6/27/22 at 12:02 p.m., the RDCO provided a current policy, dated August 2006, titled "Department Supervision." This policy indicated, " ...The Nursing Services department shall be under direct supervision of a Registered or Licensed Practical/Vocational Nurse at all times...			

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	A Registered Nurse (RN) is employed as Director of Nursing Services (DNS). The DNS is on duty the day shift Monday through Friday. During the absence of the DNS, a Nurse Supervisor/Charge Nurse is responsible for the supervision of all nursing department activities including the supervision of direct care staff...." 3.1-17(a) 3.1-17(b)(2) 3.1-17(b)(3) 3.1-17(b)(4)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on observation, interview, and record review, the facility failed to ensure they had employed Registered Nurses RNs) to meet minimum requirements to perform required resident assessments and ensure comprehensive assessments were complete and accurate. This deficient practice had the potential to effect 25 of 25 residents who resided in the facility and	F 0727	It is the standard of this facility to have adequate RN coverage. **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident 3, 15, and 21 MDS assessments were corrected and	07/27/2022

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	required skilled nursing services. Findings include: On 6/22/22 at 9:35 a.m., the Administrator (ADM) indicated the facility did not have a Director of Nursing Services (DNS) or Minimum Data Set Coordinator. The Regional Director of Clinical Operations (RDCO) was assisting the facility until they hired some Registered Nurses (RNs). On 6/24/22 at 9:25 a.m., one month of nursing schedules were reviewed for RN coverage. On 6/3/22, 6/17/22, and 6/18/22 there was no RN coverage on the schedule. There was no RN coverage scheduled for the upcoming days of 6/28/22 and 6/22/22. On 6/24/22 at 9:27 a.m., during an interview, the Administrator indicated they used the RDCO to support their RN coverage, Monday through Friday. She did not work weekends, so they had not had an RN in the building on Saturday 6/18/22. She was not on the schedule for Friday 6/17/22. To his knowledge the schedule provided was correct. The DNS and the MDS Coordinator positions were both open. He indicated RN 16 who was listed on the IDOH records as the DNS had been gone "quite a while." She left before he became Administrator. They had another DNS since then, who was now gone also. He had not reported any change in DNS status to the state. He thought corporate would do that. The MDS Coordinator had left at the beginning of April. On 6/24/22 at 11:13 a.m., during an interview, the RDCO indicated she guessed she was the acting DNS, but she was not sure. The facility did not have a DNS. She did not think her license was displayed in the facility as the DNS. It would be		resubmitted. **How 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 by this alleged deficient practice. No other residents were found to have been affected. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Facility will ensure there is an RN on staff each day as required. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee to monitor schedule for 6 months and ensure an RN is on staff 8 consecutive hours a day. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and plan adjusted accordingly. **Date of Completion:** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and	

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	up to the Administrator to notify the Health Department of DNS changes. The Facility Assessment, dated 3/2/22 and reviewed with QAPI (Quality Assurance and Performance Improvement) on 3/14/22, indicated the average daily census was 26 residents and 77% occupancy. The staffing plan, included, but was not limited to: One Full Time Equivalent (FTE) RN for DNS, Licensed nurses who provided direct care: Licensed Practical Nurses (LPNs) or RNs for 24 hours per 24-hour period Other nursing personnel with administrative duties: 1 MDS/Medical Records FTE The Facility Assessment, dated 3/2/22 and reviewed with QAPI (Quality Assurance and Performance Improvement) on 3/14/22, indicated the scheduling of Licensed Nurses providing direct care was listed as: One LPN or RN from 6:00 a.m. to 2:30 p.m. One LPN or RN from 2:00 p.m. to 10:30 p.m. One LPN or RN from 10:30 p.m.-6:30 a.m. At least one RN for a minimum of 8 hours per day. One FTE for Medical Records and MDS (Nurse with Administrative Duties) The facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for 3 of 13 residents reviewed for MDS assessments (Residents 3, 15, and 21). On 6/22/22 at 9:00 a.m., the RDCS provided the printed matrix generated from the MDS assessment reports. A comparison of the two reports indicated several differences: a. Resident 3 was coded as excessive weight loss on the handwritten matrix, but he was not coded for weight loss on the printed matrix. b. Resident 15 was not coded for an indwelling urinary catheter on the handwritten matrix, but the printed matrix indicated the presence of an		processes adapted we will obtain and maintain continued compliance.	

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	indwelling catheter. c. Resident 21 was coded for dialysis on the handwritten matrix, but not on the printed one. Cross Reference F641. On 6/27/22 at 11:33 a.m., during an interview, the ADM indicated he was trying to hire a DNS and MDS, but no one was applying. He did not know why it was "so hard" to get staff. He recently switched the nurse schedules (RN/LPN) to 12 hour shifts, requiring 2 nurses per day, from 8 hours, requiring 3 nurses per day, to try and maximize time. He had agency do some shifts over the week end just to give staff a little break. On 6/27/22 at 12:02 p.m., the RDCS provided a current policy, dated August 2006, titled ""Department Supervision." This policy indicated "The Nursing Services department shall be under direct supervision of a Registered or Licensed Practical/Vocational Nurse at all times... A Registered Nurse (RN) is employed as Director of Nursing Services (DNS). The DNS is on duty the day shift Monday through Friday. During the absence of the DNS, a Nurse Supervisor/Charge Nurse is responsible for the supervision of all nursing department activities including the supervision of direct care staff...." 3.1-17(b)(4) 3.1-17(c) 3.1-17(c)(1) 3.1-17(c)(2) 3.1-17(c)(3) 3.1-17(c)(4)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing			

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	The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these			

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	requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. Based on observations, interviews, and record reviews, the facility failed to ensure a newly hired Dietary Manager was provided the necessary training and orientation to effectively implement and facilitate operations of the Kitchen. This deficient practice had the potential to effect 25 of 25 residents who were served from the kitchen.	F 0801	It is the standard of this facility to employ a qualified dietary manager. **-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	07/27/2022

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	Findings include: On 6/24/22 at 10:00 a.m., The DM's employee file was selected for review. Her Job Description was signed on 5/29/22. The minimum requirements included, but were not limited to, a minimum of one (1) year experience in food service, or equivalent combination of education & experience, a Dietary Manager certificate from a recognized accrediting body, and institutional dietary experience was preferred. She had a job-specific orientation checklist titled, "Dietary Manager Orientation," but the orientation checklist was neither dated, or signed off by a supervisor as having been completed. During a follow up interview on 6/24/22 at 10:46 a.m., the DM indicated she only had two short days of training which had been provided by the previous manager before she quit. She indicated she had not completed the job-specific checklist with a supervisor. During an interview on 6/24/22 at 11:03 a.m., the Registered Dietician (who worked directly with the facilities DM) indicated there had been some new management changes at the facility, and the new kitchen manager was "probably just left to the wind" in reference to her training and orientation. On 6/22/22 at 9:30 a.m., an initial kitchen tour was conducted with the Dietary Manager (DM) present. Upon entrance into the kitchen, the DM apologized "in advance." She indicated although she had worked in the building for many years, she had been newly promoted to the kitchen, and was "learning as she went."		No residents were affected by the alleged deficient practice. **-How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. **-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?** The current dietary manager is working closely with our registered dietician to be trained so she may effectively implement and facilitate operations of the kitchen. She is also training with a sister facility's dietary manager. The dishwashing machine has been descaled and the vendor has been contacted regarding the cracked seal. The floor in the back corner of the kitchen has been cleaned. The freezer in the dry storage room has been defrosted. **-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?** The Administrator/designee will perform weekly rounds of the kitchen x 6 months. Deficient findings will be corrected immediately. The Administrator will report findings to the QAPI	

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	155404	A. BUILDING 00 B. WING	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	The kitchen dishwasher was in use and a wash cycle was observed. The DM indicated she did not know if the machine was a high or low temperature machine, and the thermometer gauge was broken. In order to check the temperature of the water for her daily logs, she used a food thermometer and measured the temperature of the draining water, which at that time read 140 degrees. Because the DM did not know what the temperature was supposed to be, in order to ensure dishes were sanitized, she mixed a sanitizer bucket. The sanitizer buck was observed on the counter next to the dish machine and the DM was asked to check the PPM (parts per million- a numerical chemical test to ensure to correct amount of sanitizer is present). The DM indicated she knew to use a certain "strip" but did not know how to test the water. When she dipped the test strip into the sanitizer water, the test strip did not change color to indicate the presence of sanitizer. The DM got a second bottle of test strips, but after it too did not turn colors, she indicated the strips were expired. She got a third bottle of test strips, which still did not turn the correct shade of purple to indicate the correct 200 PPM required. The DM indicated she did not know what to do besides call EcoLab (the contracted service company used by the facility). The dishwashing machine was observed to have buildup with copious amounts of lime, rust, and other build up debris around the seals of the door. The plastic seal of the machine door was also observed to be cracked, and sections of the seal were missing. The DM indicated she had not been trained on how to properly descale the machine, or what she could use to get the buildup off. On the floor, in the back corner of the kitchen, to the left of the stove, there was a copious amount		committee monthly. **-By what date will the systemic changes for each deficiency be completed?** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	of unidentifiable debris. It was raised up on the floor, molded, black, green, and fuzzy. The DM indicated she had no idea what it was, and had intended to get it cleaned up, but she had been too busy trying to keep up with her daily tasks and learning all her new responsibilities. There was a refrigerator/freezer in the dry storage room which was observed to have inches of thick ice and frost built up on the inside. Items in the freezer were not able to be identified due to the buildup. The DM indicated she was not sure if the freezer had ever been defrosted, when, or how it should be done. The DM apologized and indicated she was new, and still had a lot to learn. Cross reference F812. During an interview on 6/24/22 at 11:23 a.m., the Administrator indicated the previous Dietary Manager left without proper notice. The current DM had worked for many years in the housekeeping department, and helped a little in the kitchen when needed, so she was promoted to the DM. She could probably use some more help and more specific training. The Administrator indicated he was not sure if there was as a specific policy related to the Dietary Manager, but her Job Description would be considered a policy if there was no additional policy. The DM's job description was titled, "Facility Dietary Manager" and dated as received and acknowledged on 5/29/22. The Job description indicated, " ...Under supervision of the Administrator and Regional Dietician, the Dietary Manger oversees meal planning, food preparation, tray preparations, & food service in accordance with Federal & State regulations and facility policy. This position is responsible for assuring			

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	that the highest degree of quality Resident nutrition care is maintained, and residents are served according to their nutritional orders, needs and preferences ...." 3.1-20(h)			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to ensure that 2 of 25 residents received nutritional supplements as ordered as recommended by the Dietician and	F 0803	It is the standard of this facility to ensure that all residents receive nutritional supplements as ordered and as recommended by the	07/27/2022

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	resident preference (Resident 3 and 16). Findings include: 1. During an observation on 6/23/22 at 12:10 p.m., Resident 3 was observed sitting in his wheelchair eating lunch. The meal tray ticket revealed that Resident 3 was to receive a magic cup with every meal. He did not have a magic cup with his lunch tray. During an observation on 6/24/22 at 12:31 p.m., Resident 3 was observed sitting up in his wheelchair eating lunch. He did not have a magic cup with his lunch tray. Resident 3/'s record was reviewed on 6/22/22 at 2:11 p.m., Resident 3's diagnosis included but were not limited to paraplegia, dementia with behavioral disturbances, muscle weakness, pressure ulcer, sarcopenia, lack of coordination, amputation of left lower leg, protein calorie malnutrition, carcinoma, vitamin D deficiency. Resident 3's diet order, dated 3/27/22, indicated resident was to have a regular diet, regular texture, thin-regular consistency, give magic cups with every meal. During an interview with the Dietary Manager (DM) on 6/27/22 at 12:20 p.m., she indicated Resident 3 was supposed to get magic cups with meals. She had provided Resident 3 with a magic cup today at lunch time. 2. During an observation on 6/23/22 at 12:15 p.m., Resident 16 was observed sitting up on the side of his bed, eating lunch. His tray ticket revealed that he should have received a "mighty shake." He did not have a "mighty shake" on his lunch		dietician and according to resident preference. **-What corrective action is to be accomplished for those residents found to have been affected by the deficient practice?** Dietary staff were instructed to ensure that resident 3 receives a magic cup as indicated on the tray card, and that resident 16 receives mighty shakes as indicated on the tray card. **-How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents receiving meal trays have the potential to be affected by this alleged deficient practice. No other residents were found to be affected. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?** All dietary staff will be inserviced on 7/21/2022 by the Administrator regarding proper interpretation of meal tray cards. All tray cards will be updated by the DSM to ensure they are up to date. **How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?** An audit tool has been created that monitors resident tray cards at random match up to what is on	

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	tray. During an observation on 6/24/22 at 12:28 p.m., Resident 16 was observed sitting up on the side of his bed, eating lunch. He did not receive a "mighty shake" with lunch. During an observation on 6/27/22 at 12:12 p.m., Resident 16 was observed sitting up on the side of his bed, eating lunch. He did not receive a "mighty shake" with lunch. During an interview with Resident 16 on 6/27/22, he indicated he would have liked his shake with lunch. Resident 16's record was reviewed on 6/23/22 at 2:19 p.m., Resident 16's diagnosis included but were not limited to hemiplegia affecting right side, osteoporosis, unspecified dementia, personal history of traumatic brain injury, paranoid schizophrenia, bi-polar disorder, vitamin D deficiency Resident 16's diet orders, dated 6/22/21, indicated Resident 16 was to receive a regular diet, regular texture, thin-regular consistency diet. On 6/26/21 an order for mighty shake, offer daily at lunch. During an interview with the DM, she acknowledged that Resident 16 did not receive his "mighty shake" at lunch time. A policy was provided by the Regional Director of Clinical Operations on 6/24/22 at 10:35 a.m. titled, "Supplement Use and Indications," dated 6/18. It indicated, "...Resident with increased nutritional needs will receive additional food items and commercially prepared supplement, as necessary ....If a resident demonstrates the need for		the meal tray. Administrator or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 3 months, and weekly for the next 2 months. Results will be shared monthly with the facility QAPI committee for additional recommendations. **-By what date will the systemic changes for each deficiency be completed?** 07/27/2022	

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	additional calories, protein and/or fluids then a nourishment will be ordered for that resident...." 3.1-20(i)(1)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the dishwashing machine was clean and its seals were maintained in good condition, the kitchen floors were clean, the sanitizer bucket which was in use measured at a minimum was 200 PPM and failed to ensure the dry storage refrigerator was not built up with ice/frost. This deficient practice had the potential to effect 25 of 25 residents served out of the kitchen.	F 0812	It is the standard of this facility to ensure that the kitchen is properly sanitized, including but not limited to, ensuring the dish machine is properly de-limed and maintained in proper working condition, ensuring the chemical sanitation program is followed, and that the freezers are on a defrosting schedule.	07/27/2022

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	Findings include: On 6/22/22 at 9:30 a.m., an initial kitchen tour was conducted with the Dietary Manager (DM) present. Upon entrance into the kitchen, the DM apologized "in advance." She indicated, although she had worked in the building for many years, she had newly been promoted to the kitchen, and was "learning as she went." The kitchen dishwasher was in use and a wash cycle was observed. The DM indicated she did not know if the machine was a high or low temperature machine, and the thermometer gauge was broken. In order to check the temperature of the water for her daily logs, she used a food thermometer and measured the temperature of the draining water, which at that time read 140 degrees. Because the DM did not know what the temperature was supposed to be, in order to ensure dishes were sanitized, she mixed a sanitizer bucket. The sanitizer buck was observed on the counter next to the dish machine and the DM was asked to check the PPM (parts per million- a numerical chemical test to ensure to correct amount of sanitizer is present). The DM indicated she knew to use a certain "strip" but did not know how to test the water. When she dipped the test strip into the sanitizer water, the test strip did not change color to indicate the presence of sanitizer. The DM got a second bottle of test strips, but after it too did not turn colors, she indicated the strips were expired. She got a third bottle of test strips, which still did not turn the correct shade of purple to indicate the correct 200 PPM required. The DM indicated; she did not know what to do besides call EcoLab (the contracted service		**-What corrective action is to be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. The dishwashing machine has been descaled and the vendor has been contacted regarding the cracked seal. The floor in the back corner of the kitchen has been cleaned. The freezer in the dry storage room has been defrosted. **-How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the alleged deficient practice. **-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur.** When the survey team brought the dish machine to our attention, we had Ecolab come in while the survey team was here and address the broken seals, lime buildup, and expired test strips for our dish machine. All dietary staff will be inserviced on 7/26/2022 by the Maintenance Director regarding the low temperature dish machine operation, sanitization, and maintenance, as well as on proper defrosting techniques for our dry	

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	company used by the facility). The dishwashing machine was observed to have buildup with copious amounts of lime, rust, and other build up debris around the seals of the door. The plastic seal of the machine door was also observed to be cracked, and sections of the seal were missing. The DM indicated she had not been trained on how to properly descale the machine, or what she could be used to get the buildup off. On the floor, in the back corner of the kitchen, to the left of the stove, there was a copious amount of unidentifiable debris. It was raised up on the floor, molded, black, green, and fuzzy. The DM indicated she had no idea what it was, and had intended to get it cleaned up, but she had been too busy trying to keep up with her daily tasks and learning all her new responsibilities. There was a refrigerator/freezer in the dry storage room which was observed to have inches thick of ice and frost built up on the inside. Items in the freezer were not able to be identified due to the buildup and the DM indicated she was not sure if the freezer had ever been defrosted, when, or how it should be done. On 6/24/22 at 9:44 a.m., an EcoLab Technician was in to service the dishwashing machine. At this time, the Technician indicated the machine needed to be deep cleaned, and the seals were broken and in need of replacement. On 6/24/22 at 9:50 a.m., the Regional Nurse Consultant (RNC) provided copies of the Registered Dietician's (RD) quality assurance sanitation checklist. The RNC indicated when the RD visited, she conducted quality assurance sanitation checks and made comments about		goods freezer. The current dietary manager is working closely with our registered dietician to be trained so she may effectively implement and facilitate operations of the kitchen. She is also training with a sister facility's dietary manager. **-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?** An audit tool has been created that monitors kitchen sanitation, specifically dish machine deliming and testing for proper sanitizer levels, proper floor cleaning, and freezer defrosting. DSM or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 3 months, and weekly for the next 2 months. Results will be shared monthly with the facility QAPI committee for additional recommendations. The administrator or designee will perform weekly rounds of the kitchen x 6 months. Deficient findings will be corrected immediately. The administrator will report findings to the QAPI committee monthly. **-By what date will the systemic changes for each deficiency be completed?** 07/27/2022 Essex Nursing and Rehab would like to request a desk review for compliance with this deficiency as	

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	items which needed to be addressed. On 5/24/22 at 2:30 p.m., the RD indicated on a checklist, the kitchen floors needed to be cleaned, specifically "to left of stove/items on floor." On 6/20/22 at 3:15 p.m., the RD indicated on a checklist indicated the floor next to the left of the stove still needed to be cleaned. On 6/24/22 at 10:45 a.m., the DM provided copies of current facility policies. A policy titled, "Cleaning Floors," was dated 6/2018 and indicated, "The kitchen floors are to be maintained in a clean safe condition." A policy titled, "Sanitation Buckets," was dated 6/2019 and indicated, "Sanitation buckets must be available in the Dietary Department at all times ... the desired concentration of the active ingredient should be 50-100 ppm for bleach and 150-400 ppm for Quat...test solution strength as needed using the correct set of test strips...." A policy titled, "Cleaning & Maintenance of the Reach-In Refrigerator & Freezer," was dated, 6/2018 and indicated, "It is necessary to ensure that reach-in units are kept clean, organized, and operating safely...." 3.1-21(i)(1)		we feel with the new training and processes adapted we will obtain and maintain continued compliance.	