STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Residential Complaint IN00392950. Complaint IN00392950 - Unsubstantiated due to lack of evidence. Survey dates: October 17, 18, 19, 20, 21, 24, 26, 26, 27, and 28, 2022 Facility number: 001127 Provider number: 155771 AIM number: 200247220 Census Bed Type: SNF/NF: 44 NF: 93 Residential: 139 Total: 276 Census Payor Type: Medicare: 27 Medicaid: 82 Other: 28 Total: 137 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 1, 2022.	F 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	
F 0600 SS=G	483.12(a)(1) Free from Abuse and Neglect			

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

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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Bldg. 00	§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents right to be free from sexual and physical abuse for 3 of 4 residents reviewed. This deficient practice resulted in three residents being sexually and physically abused by another resident within one and a half hours. (Resident 225, Resident 10, Resident 71, Resident 93) Findings include: On 10/21/22 at 10:10 a.m., a facility reportable incident was received. The reportable incident, dated 10/20/22, indicated Resident 225 was found by staff in Resident 10's room. Resident 225 had her hand on Resident 10's genital area. Resident 225 was redirected out to the nurse's area. A half an hour later Resident 225 was observed to be sitting on Resident 71's lap. Resident 225 was touching Resident 71's face and attempting to kiss him on the face. The residents were separated. Within the next half hour, Resident 225 was observed by staff to make physical contact to Resident 93's face with an open hand.	F 0600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 225 was brought to the common area for increased supervision and then placed on 1:1 supervision while a referral was made to Witham Behavioral Hospital. On 10/20/2022, nursing staff determined there were no other residents on MSCU exhibiting any type of similar behaviors. On 10/21/2022, Resident 225 was transferred to Witham Behavioral Hospital for evaluation. On 11/15/2022, Resident 225 returned to the facility; medications have been revised, care plans updated, and the resident will be followed by Geri-Psych. **How other residents having the**	11/16/2022

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	On 10/21/22 at 12:00 p.m., Resident 225's clinical record was reviewed. The diagnosis included, but was not limited to, generalized anxiety disorder. The Medicare MDS (Minimum Data Set) assessment, dated 10/4/22, indicated Resident 225 had severe cognitive impairment. A care plan, dated 9/28/22 and current through 1/20/23, indicated Resident 225 had a behavior problem related to dementia. The interventions included, but were not limited to, provide one on one observation, as needed. A Behavior Note, dated 10/8/22 at 3:24 a.m., indicated Resident 225 was awake at this time. Regularly attempting to enter other resident and becomes agitated and combative when not allowed to enter other resident rooms. A Behavior Note, dated 10/10/22 at 5:49 a.m., indicated Resident 225 was going into other residents rooms and going through their things. When reminded that was not her room and trying to redirect, resident became agitated and combative. Resident 225 continued to wander the unit at that time. A Behavior Note, dated 10/10/22 at 8:55 a.m., indicated Resident 225 was going into other resident's rooms and getting in their beds with them. Resident 225 was trying to pull other residents out of their beds. A Behavior Note, dated 10/10/22 at 5:55 p.m., indicated Resident 225 continues to go into other resident's rooms. Staff has tried to remove resident to another area and she starts yelling "Stop, I will hit you and call the police."		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside on MSCU have the potential to be affected. The Nursing Staff determined there were no other residents on MSCU exhibiting any type of similar behaviors. When wandering behaviors occur, staff will engage in purposeful activities to deter the behavior. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Any noted similar behaviors will be managed according to policy. The Administrator and/or designee will re-educate all staff on the facility abuse policy and when to increase supervision with a signed understanding of the policy, to be completed by 11/16/2022. Written counseling will be rendered for continued non-compliance. All behaviors will be monitored daily and discussed in the clinical meeting Monday through Friday. In the event, similar behaviors occur, an audit will be conducted by the unit manager to ensure all partners are following policy. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	A Behavior Note, dated 10/12/22 at 8:37 p.m., indicated Resident 225 was in the common area bothering the other residents while they were watching a movie. Resident 225 then sat down on another resident's lap. A Behavior Note, dated 10/13/22 at 9:12 a.m., indicated another resident complained that Resident 225 entered her room in the middle of the night. Resident 225 allegedly had woken and scared this female resident. Resident 225 was touching the residents face. On 10/20/22 between 5:30 p.m., and 6:45 p.m., the following aggressive behaviors were exhibited: 1. A Behavior Monitoring Record, dated 10/20/22 at 5:50 p.m., indicated staff found Resident 225 in Resident 10's room. Resident 225 had her hand over Resident 10's incontinence brief, over the penis area. Resident 10 appeared uncomfortable and was trying to get up. Resident 225 held Resident 10 down by his arm. 2. A Behavior Monitoring Record, dated 10/20/22 at 6:40 p.m., indicated Resident 225 was observed to be sitting on Resident 71's lap. "Resident 225 was stroking his face and ready to kiss him." 3. A Behavior Monitoring Record, dated 10/20/22 at 6:45 p.m., indicated Resident 225 had went into Resident 93's room and slapped Resident 93 on the hand. The clinical record for Resident 10 was reviewed on 10/21/22 at 10:30 a.m. A Quarterly MDS assessment, dated 7/27/22, indicted Resident 10 had severe cognitive impairment.		**into place?** The Director of Social Services will bring all behavior monitor tracking to the Quality Assurance Meeting monthly for six months. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits; however, the review by the IDT on a Monday through Friday basis will continue. The Administrator and IDT are responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 11/16/2022	

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	The clinical record for Resident 71 was reviewed on 10/21/22 at 12:00 p.m. A Quarterly MDS assessment, dated 9/21/22, indicated Resident 71 had severe cognitive impairment. During an interview on 10/21/22 at 10:47 a.m., Resident 71's indicated that he was fine. Resident 71 has no recollections of any negative interactions with staff or other residents. The clinical record for Resident 93 was reviewed on 10/21/22 at 12:30 p.m. A Quarterly MDS assessment, dated 10/1/22, indicated Resident 93 had mild cognitive impairment. During an interview on 10/21/22 at 10:30 a.m., Resident 93 indicated she does recall being slapped by Resident 225. Resident 93 also indicated Resident 225 goes in and out of other resident rooms. Resident 225 gets into other resident's belongings. She gets agitated and combative when someone attempts to get her out of the other residents rooms. During an interview on 10/21/22 at 11:05 a.m., CNA 7 indicated she was working the evening of 10/20/22. CNA 7 witnessed Resident 225 touching Resident 10 inappropriately. She indicated Resident 10 was a retired minister and was actively trying to get away from Resident 225. He was visibly uncomfortable and trying to move away from Resident 225. Resident 225 was holding him and physically preventing him from stopping her or getting away. Resident 225 has had ongoing aggression since she was admitted. Resident 225 at times has tried to pull other residents out of their beds. We were unable to provide one on one observation of Resident 225 during the incidents. She indicated staff did try to keep Resident 225 in sight. She indicated there			

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	was only one nurse and one CNA working the unit that shift. During an interview on 10/21/22 at 10:17 a.m., LPN 6 indicate she had worked during the evening of 10/20/22. She indicated three incidents all occurred close together yesterday evening with Resident 225 engaging in inappropriate/abusive behaviors with three other residents on the memory care unit. Resident 225 was inappropriately touching a male resident, Resident 10, in a sexual way, she was sitting on another male resident, Resident 71's, lap trying to kiss him, and then slapped a third female resident, Resident 93. LPN 6 indicated they were unable to provide one on one observation of Resident 225 due to only one nurse and one CNA working at that time. On 10/28/22 at 12:30 p.m., the Administrator indicated Resident 225 should have been placed on one on one observation after the first incident. She also indicated she thought Resident 225 was put on one on one observation after the first incident. On 10/18/22 at 9:00 a.m., the Administrator provided a policy titled Abuse Policy, undated, and indicated it was the current policy being used by the facility. "The following are examples of abuse...a. Physical Abuse...slapping...b. Sexual Abuse ...1. Nonconsensual sexual contact with a resident by another resident or visitor." 3.1-27(a)(1)			
F 0725 SS=G 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			

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	sets to provide nursing and related services 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 observation, interview, and record review, the facility failed to ensure sufficient nursing staffing services were available and provided to the residents residing in 1 of 5 units within the facility. The lack of sufficient staff failed to meet the expectations outlined in the facility's assessment; the established staff to resident ratio; and the resident population acuity level. This deficient practice resulted in 3 residents being sexually and physically abused. (Murphy Special Care unit) Findings include:	F 0725	The IDR, and the basis for the Dispute will be emailed under separate cover. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 10, 71, 93, and 225 were assessed by a licensed nurse at the time with no notation of injury or adverse effects. **How other residents having the potential to be affected by the same deficient practice will be**	11/16/2022

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	1. During the survey period, from 10/17/22 to 10/28/22, the following interviews were conducted: a. The Murphy Special Care unit was supposed to have 2 CNAs (Certified Nursing Assistant) assigned to the unit. However, often a CNA would be reassigned to a different unit because it was "short staffed" which then led the Murphy Special Care unit to also be short staffed. Not having enough staff made it difficult to meet the needs of the residents, especially when a resident required one-to-one supervision due to behavioral issues. On 10/20/22 between 5:30 p.m. to 6:30 p.m., a resident needed one-to-one supervision because of inappropriate/abusive behaviors toward three residents. During that time, only one licensed nurse (Registered Nurse or Licensed Practical Nurse) and one CNA were working in the unit and they were unable to provide one-to-one supervision for the resident due to lack of staff. b. When only 1 CNA was working in the Murphy Special Care unit, it was "tough" to take care of the residents when they were exhibiting behavioral issues. On 10/20/22 between 5:30 p.m. and 6:30 p.m., one licensed nurse and one CNA were working in the unit. A resident was in need of one-to-one supervision because of inappropriate behaviors. There were not enough staff to provide the one-to-one supervision and provide care for the other residents on the unit. c. The Memory Care Unit was to have one licensed nurse and 2 CNAs for the 6:45 a.m. to 6:45 p.m. shift. There were times when a CNA was reassigned to another unit and that CNA was not replaced on the memory care unit. d. The CNA scheduled work hours were from 6:45		**identified and what corrective action(s) will be taken?** All residents of MSCU have the potential to be affected. The facility will seek not to pull MSCU staff to help cover another unit; however, in the event necessary, Leadership will assess all resident needs in order to ensure appropriate staffing on a case-by-case basis. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Weekday staffing meetings will occur with the Administrator, DON, and Scheduler. Unit Managers will educate the nursing staff on not pulling staff from the MSCU and if there is a need for increased supervision and additional staffing, they will reach out to the supervisor for instruction; in-service to be completed by 11/16/2022. Written counseling will be rendered for non-compliance. On 11/14/2022, the Administrator provided education to the scheduling personnel responsible for providing the necessary 24-hour staff to provide nursing and related services and to assure safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident	

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	a.m. to 6:45 p.m. Only one CNA was working in the memory care unit on the day of the interview. On 10/20/22 a CNA was originally assigned to the memory care unit. At 2:30 p.m., the CNA was reassigned to another unit which left one nurse and one CNA in the memory care unit for the remainder of the shift. It was reported "probably half of the residents" on the unit had behavioral issues including physical aggression toward others. e. The Memory Care Unit was to have one licensed nurse and 2 CNAs for each day from 6:45 a.m. to 6:45 p.m. On 10/24/22, there was one CNA and a CNA in training (who was not able to perform all the duties of a CNA) working on the unit. f. On the date of the interview, there was a nurse, one Helping Hand worker, one student CNA, one CNA, and a new CNA (in orientation) working in the memory care unit. It was rare to have that many staff working on this unit at one time. On 10/20/22 the schedule showed there were to be 2 CNAs working with the licensed nurse on the unit. One CNA was reassigned to another unit at 2:45 p.m. which left just one CNA and the licensed nurse in the memory care unit. It was indicated "possibly" a resident's behavioral issues were caused by the lack of staff working on the unit. g. For the past several weeks, there had not been enough staff to take care of all the residents. Staff are "pulled from this unit to work in another area and that leaves us short." 2. The following observations were noted during the survey. a. On 10/21/22 from 10:45 a.m. to 11:25 a.m., the		assessments, individuals plans of care and considering the number, acuity, and diagnoses of the facility's resident population. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Unit Managers will bring the audit showing that no partners were pulled from MSCU to the Quality Assurance Meeting monthly for six months. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits. The Administrator and IDT are responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 11/16/2022	

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	Murphy Special Care unit had one licensed nurse and two CNAs working at that time. b. On 10/24/22 from 2:45 p.m. to 3:00 p.m., the Murphy Special Care unit had one licensed nurse and one CNA working at that time. c. On 10/25/22 from 9:30 a.m. to 9:45 p.m., the Murphy Special Care unit had one licensed nurse, one CNA and two CNAs in training working at that time. 3. On 10/24/22 at 11:10 a.m., the Administrator provided a copy of the Murphy Special Care Unit's staffing grid. A review of the document indicated for the memory care census of 23 residents, the unit required one licensed nurse and 2 CNAs for the 6:45 a.m. to 6:45 p.m. shift; one Helping Hand for an eight-hour shift; and one nurse and one CNA for the 6:45 p.m. to 6:45 a.m. shift. On 10/24/22 at 11:10 a.m., the Administrator provided a copy of the Murphy Special Care unit "as worked" licensed nurse and CNA staffing schedule. A review of the document indicated the following: -On 9/25/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA was listed as having worked during that shift while the other CNA was reassigned to another unit. The CNA was not replaced. -On 9/30/22 from 6:45 p.m. to 6:45 a.m., one CNA and one QMA (Qualified Medication Aide) were on the schedule. No licensed nurse was on the schedule. -On 10/1/22 from 6:45 p.m. to 6:45 a.m., one CNA			

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	and one QMA were on the schedule. No licensed nurse was on the schedule. -On 10/7/22 from 6:45 p.m. to 6:45 a.m.. one CNA and one QMA were on the schedule. No licensed nurse was on the schedule. -On 10/8/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA was listed as having worked during that shift while the other CNA was reassigned to another unit. The CNA was not replaced. -On 10/9/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA was listed as having worked during that shift while the other CNA was reassigned to another unit. The CNA was not replaced. -On 10/9/22 from 6:45 p.m. to 6:45 a.m., one CNA was on the schedule. One QMA was on the schedule who worked from 6:30 p.m. to 11:00 p.m. and the licensed nurse was scheduled to work from 11:00 p.m. to 7:00 a.m.; however, the licensed nurse on the schedule was reassigned to another unit. The licensed nurse was not replaced and the CNA worked alone during the remainder of the shift. -On 10/10/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA was listed as having worked during that shift while the other CNA was reassigned to another unit. The CNA was not replaced. -On 10/10/22 from 6:45 p.m. to 6:45 a.m., one CNA was on the schedule but called in and did not work her shift. The CNA was not replaced and so the licensed nurse worked alone during that shift.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-On 10/12/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA called in and did not work her shift. The CNA was not replaced. -On 10/12/22 from 6:45 p.m. to 6:45 a.m., the licensed nurse listed on the schedule was reassigned to another unit. The licensed nurse was not replaced. One CNA on the schedule worked alone during that shift. -On 10/13/22 from 6:45 p.m. to 6:45 a.m., the licensed nurse listed on the schedule was reassigned to another unit. The licensed nurse was not replaced. One CNA on the schedule worked alone during that shift. -On 10/14/22 from 6:45 a.m. to 6:45 p.m., one QMA was on the schedule and no licensed nurse worked on that shift. -On 10/14/22 from 6:45 p.m. to 6:45 a.m., one QMA was on the schedule and no licensed nurse worked on that shift. -On 10/15/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA was listed as having worked during that shift while the other CNA was reassigned to another unit. The CNA was not replaced. -On 10/17/22 from 6:45 p.m. to 6:45 a.m., one QMA was on the schedule. No licensed nurse was on the schedule. -On 10/19/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA called in and did not work her shift. The CNA was not replaced. -On 10/22/22 from 6:45 a.m. to 6:45 p.m., one CNA was on the schedule.			

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	155771	A. BUILDING 00 B. WING	10/28/2022

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-On 10/22/22 from 6:45 p.m. to 6:45 a.m., one QMA was on the schedule. No licensed nurse was on the schedule.

-On 10/23/22 from 6:45 a.m. to 6:45 p.m., two CNAs were on the schedule. One CNA left work at 1:00 p.m. and was not replaced.

During an interview, on 10/24/22 at 11:18 a.m., the Director of Nursing Services and Administrator indicated the "as worked" schedule, from 9/25/22 through 10/23/22, was updated as staff changes occurred and the report reflected who worked which shift, date, and work location. The Murphy Special Care unit staffing grid was developed for the facility by the corporate office based on the resident's acuity level and as determined by the facility assessment. The staffing grid was to be updated as the acuity levels changed. Based on the documents, the memory care unit required one licensed nurse and 2 CNAs for the 6:45 a.m. to 6:45 p.m. shift; one Helping Hand for an eight-hour shift; and one nurse and one CNA for the 6:45 p.m. to 6:45 a.m. shift.

4. The lack of sufficient nursing staff resulted in three residents being sexually and physically abused.

Cross reference F600.

During an interview, on 10/25/22 at 11:30 a.m., the Administrator indicated the facility lacked a sufficient staffing policy.

On 10/24/22 at 1:15 p.m., the Administrator provided a copy of the Certified Nursing Assistant job description, dated 9/21/19, and indicated it was the current job description in use

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	by the facility. A review of the document indicated, "...assure that resident rights are maintained at all times..." On 10/25/22 at 11:05 a.m., the Administrator provided a copy of the Proactive Medical Review Facility Assessment, dated 7/5/2022, and indicated it was the current guidelines in use. A review of the document indicated, "...Census levels are reviewed on a daily basis and scheduling tool is used to assist in determining staffing levels required based on changes in census levels. When changes in resident needs arise, such as increased levels of supervision, staffing levels are adjusted accordingly to ensure resident needs are met. Acuity levels are discussed daily...(i.e. behaviors...changes in condition...changes in supervision...higher ratios due to higher acuity levels and behavioral and cognitive needs..." 3.1-17(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview the facility failed to ensure infection control measures were implemented to prevent the spread of COVID-19 for 1 of 5 units observed. Staff were not wearing PPE (Personal Protective Equipment) as indicated by facility policy and trash receptacles were not placed inside the resident rooms to remove PPE prior to exiting the room. (Murphy Special Care Unit, Resident 3, Resident 29) Findings include: 1. On 10/19/22 from 9:15 a.m. until 9:35 a.m., Helping Hand (HH) 1 was observed working on the Murphy's Special Care Unit. HH 1 had a face mask on. The face mask was observed to be under her chin and around her neck, exposing her nose and mouth. During an interview at that time, HH 1 indicated she pulls the mask up to the correct position if she was helping a resident. On 10/20/22 at 11:00 a.m., the Administrator provided signage that indicated "Notice: "Face masks are required." Additional signage indicated	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 10/19/2022, HH 1 was reported to the Administrator for not properly wearing a facemask. No residents were within six feet of HH 1 during the time of the potentially negative practice. HH 1 was educated by DON and Administrator; then, counseled by the Unit Manager and DON. HH1 is pregnant and stated difficulty breathing in an N95 mask. The intervention was for HH1 to take a break and leave the resident care area to remove the mask when needed. On 10/17/2022 trash receptacles were immediately emptied and put in their proper place. No residents were adversely affected by any potentially	11/16/2022

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	"Don't wear your facemask under your nose or mouth. On 10/19/22 at 10:55 a.m., the Administrator provided a policy titled, COVID-19 policy and procedure, dated 9/30/22, and indicated it was the current policy being used by the facility. A review of the policy indicated, "Personal Protective Equipment: ...Facemask, eye protection. On 10/19/22 at 9:33 a.m., the Administrator indicated a resident who resided on the Murphy's Special Care unit was positive for COVID-19. 2. On 10/17/22 from 11:25 until 11:40 a.m., during the initial tour an uncovered trash receptacle and Personal Protective Equipment (PPE) was observed outside of Room 213. The trash receptacle was full and overflowing with used PPE. Room 213 had a sign on the door that indicated, "STOP Droplet isolation". On 10/18/22 at 12:15 p.m., a Health Note, dated 10/10/22 at 11:26 a.m. was reviewed. The note indicated Resident 3, who resided in Room 213, tested positive for COVID-19 on 10/10/22 at 11:26 a.m. 3. On 10/17/22 from 11:25 until 11:40 a.m., during the initial tour, a trash receptacle and PPE was observed outside of Room 204. The trash receptacle was full and overflowing with used PPE. Room 204 had a sign on the door that indicated, "STOP Droplet isolation". On 10/18/22 at 12:15 p.m., a Health Note, dated 10/11/22 at 7:44 p.m., was reviewed. The note indicated Resident 29, who resided in Room 204, had tested positive for COVID-19 and was placed		negative practice. **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 within six feet of a staff member not properly wearing a mask or in the vicinity of inappropriately placed trash receptacles containing PPE have the potential to be affected. The DON will conduct an in-service with all staff regarding our policy and procedures and CDC guidelines on how to don and doff PPE with return demonstration, including but not limited to, mask, respirator devices, gloves, gown, and eye protection; as well as, the proper placement of trash receptacles containing PPE, and the cited regulation F880 Infection Prevention & Control; in-service to be completed by 11/16/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Monitoring of staff wearing proper PPE will be completed by Unit Managers and/or designees daily times six weeks. Residents who test positive for COVID will have their rooms audited daily for proper placement of trash receptacles containing PPE. If any issues are identified as part	

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	in isolation. During an interview on 10/17/22 at 11:40 a.m., LPN 3, indicated she was not sure if the trash receptacles were supposed to be inside or outside of the isolation room. During an interview on 10/17/22 at 11:44 a.m., LPN 4 indicated, she was not sure of the correct placement of the isolation trash receptacle and had not had a chance to ask anyone yet. On 10/28/22 at 11:00 a.m., the Administrator indicated a policy for correct isolation room set up was not available. 3.1-18(b)(1)		of the audit, the Licensed Nurse completing the audit will re-train the staff involved regarding the facility policy. Written counseling will be rendered for continued non-compliance. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting for six months. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits; however, the monitoring by the shift nurses on at least a daily basis will continue. The DON and Unit Managers are responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 11/16/2022	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must			

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	develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's			

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	representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to follow to ensure vaccinations were administered for 1 of 8 residents reviewed. A pneumococcal vaccination was not given. (Resident 50) Finding includes: On 10/18/22 at 10:03 A.M., Resident 50's clinical record was reviewed. Resident 50's immunization record showed that she received a pneumococcal conjugate (Prevnar 13) vaccine on 11/12/20 but the record lacked documentation of a pneumococcal polysaccharide (PPSV23) vaccine. On 10/19/22 at 11:00 A.M., the Administrator provided a copy of Resident 50's signed "Consent to Administer Pneumococcal Polysaccharide (PPSV23) Vaccine." The consent for the vaccination was signed by Resident 50's power of attorney (POA) for healthcare on 11/5/20. At the bottom of the form was a handwritten notation dated for 11/5/20 at 2:15 PM which read, "POA would like [Resident 50] to receive." During an interview on 10/19/22 at 11:25 A.M., the Administrator and the Director of Nursing (DON)	F 0883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 50 received the PPSV23 vaccination from the facility on 10/21/2022 at 8:15 a.m. **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. A facility-wide audit was completed on 11/13/2022 by the DON to determine the resident's Pneumococcal Immunization status to assure that if the resident (or resident representative) consented to the vaccine, it has been administered or will be once identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/16/2022

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	indicated they did not have a record for Resident 50's PPSV23 immunization and that it should have been administered to Resident 50. On 10/26/22 at 9:20 A.M., the Administrator provided a copy of Resident 50's PPSV23 immunization record which indicated that Resident 50 received the vaccination from the facility on 10/21/22 at 8:15 A.M. On 10/24/22 at 1:15 P.M., the Administrator provided a copy of the facility policy titled, "Influenza and Pneumococcal Immunization," dated as revised for 6/19/19, and indicated it was the policy currently in use. Under the pneumococcal heading, it stated that each resident should be offered pneumococcal vaccinations upon admission, that residents or their representatives are to receive education regarding the benefits and potential side effects of the vaccine, and that residents or their representatives have the right to refuse the immunization. 3.1-13(a)		**practice does not recur?** DON will provide training to nurses related to the residents identifying consent or declination at the time of admission based on educational information that has been provided to them related to the pneumonia vaccine; in-service to be completed by 11/16/2022. During routine clinical meetings, new admissions will be reviewed by the IDT to assure that the resident or resident representative has made a documented decision for either consent or declination related to the Pneumonia vaccine. For those residents that consented to the vaccine, the IDT will follow until administered. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Unit Managers will bring the results of these audits on all new admissions to the monthly Quality Assurance Meeting for six months. The QA committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits; however, medical records will continue to monitor on at least a daily basis. The DON and	

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			Administrator are responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 11/16/2022	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Residential Complaint IN00392950. Complaint IN00392950 - Unsubstantiated due to lack of evidence. Survey dates: October 17, 18, 19, 20, 21, 24, 25, 26, 27, and 28, 2022 Facility number: 001127 Residential Census: 139 Otterbein Franklin Seniorlife Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	