STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

(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. Survey dates: November 14, 15, 16, 17, and 18, 2022 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Census Bed Type: SNF/NF: 100 SNF: 15 Total: 115 Census Payor Type: Medicare: 12 Medicaid: 71 Other: 32 Total: 115 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 30, 2022.	F 0000	/p> 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 on or after (12/15/22)	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure a resident was	F 0558	**What corrective action will be accomplished for those**	12/15/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Bowman	Executive Director	12/20/2022

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	provided a bed and mattress that could accommodate his height comfortably for 1 of 108 resident beds observed. (Resident 309) Finding includes: During an observation of Resident 309 on 11/14/22 at 11:46 a.m., the mattress was observed to be too short for the bed. The resident's feet were touching the footboard as the mattress was down low on the bed and touched the foot board. A 1 foot gap was observed at the head of the bed. If the mattress was pulled up to the head board, the resident's feet would hang off the edge of the mattress. The resident indicated that the mattress could be pulled up in the bed and that this was the bed he was admitted to. When the resident fully extended his body in the bed, his feet were at the end of the mattress and the top of his head was slightly hanging off the mattress. During a second observation of the resident in bed on 11/15/22 at 10:10 a.m. the resident was curled up on his right side. A gap of 1 foot at head of bed was observed. Although the resident was curled up in bed, he was still the length of the mattress. The clinical record for Resident 309 was reviewed on 11/15/22 at 12:39 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, history of pulmonary embolism, status post heart transplant, chronic obstructive pulmonary disease and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 11/14/22, indicated the resident was cognitively intact. The resident's admitting height, on 11/8/22,		**residents found to have been affected by the deficient practice?** On 11/16/22 bed extension pad was put in place for resident 309. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Any resident 6'4" or taller have the potential to be affected by the alleged deficient practice. A Vital Report was ran identifying the height of all residents in the facility. Any resident identified as 6'4" or greater will be evaluated for the proper installation of a bed extender. Currently, no other residents in the facility are 6'4" or taller and or have a physician's order for a bed extender. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** On 11/16/22, an in-service was given by the ED to all IDT members, maintenance, and central supply staff regarding the need for an extender pad to be placed when installing a bed extender. On 12/6/22 the Maintenance Director completed an Environmental Quality Control Checklist audit to ensure that any beds with bed extenders have an extension pad in place. **How the corrective action(s)**	

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	indicated he was 6 foot 6 inches tall. During an observation of Resident's 309's mattress on 11/16/22 at 8:30 a.m., while accompanied by the Executive Director, the resident was observed on his left side in the bed. The resident was curled up but was still the length of the mattress. A gap of 1 foot at the top of the bed as the mattress did not fit the bed. The Executive Director indicated maintenance added a bed extension to his bed when he first came in as he was tall, but apparently maintenance did not look at the mattress to see if it fit. 3.1-3(v)(1)		**will be monitored to ensure the deficient practice will not recur?** DNS/Designee will monitor each new admission's height to determine the need for a bed extender and a physician's order will be obtained. Maintenance/Designee will be responsible for proper installation of bed extender to include the extension pad and complete the environmental quality control checklist audit weekly for 4 weeks, bi-weekly for 8 weeks and then monthly for six months. The results of these audits will be reviewed monthly by the QAPI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 12/15/22**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.			

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	§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, record review, and interview, the facility failed to ensure resident preferences and choices for meal service were honored for 1 of 3 residents reviewed for food choices. (Resident 35) Findings include: During an observation on 11/15/22 at 1:16 p.m., Resident 35 was served her lunch tray. The tray had a main course meal of broccoli chicken rice casserole. The resident indicated she did not like rice, and she had been served sweet and sour meatballs with rice just the night before. The information on her tray ticket only indicated the resident did not want Chinese food. The resident indicated she would just pass on the meal. The clinical record for Resident 35 was reviewed on 11/15/22 at 1:29 p.m. The diagnoses included, but were not limited to, major depressive disorder, vitamin deficiency, and constipation. The Annual MDS (Minimum Data Set) assessment, dated 9/7/22, indicated the resident	F 0561	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** On 11/20/22, Culinary Manager completed a new dietary interview with resident 35 and updated resident 35's meal preferences in the meal tracker system. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by the alleged deficient practice. On 11/28/22, the facility began QIS interviews on all residents regarding choices related to meal choices and preferences. The culinary Manager met with each resident that reported meal preference	12/15/2022

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	was cognitively intact. The care plan, dated 8/25/15 and last revised 9/20/22, indicated the resident consumed 50% or less of her regular diet at times and was at altered nutritional risk. The interventions included, but were not limited to, dislikes kale, cauliflower, Chinese food, spinach, and rice, regular diet, and encourage 75% of intake at meals. The physician's order, dated 12/30/19, indicated the resident received a regular diet. The resident's meal tracking profile included a list of 65 dislikes, which included but was not limited to, chicken and rice casserole, steamed, fried, brown, white, and yellow rice. The resident's meal slips for the week of 11/14/22 thru 11/18/22, indicated the following: - On 11/14/22, the resident received sweet and sour meatballs with rice, mixed vegetables, and egg rolls. - On 11/15/22, the resident received chicken broccoli and rice casserole for the lunch meal and was supposed to receive salisbury steak, brown gravy, alternate vegetables, a baked potato and sour cream for dinner. During an interview on 11/14/22 at 9:30 a.m., Resident 35 indicated she had hated rice and Chinese food and every time she turned around it was on her plate. She had told the facility she did not like it several times and they still gave it to her. Resident 35's roommate as well indicated she had observed the resident receiving rice and there was an issue with not getting what they put on their menus.		concerns during QIS interview, completed a dietary interview and updated their preferences in the meal tracker system. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** On 12/2/22, Culinary Manager and Staff received additional training on the meal tracker system to ensure proper input of likes, dislikes, preference, and allergies. Additionally, Culinary Manager in-serviced all culinary staff on following diet orders, preferences, and dislikes. On 12/6/22, Culinary Manager completed a Tray line Observation QAPI Tool to ensure Diet Orders / preferences are followed per tray ticket. Culinary Manager is responsible for completing dietary interviews on all new admissions within 72 hours then quarterly and as needed thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Culinary Manager / designee will complete Trayline Observation QAPI tool weekly for one month, bi-weekly for two months, and then monthly for six months to ensure compliance is maintained. The results of these audits will be reviewed monthly by the QAPI	

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	During an interview on 11/16/22 at 1:20 p.m., Resident 35 indicated on 11/15/22 she was supposed to receive a baked potato with sour cream and she did not get it. During an interview on 11/18/22 at 11:18 a.m., RN 14 indicated she was familiar with the resident but off the top of her head she did not know the resident's dietary dislikes. There was a form with dietary dislikes for the residents. She was not aware off hand, that the resident did not like rice. The resident's dislikes would be on their paper card that was on their tray and that was how she monitored to see if they were getting a food that was on their dislike list. They would get them a meal replacement if they disliked something. When passing the tray she looked and made sure they got what they ordered and checked their dislikes. During an interview on 11/18/22 at 11:26 a.m., the Registered Dietician indicated the Dietary Manager interviewed the residents on their preferences. The resident's dislikes and likes should be on her meal ticket and most of the time it was also on the care plan. Resident 35's dislikes were kale, cauliflower, Chinese food, and rice, according to her care plan. When they put her dislikes into their meal tracking system, then it should automatically kick out something that would conflict with the meal. It should be kicking her dislikes out, it was a systemic issue they were going to have to fix. During an interview on 11/18/22 at 11:31 a.m., the Dietary Manager indicated the resident's dislikes did not show up on her physical meal ticket. During an interview on 11/18/22 at 11:38 a.m., the		committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Compliance date: 12/15/22**	

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	Dietary Assistant indicated chicken and rice casserole was on the resident's dislikes and it should have been taken off. It shouldn't print it as a meal choice for her. She should not be served anything with rice, but they wouldn't know it because it doesn't show on her meal ticket. The sweet and sour meatballs had included rice and she should not have gotten it as a meal option. The Daily Requirement - Personal Food Preferences policy and procedure, last reviewed December 2017, provided on 11/18/22 at 1:30 p.m. by the Director of Nursing, included, but was not limited to, "... Procedure ... 3. The Community will give consideration to religious, ethnic, and personal preferences ..." 3.1-3(u)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure appropriate documentation of blood sugar levels and administration of insulin for a resident with diabetes, for 1 of 5 residents reviewed for quality of care. (Resident 66) Findings include:	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Resident 66 is receiving accuchecks and insulin per physician order and per policy.	12/15/2022

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	The clinical record for Resident 66 was reviewed on 11/18/22 at 12:16 p.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus. The Annual MDS (Minimum Data Set) assessment, dated 9/21/22, indicated the resident was cognitively intact and received insulin daily. The care plan, dated 11/3/21, indicated the resident was at risk for adverse effects of hyperglycemia related to the use of glucose lowering medication and a diagnosis of diabetes mellitus. Interventions included, but were not limited to, medications as ordered and monitor blood sugars as ordered. The physician's order, dated 11/10/21, indicated the resident received insulin lispro per sliding scale four times daily at 8:00 a.m.,12:30 p.m., 5:00 p.m., and 8:00 p.m., as follows: If blood sugar was less than 60, call MD. If blood sugar was 0 to 199, give 0 Units. If blood sugar was 200 to 250, give 3 Units. If blood sugar was 251 to 300, give 6 Units. If blood sugar was 301 to 350, give 8 Units. If blood sugar was 351 to 400, give 12 Units. If blood sugar was greater than 400, give 15 Units. If blood sugar was greater than 400, call MD (Medical Doctor). The resident's June 2022 Medication Administration Record (MAR) for insulin lispro per sliding scale 4 times daily was not documented as completed on the following dates, as indicated by a blank hole in the MAR on June 13 at 8:00 a.m., June 20 at 12:30 p.m., and June 26 at 8:00 p.m. The resident's July 2022 MAR for insulin lispro per sliding scale 4 times daily was not		**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 with orders for accuchecks and insulin have the potential to be affected by the allege deficient practice. An audit of residents with accuchecks and insulin was completed by IDT to ensure accuchecks and insulin administration was documented. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · All nurses will be in-serviced on medication pass procedure. DNS/nurse manager/designee will complete every shift audits to ensure documentation of blood sugar levels and administration of insulin for residents with diabetes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · QAPI tool on Diabetic Monitoring will be completed every shift, weekly for 4 weeks, then monthly for 6 months or until 100% compliance is achieved. As an ongoing measure Medication administration and Insulin Pen Administration QAPI tool will be completed quarterly thereafter.	

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	documented as completed on the following dates, as indicated by a blank hole in the MAR on July 10 and 17 at 8:00 p.m., July 18 at 8:00 a.m., July 19 at 12:30 p.m., and July 22 at both 12:30 p.m. and 5:00 p.m. The resident's August 2022 MAR for insulin lispro per sliding scale 4 times daily was not documented as completed on the following dates, as indicated by a blank hole in the MAR on August 4 and 17 at 8:00 a.m. and August 30 at 12:30 p.m. The resident's September 2022 MAR for insulin lispro per sliding scale 4 times daily was not documented as completed as indicated by a blank hole in the MAR on September 20 at 8:00 a.m. and September 26 at 12:30 p.m. The resident's October 2022 MAR for insulin lispro per sliding scale 4 times daily was not documented as completed on the following dates, as indicated by a blank hole in the MAR on October 18 and 21 at 5:00 p.m., October 30 at both 8:00 a.m. and 8:00 p.m., and October 31 at 5:00 p.m. During an interview on 11/18/22 at 11:08 a.m., RN 14 indicated the resident was on insulin. They obtained her blood sugars before meals and administered her insulin accordingly. When documenting, she would put in the resident's blood glucose value, see what her sliding scale was, then get the insulin and administer it to the resident. She would then document the administration. During an interview on 11/18/22 at 11:58 a.m., the Director of Nursing (DON) indicated the blanks on the MAR would be a hole in the MAR, which would indicate the medication was not		Results of these reviews will be reported to facility QAPI Committee monthly. If 90%compliance is not achieved an action plan will be developed. **By what date the systemic changes for each deficiency will be completed.** · Date of systemic changes to be completed will be December 15, 2022.	

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	documented as given. It was an omission. All medications should be given as ordered, and documented. If the medication was not given she would expect staff to document it. The Medication Pass Procedure policy, last reviewed December 2016, provided on 11/18/22 at 1:30 p.m. by the DON, included, but was not limited to, "... 16. Medication administration will be recorded on the MAR... after given..." 3.1-37(a)			
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, record review, and interview, the facility failed to ensure interventions were initiated or implemented and failed to prevent the development of two Stage 2 pressure ulcers for 2 of 11 residents reviewed for pressure ulcers. (Residents 39 and 110) Findings include:	F 0686	**F - 686: Treatment / Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Residents 39 and 110 are receiving pressure ulcer interventions per plan of care to	12/15/2022

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	1. During an observation of Resident 39 on 11/16/22 at 12:50 p.m., he was in his room, in his wheelchair. His heels were not elevated, he had no non-skid socks on, and his bandaged heels were resting on the floor. The clinical record for Resident 39 was reviewed on 11/15/22 at 1:32 p.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus with diabetic polyneuropathy, low back pain, anemia, atherosclerotic heart disease, unsteadiness on his feet, difficulty in walking, abnormalities of gait and mobility, reduced mobility, and severe sepsis with septic shock. The care plan, dated 2/11/22 and last revised on 11/10/22, indicated the resident was at risk for further skin breakdown. Pressure injury to the left heel, right heel and left ankle. The interventions indicated: dated 9/26/22, to apply no shoe to the left foot and to apply a preventative treatment as ordered; dated 2/18/22, to apply a low air loss mattress with bolsters; dated 2/11/22, to assess and document his skin condition weekly and as needed. Notify the MD (medical doctor) of abnormal findings, to encourage the resident to turn and reposition at least every 2 hours, to float bilateral heels while in bed, and to provide a preventative treatment as ordered. The Quarterly MDS (Minimum Data Set) assessment, dated 6/9/22, indicated the resident was moderately cognitively impaired. He required extensive assistance of one staff for bed mobility, walking, personal hygiene, and dressing. He required limited assistance for transfer and toilet use. The care plan, dated 7/6/22 and last revised on 11/4/22 at 11:03 a.m., indicated the resident had		prevent development and/or worsening of pressure ulcers. **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 the allege deficient practice. All residents with potential to develop pressure wounds will have IDT review of orders and care plans for preventative measures for pressure ulcers. · All nursing staff will be educated by DNS/designee on Skin Management Program Policy which includes the use of preventative measures for pressure ulcer development. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** · All nursing staff will be educated by DNS/designee on Skin Management Program Policy which includes the use of preventative measures for pressure ulcer development. · DNS/designee will round each shift to ensure preventative measures for pressure ulcers are in place per plan of care for all at risk residents. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	impaired skin integrity pressure injury to the left ankle, right heel, and a blister to the left heel. The resident was at risk for further skin breakdown. The interventions indicated: dated 9/26/22, to use preventative treatment as ordered; dated 9/22/22, to apply no shoe to the left foot; dated 9/13/22, to use a heel float cushion for the bilateral heels; dated 9/6/22, provide a low air loss mattress with bolsters; dated 7/6/22 to assess the wound weekly, documenting measurements and description, to notify the MD of changes in the wound such as worsening or signs of infection, and to observe for signs of infection. The physician's order, dated 7/14/22, indicated to complete the weekly skin assessment at bedtime on Fridays. The Wound Management note, dated 7/5/22, indicated the resident was admitted from the hospital with a stage 3 pressure ulcer to the left outer ankle. The Weekly Skin Assessment, dated 9/16/22, indicated no edema and no new open areas. The bilateral feet had warm, dry and intact skin. No reddened or discolored areas were observed. The Wound Management note, dated 9/22/22 at 6:22 p.m., indicated a stage 2 wound to the left lateral heel was first observed of the clear fluid filled blister. The wound measured 5 cm (centimeters) long by 9 cm wide. The physician's order, dated 9/22/22 and discontinued 11/10/22, indicated to apply a skin prep to the blister on the left posterior heel, cover with an ABD (abdominal) pad and wrap with a rolled gauze.		**recur, i.e., what quality assurance program will be put into place.** · QAPI tool on pressure ulcer prevention and development QAPI tool will be completed weekly for 4 weeks, then monthly for 6 months or until 100% compliance is achieved. As an ongoing measure Pressure ulcer prevention and development QAPI tool will be completed quarterly thereafter. Results of these reviews will be reported to facility QAPI Committee monthly. If 90%compliance is not achieved an action plan will be developed. **By what date the systemic changes for each deficiency will be completed.** · Date of systemic changes to be completed will be December 15, 2022.	

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	The IDT (Interdisciplinary Team) initial wound review note, dated 9/23/22 at 3:24 p.m., indicated a new wound or skin injury of the fluid filled blister to the left lateral heel at a stage 2. The orders were to continue the current treatment order of a skin prep to the blister and an ABD pad to the heel. The Weekly Skin Assessment, dated 9/24/22, indicated no edema and no new open areas. The bilateral feet had warm, dry and intact skin. No reddened or discolored areas were observed. The Wound Management note, dated 10/7/22 at 10:32 a.m., indicated the stage 2 wound to the left lateral heel measured 4 cm long by 5.5 cm wide. The blister was intact. The Weekly Skin Assessment, dated 10/14/22, indicated no new open areas to the right heel. The bilateral feet had warm, dry and intact skin. No reddened or discolored areas were observed. Edema was present. The Wound Management note, dated 10/21/22 at 11:59 a.m., indicated the stage 2 wound to the left lateral heel measured 4 cm long by 3.5 cm wide. The blister was intact. The Weekly Skin Assessment, dated 10/22/22, indicated no edema or new open areas to the right heel. The bilateral feet had warm, dry and intact skin. No reddened or discolored areas were observed. The Wound Management note, dated 10/29/22 at 10:01 p.m., indicated the resident had an unstageable deep tissue wound to the right heel was first observed. The wound measured 5 cm long by 3 cm wide with a maroon colored blood			

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	filled blister. The physician's orders, dated 10/30/22 and discontinued on 11/10/22, indicated to clean the right heel with normal saline, pat dry, skin prep and cover with dry dressing and wrap with a rolled gauze every shift. The IDT initial wound review note, dated 10/31/22 at 3:29 p.m., indicated a DTI (deep tissue injury) to the right heel, which was a maroon colored blood filled blister. The diagnosis and contributing factors related to the wound development was the new onset of edema to the right leg. The Weekly Skin Assessment, dated 11/1/22, indicated no edema to the feet and no new open areas to the right heel. The bilateral feet had warm, dry and intact skin. No reddened or discolored areas were observed. The Wound Management note, dated 11/4/22 at 11:18 a.m., indicated the unstageable deep tissue wound to the right heel measured 4.8 cm long by 3 cm wide. The blood filled blister was improving. The Wound Management note, dated 11/4/22 at 11:12 a.m., indicated the stage 2 wound to the left lateral heel measured 3.9 cm long by 3 cm wide. The wound was stable with 4 cm of wound edge surrounding the wound. The Quarterly MDS assessment, dated 11/10/22, indicated the resident was severely cognitively impaired. He required extensive assistance of one staff for bed mobility, walking, personal hygiene, dressing, transfer and toilet use. The nurse's note, dated 11/10/22 at 12:21 p.m., indicated a wound culture was obtained from the			

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	left lateral heel. The culture was obtained by the wound company's NP at bedside. The wound culture was sent to a local hospital laboratory for review. The Wound Culture results, collected 11/10/22, indicated on 11/13/22, the culture results indicated MRSA (methicillin resistant staphylococcus aureus). The Wound Management note, dated 11/10/22 at 2:32 p.m., indicated the wound to the left lateral heel was now an unstageable deep tissue injury and measured 3 cm long by 2 cm wide. The wound was covered with 100 percent slough and was declining. The resident was now followed by a wound company and the treatment was changed to betadine paint every shift. The physician's order, dated 11/10/22, indicated to cleanse the left heel with normal saline, pat dry, paint with betadine, cover with ABD and wrap with a rolled gauze twice daily. The IDT weekly wound review note, dated 11/10/22 at 2:08 p.m., indicated an unstageable wound to the right heel with a decline. An order for doxycycline 100 mg (milligrams) daily until 11/15/22. A culture was obtained. The resident was now followed by a wound company. The physician's order, dated 11/10/22, indicated to clean the right heel with normal saline, pat dry, paint the wound with betadine and cover with dry dressing and wrap with a rolled gauze every shift. The Wound Management note, dated 11/11/22 at 3:52 p.m., indicated the unstageable deep tissue wound to the right heel measured 5 cm long by 5.5 cm wide and was stable.			

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The nurse's note, dated 11/15/22 at 10:15 a.m., indicated the resident was continued on an antibiotic related to the wound infection. The wound culture was positive for MRSA. The resident was placed in isolation precautions.

The physician's order, dated 11/15/22, indicated the resident was to be in Contact and Droplet Isolation for ten days or until the criteria had been met for removal related to MRSA of the left foot.

The care plan, dated 11/15/22 and last revised on 11/15/22 at 9:34 a.m., indicated the resident had the need for contact isolation related to MRSA of the left foot. The interventions included, but were not limited to, 11/15/22 educate visitors on necessary precautions needed for the specific type of infection, to follow the facility's infection control policies and procedures when cleaning and disinfecting the room, handling of soiled or contaminated linen, disinfecting equipment, etc., to use contact isolation precautions, and to utilize guidelines for transmission-based precautions.

The care plan lacked documentation of the resident's non-compliance with pressure ulcer interventions.

During an observation of Resident 39 on 11/17/22 at 9:55 a.m., he was sitting in his room, in his wheelchair. His left heel was wrapped in a rolled gauze. His right foot was bare. Both heels were resting on the floor.

During an observation and interview on 11/17/22 at 10:25 a.m., by the Wound NP (Nurse Practitioner) 4 with the assistance of Wound Nurse 5 for Resident 39, indicated the NP did not observe the resident being in contact precautions

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	for MRSA. The NP entered the resident's room twice without PPE (Personal Protective Equipment) and was told by the wound nurse to wear the PPE. The NP indicated when a door was open, it was hard to see the signage. The resident indicated the bandage to his right heel came off last night. He wasn't sure what happened to it. The NP measured the left outer ankle, which he was admitted with, at 1.4 cm (centimeters) long by 0.8 cm wide. There was 100% slough and no drainage. The left foot had one plus edema. The NP indicated the resident was non-compliant with offloading his heels. The resident asked her if she had a "bi-plane" for him to float his heels with. She did not respond. The NP measured the left lateral heel at 1.8 cm long by 1 cm wide. There was 100% eschar and no drainage. The right heel was sitting on the floor with no dressing. The NP measured the right heel at 4 cm long by 5 cm wide. There was no drainage with 100% eschar. The NP indicated to continue the current dressing orders and the wounds had improved. The resident indicated the dressing to his right heel fell off around 2:30 a.m. When he was awakened by staff to go to the bathroom, he did not tell staff it fell off, but he indicated they knew. During an observation and interview on 11/17/22 at 10:35 a.m., Wound Nurse 3 entered the room with the dressing to cover the wounds. She indicated the left outer heel wound was caused from the metal brace applied at the hospital. The resident had four plus edema to the bilateral feet at that time. The resident had a fluid filled blister to the left heel and a blood filled blister to the right heel. The blister to the left heel popped open when the resident used his heel to help staff position him in bed. She indicated the left outer heel was where the MRSA was.			

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	During the dressing application on 11/17/22 at 10:37 a.m., by RN 8 with the assistance by Wound Nurse 3, the left wounds were cleaned with a normal saline soaked gauze. Betadine was applied to cover the wounds and an ABD dressing was applied. The left heel was wrapped with a rolled gauze. The right heel was treated and dressed in the same manner. The heels were not offloaded by the staff. During an interview on 11/17/22 at 10:59 a.m., Wound Nurse 3 indicated the resident stayed up in his wheelchair most of the day. Pressure relieving boots would have been applied, but the resident was a fall risk. He was encouraged to lift his heels while in bed. She did not know that the dressing to the right heel was missing, but the nurse should replace the dressing if it was missing. The treatment could have been done, even if the NP was going to conduct an assessment. During an interview on 11/17/22 at 11:12 a.m., RN 8 indicated she first observed the dressing missing to the resident's right heel around 10:35 a.m., that morning. During an interview on 11/18/22 at 9:40 a.m., the DON (Director of Nursing) indicated the nurse should have gotten the dressing re-applied as soon as she could. The edema and his scooting in his wheelchair caused the pressure ulcers. He developed the pressure ulcers to the heels and ankle in house. He spent most of his day in his wheelchair. He was independent and non-compliant with offloading and using his call light for assistance. He was a fall risk and she felt the boots would slide and cause a fall. The resident was severely cognitively impaired.			

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	During an interview on 11/18/22 at 9:59 a.m., CNA (Certified Nurse Aide) 9 indicated she observed the dressing was off of the resident's right heel a little after breakfast between 7:00 a.m. and 9:30 a.m. She informed the nurse at that time. The resident was compliant with using his wedge when he was in bed. He was not like that when he first admitted. He would not offload his heels. 2. The clinical record for Resident 310 was reviewed on 11/15/22 at 1:46 p.m. The diagnoses included, but were not limited to, cellulitis of perineum, diarrhea, vitamin B12 deficiency, pressure ulcer of sacral region, muscle weakness, abnormalities of gait and mobility, and reduced mobility. The nurse's note, dated 10/28/22 at 6:48 p.m., indicated the resident was admitted to the facility with a decubitus ulcer to the sacrum area which was very large, described as baseball sized and had a depth that revealed bone. The wound observation, dated 10/28/22, indicated the resident had a deep tissue injury to the left heel measuring 2 cm in length by 2 cm in width. The wound observation, dated 10/28/22, indicated the resident had a stage 4 pressure ulcer to her sacrum which was present on admission. The wound measured 8 cm in length, 11 cm in width, and 4.5 cm in depth. The wound had 5 cm of undermining and was 50% granulation tissue and 25% slough, with 25% eschar. The physician's order, dated 10/28/22, indicated to turn and reposition the resident every 2 hours while in bed. The Admission Minimum Data set assessment, dated 11/3/22, indicated the resident was severely			

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	cognitively impaired, required extensive assistance of 2 or more staff with bed mobility, transfers, and toileting, was at risk for developing pressure ulcers, had one stage 4 pressure ulcer and one unstageable deep tissue injury which were both present on admission. The care plan, dated 11/4/22, indicated the resident had impaired skin integrity with pressure injuries to her left heel and sacrum. Interventions included, but were not limited to, turn and reposition every 2 hours. The wound observation, dated 11/4/22, indicated the wound to the resident's coccyx was stable and measured 8.3 cm in length, 11.1 cm in width, and 4.3 cm in depth with 5 cm of undermining. The wound was 50% slough. The physician's order, dated 11/14/22, indicated to change the dressing to cleanse the resident's wound to her buttocks, pat dry, and apply a moist to moist Dakin's dressing every night shift. The wound observation, dated 11/11/22, indicated the wound was stable, measuring 2.4 cm in length by 2 cm in width. The wound observation, dated 11/14/22, indicated the wound to the resident's coccyx was stable and measured 8.3 cm in length, 9.5 cm in width, 4 cm in depth, with 4 cm of undermining. The wound was 50% granulation and 50% slough. During an interview on 11/16/22 at 1:15 p.m., the resident's family member indicated he was in the facility with her daily from 12:00 p.m. to 6:00 p.m. and he did not see staff turn or reposition her. He believed she was supposed to be turned every 2 hours to get her off her rear end, but he did not			

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	ever see them do it. They sometimes put a pillow under one side. During an observation on 11/17/22 at 9:07 a.m., Resident 310 was lying flat on her back with an air mattress bed in place. There were no pillows in place for positioning. During an observation on 11/17/22 at 10:54 a.m., Resident 310 was lying flat on her back with no pillows in place for positioning. The resident's family member was present in the room and indicated they had been in the room since around 9:00 a.m. and no one had turned the resident. He had not ever seen pillows for positioning in place. During an observation on 11/17/22 at 11:49 a.m., Resident 310 remained lying flat on her back with two family members at her bedside. Family indicated they had remained in the room continuously and no staff members had turned or repositioned the resident yet. There were still no pillows in place for positioning. During an observation on 11/17/22 at 1:14 p.m., the resident remained flat on her back with no pillows for positioning. The resident's family member indicated a nurse had been in to give the resident a pain pill, but had not repositioned the resident. During an interview on 11/17/22 at 1:17 p.m., CNA (Certified Nurse Aide) 13 indicated she was the only one taking care of Resident 310. She had not turned the resident that day since around 9:00 a.m. or 9:30 a.m. She had gone back in at 10:50 a.m., but it had been close to lunch so she hadn't turned her because she needed to be on her back for lunch.			

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	During an interview on 11/17/22 at 2:34 p.m., the Wound Nurse indicated the resident's wound was improving and looked better than it had the week prior. Staff were to turn the resident every 2 hours. During an interview on 11/17/22 at 2:43 p.m., the Director of Nursing (DON) indicated she thought perhaps staff were more cautious to turn the resident because of her pain level, but the rule of thumb was to turn the resident every 2 hours. She did not know why the CNA waited over 4 hours. Staff knew to turn resident's every 2 hours. She did know the resident's wound was improving, she was on a low air loss mattress and was still getting her treatments done. During an observation on 11/18/22 at 9:33 a.m., the ADON (Assistant Director of Nursing) and LPN (Licensed Practical Nurse) 17 provided wound care for Resident 310. The resident was rolled to her left side and a very large open wound was observed to the resident's coccyx. The ADON indicated the wound appeared to be 50% slough, which was yellow in color. The rest of the wound bed was beefy red. There was approximately 25% of the wound margins covered in yellow slough tissue. The ADON measured the wound, indicating it measured 7 cm in length, 10 cm in width, and 4 centimeters in depth with 4 centimeters of undermining. The Skin Management Program policy, last revised May 2022, provided on 11/17/22 at 2:35 p.m. by the DON, included, but was not limited to, "... It is the policy of [Name of Company] to ensure that each 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 a			

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	resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure ulcers from developing... 3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors... Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)..." 3.1-40(a)(1)			
F 0880 SS=E 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: §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;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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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
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, and interview, the facility failed to ensure infection control practices were followed related to proper use of personal protective equipment (PPE) for 5 of 9 staff observed for Infection Prevention. (Dietary Cook 11, Dietary Aide 12, Dietary Aide 13, Dietary Cook 12, and NP 4) Findings Include, 1. During the initial tour of the kitchen with the Dietary Manager (DM), on 11/14/22 between 9:20 a.m. and 10:00 a.m., the following concerns were observed: The Dishwashing Aide 18 was observed with his mask down below his nose and chin while washing dishes and interacting with the other dietary staff. Dishwashing Aide 18, Dietary Cook 11, and Dietary Aide 12 were observed wearing their masks improperly. Dietary Cook 11 was observed with her mask below her nose and chin. Dietary Aide 12, was observed with her mask below her nose. During the lunch tray observation on 11/14/22, at 11:15 a.m., the Dietary Cook 11 and Dietary Aide 12 were observed serving food with their mask down below their nose and chin while setting up resident food trays. During an observation on 11/15/22, 12:30 p.m., the	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Employees identified during survey were educated on the importance of wearing face mask and PPE in resident rooms with transmission-based precautions. All employees verbally communicated understanding with the IP nurse. Employees completed PPE donning and doffing skills competency with return demonstration overseen by the IP nurse. · DNS, Administrator, and IP nurse were all educated on the Standard and Transmission-Based Precautions (Isolation) Policy and where to locate information on PPE usage, including wearing face mask correctly and to keep mask over mouth and nose. They were also educated on wearing required PPE in transmission -based precaution resident rooms. Education was completed by the Consultant IP. **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:**	12/15/2022

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	155203	A. BUILDING 00 B. WING	11/18/2022

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	Dietary Cook 12 was observed with her mask below her nose and chin while sitting up the resident's lunch trays and interacting with the dietary staff. During an observation on 11/18/22, at 8:10 a.m., Dietary Cook 12 and Dietary Aide 13 were observed with their masks below their nose while preparing the resident's breakfast. The current county positivity rate, dated 11/11/22, indicated the county positivity rate was high at 21.56%. Surgical masks were required for all staff members. During an interview on 11/18/22, at 8:10 a.m., Dietary Aide 13 indicated staff are supposed to wear a mask at all times. Mask should cover the nose and mouth. During an interview on 11/18/22, at 8:15 a.m., Dietary Cook 12 indicated all staff were supposed to wear a mask. The mask should cover the nose and the mouth. The mask should be worn at all times. During an interview on 11/18/22 at 1:35 p.m., the Infection Preventionist indicated the county positivity rate was 21.56%. She would consider that a high percentage for the county. All staff must wear a mask regardless of the staff members vaccination status. 2. During an observation and interview on 11/17/22 at 10:25 a.m., by the Wound NP (Nurse Practitioner) 4 with the assistance of Wound Nurse 5 for Resident 39, indicated the NP did not observe the resident being in contact precautions for MRSA (methicillin resistant staphylococcus aureus). The NP entered the resident's room twice without PPE (Personal Protective Equipment) and		· All residents have the potential to be affected by the alleged deficient practice. · All staff were in-serviced by the IP/designee on the Standard and Transmission-Based Precautions (Isolation) Policy and where to locate information on PPE usage, including wearing face mask correctly and to keep mask over mouth and nose. They were also educated on wearing required PPE in transmission-based precautions resident rooms. All in-servicing completed by December 15, 2022. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation, and QA tools. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause.	

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	was told by the wound nurse to wear the PPE. The NP indicated when a door was open, it was hard to see the signage. The clinical record for Resident 39 was reviewed on 11/15/22 at 1:32 p.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus with diabetic polyneuropathy, low back pain, anemia, atherosclerotic heart disease, unsteadiness on his feet, difficulty in walking, abnormalities of gait and mobility, reduced mobility, and severe sepsis with septic shock. The care plan, dated 11/15/22 and last revised on 11/15/22 at 9:34 a.m., indicated the resident had the need for contact isolation related to MRSA of the left foot. The interventions included, but were not limited to, 11/15/22 educate visitors on necessary precautions needed for the specific type of infection, to follow the facility's infection control policies and procedures when cleaning and disinfecting the room, handling of soiled or contaminated linen, disinfecting equipment, etc., to use contact isolation precautions, and to utilize guidelines for transmission-based precautions. The Wound Culture results, collected 11/10/22, indicated on 11/13/22, the culture results indicated MRSA. The nurse's note, dated 11/15/22 at 10:15 a.m., indicated the resident was continued on an antibiotic related to the wound infection. The wound culture was positive for MRSA. The resident was placed in isolation precautions. The physician's order, dated 11/15/22, indicated the resident was to be in Contact and Droplet Isolation for ten days or until the criteria had been met for removal related to MRSA of the left foot.		· The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. · The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy · All staff were in-serviced by the IP/designee COVID-19 Resident Policy and were educated on the importance of wearing face mask correctly, ensuring mask is secured appropriately with mask straps, and to keep mask over mouth and nose. IDT and nurses were also educated on increasing COVID monitoring orders to TID for COVID positive residents. All in-servicing completed by December 15, 2022. · Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the Mask Usage/PPE monitoring observational rounds tool to observe for compliance with ensuring staff are wearing face mask correctly and to keep mask over mouth and nose and wearing required PPE in transmission-based precautions resident rooms. · The consultant IP will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools	

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	The Infection Prevention and Control policy, last revised October 2022, provided on 18//24/22 at 12:15 p.m. by the Director of Nursing, included, but was not limited to, "...c. Face covering or mask (covering mouth and nose) in accordance with CDC (Center of Disease Control) guidance." The CDC guidance on 11/21/22, at 8:17 a.m., indicated when the county positivity rate was at a high level wear a high-quality mask or respirator. 3.1-18(b)		identifying on-going areas of concern or not meeting threshold. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. · Mask Usage/ PPE Monitoring QA tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. · The IP/designee will be responsible for the completion of the Mask Usage/ PPE Monitoring QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After	

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			six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed:** Completion Date: December 15, 2022.	