DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST WALDRON, IN 46182

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00353375. Complaint IN00353375 - Substantiated. Federal/state deficiencies related to the allegations are cited at F842. Survey dates: May 16, 17, 18, 19, 20 & 21, 2021 Facility number: 000423 Provider number: 155704 AIM number: 100290450 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 10 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 27, 2021	F 0000	06/09/2021 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Annual Survey Waldron Rehabilitation and Health 505 N Main St Waldron, IN 46182-0371 Dear Ms. Buroker, On May16, 2021, an annual survey along with complaint survey (IN00353375) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of June 10,2021 Please feel free to call me with any further questions at 1 (765) 525-4371. Respectfully submitted, Manoj Berry (Executive Director) Waldron Rehabilitation and	

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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			Healthcare 505 N.Main street Waldron. IN-46182	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to maintain two residents' dignity when staff failed to answer their call lights quickly enough to prevent them from being incontinent. (Residents 28 and 49) Findings include: 1. During an interview, on 5/17/21 at 01:20 p.m., Resident 28 said he sometimes soils himself waiting for staff to take him to the bathroom, he has to wait awhile for them to take him. Resident 28's record was reviewed on 5/19/21 at 12:17 p.m. The record indicated Resident 28 had diagnoses that included, but were not limited to, type 2 diabetes mellitus, abnormalities of gait and mobility, and lack of coordination. A Quarterly MDS assessment, dated 3/31/21, indicated Resident 28 was moderately impaired in cognitive skills for daily decision making, required extensive assist of 2 for most activities of daily living, was frequently incontinent of bowel and bladder, and has not had a bowl or bladder training program. A bowel and bladder assessment, dated 10/2/2020, indicated Resident 28 uses a bed pan and commode, wears incontinent briefs, and is frequently incontinent of bowel and bladder. He is able to tell staff when he needs to go.	F 0550	**F 550 D Resident Rights** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:** Residents # 28 and #49 were assessed for incontinence needs and development of toileting plans. Care plans were reviewed and revised as appropriate related to incontinent needs. **2) How the facility identified other residents:** Any resident had the potential to be affected. Audit was conducted to identify those residents that are	06/10/2021

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	On 5/21/21 at 10:10 a.m., the Director of Nursing indicated they toilet Resident 28 as he puts his light on, after meals, and at bedtime. He wears incontinent briefs. He prefers to go to the shower room bathroom and he takes himself down to that room. 2. During an interview, on 5/17/21 at 1:39 a.m. Resident 49 indicated she has to wait so long for her call light to be answered that she had already gone (had been incontinent) when they answer her call light, that it happens on every shift, even at night, and said she would be continent if they got to her in time because she was continent when she came in here. Resident 49's record was reviewed on 5/20/21 at 2:36 PM. The record indicate Resident 49 had diagnoses that included, but was not limited to, left lower leg fracture, chronic kidney disease, right hip pain, generalized muscle weakness, and right knee pain. A Quarterly MDS assessment, dated 5/3/21, indicated Resident 49 was cognitively intact, required extensive assist of one for toilet use, was occasionally incontinent of urine, always incontinent of bowel, and has not had a trial of a toileting program for bowel or bladder. During an interview on 5/20/21 at 12:20 a.m. Resident 49 was observed seated in her wheelchair and said everything is still the same, that she still doesn't get to the bathroom in time. She was not observed incontinent at that time and did not have any odors. During an interview, on 5/21/21 at 11:08 a.m., the Director of Nursing indicated Resident 49's care		incontinent and able to participate in toileting programs. Interviews were conducted on call light response times. Issues identified were addressed with re-education. **3) Measures put into place/ System changes:** Education provided to facility staff on resident rights/dignity, and prompt response to call lights Care plans were updated as required for those residents identified to be incontinent and able to participate in toileting programs. **4) How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee with administrative oversight. Call light audits will be conducted per Director of Nursing/designee 5 times weekly to include all shifts. Identified issues will result in immediate investigation and re-education. Resident council meetings will be conducted weekly times 4 weeks to determine immediate improvement with call light response. Residents will be assessed quarterly and annually and with significant change to if appropriate for toileting programs. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3	

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	plan is missing the initial comprehensive care plan and it wasn't complete. She said it didn't look like Resident 49 was on a toileting program and Resident 49 would be more continent if she was toileted regularly. 3.1-3(t)		consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 6-10-21**	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at			

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	the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review the facility failed to implement Code Status and Advanced Directives for 2 of 2 residents reviewed for Advanced Directives (Resident 36 and Resident 34). Findings include: 1.) Review of the record of Resident 36 on 5/17/21 1:20 p.m., indicated the resident did not have Advanced Directives or Code Status in the electronic health record. Review of the record of Resident 36 on 5/19/21 at 10:57 a.m., indicated the resident's diagnoses included, but were not limited to, cerebral infarction, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, morbid obesity, pressure ulcer stage three, obstructive sleep apnea, diabetes mellitus type 2, arteriosclerosis, chronic kidney disease and hypertension. The Admission Minimum Data Set (MDS) for Resident 36, dated 4/21/21, indicated the resident indicated the resident was admitted to the facility on 4/15/21. The resident was independent with	F 0578	**F 578 Formulate Advance Directives** **The facility request paper compliance for this citation** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident #36 and 34 Advance Directives and code status were clarified, orders and care plan reviewed for a**ccuracy and	06/10/2021

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	daily decision decision making and was reasonable/consistent. During an interview with the Director Of Nursing (DON) on 5/19/21 at 1:15 p.m., verified Resident 36 did not have a physician order for the resident's Code status or Advanced Directives. The DON indicated it was the admitting nurses responsibility to ensure the residents Code status was placed on the physician's order in the electronic health record. During an interview with Resident 36 on 5/19/21 at 1:20 p.m., indicated the facility had not talked with him about his wishes regarding if he wanted Cardiopulmonary resuscitation (CPR) preformed if an emergency happened. The resident indicated he wanted CPR preformed and other measures done to save his life in the event of an emergency. During an interview DON on 5/19/21 at 1:31 p.m., Resident 36's Code Status and Advanced directives were found in the Nurse Practitioner's office, the resident had not signed it yet. The facility was going to get the resident's signature and upload into the resident's electronic health record. 2.) Review of the record of Resident 34 on 5/17/21 at 1:30 p.m., indicated the resident did not have Advanced Directives or Code Status in the electronic health record. During an interview with Resident 34 on 5/19/21 at 2:25 p.m., indicated the facility had not talked to him about what his wishes were for Cardiopulmonary Resuscitation (CPR) or advanced directives. The resident indicated he definitely wanted to be full code status and wanted other life saving measures.		reflected in the electronic medical record. **2) How the facility identified other residents:** **Audit was completed to identify any discrepancies with advance directives and code status on any other** resident residing in facility. No other resident was identified to have been affected. **3) Measures put into place/ System changes:** **Education was provided to facility management staff, and nursing on advance directives and code status. New admissions will be reviewed during daily stand up meetings to ensure advance directives** are in place with orders and care plans. Social Services will conduct weekly code status/advance directive audits to ensure orders and care plans are accurately reflected in the Electronic Medical records **4) How the corrective actions will be monitored:** **The responsible party for this plan of correction will be the Social Service Director with Director of Nursing oversight. New admission audits will be reported During scheduled daily stand up meetings.** Audits	

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	During an interview with the Director of Nursing (DON) on 5/19/21 at 2:30 p.m., verified Resident 34 did not have a Code status or Advanced directive in the resident's electronic health record. The DON indicated the facility had recently went through some changes on who was responsible to obtain Code status for Residents. Review of the record of Resident 34 on 5/21/21 at 11:22 a.m., indicated the resident's diagnoses included, but were not limited to, diabetes mellitus, arteriosclerotic heart disease, sarcopenia, anxiety disorder, major depressive disorder, wedge compression fracture of the lumbar vertebra, anemia and esophageal reflux. The Admission Minimum Data Set (MDS) assessment for Resident 34, dated 4/12/21, indicated the resident was admitted to the facility on 3/25/21. The resident was independent with daily decision decision making and was reasonable/consistent. The Advance Directive policy provided by the DON on 5/20/21 at 11:00 a.m., indicated the purpose of the policy was to ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. Advanced Directives shall not be required as a provision of service or admission. "At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law." "Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making this inquiry." "This information shall then be included,		will be conducted 1 time weekly on all residents to include all new admissions to determine accurate code status orders and care plans are in place and reflected in the electronic medical record. Any issue identified will be immediately addressed. **The results of these audits will be reviewed in QAPI monthly for 6 months or until** 100% compliance is achieved for 3 consecutive months. The QA Committee will **identify any trends or patterns and make recommendations to revise the plan of** correction as indicated. **5) Date of compliance: 06/10/2021**	

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	in the resident's medical record. "A written physician order is required in response to the resident's Advanced Directive(s)." The Indiana Physician orders for scope of treatment had the following information for each resident and/or resident representative to address: Code status, Medication interventions, antibiotic use and artificial nutrition. 3.1-4(f)(4)(ii)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR			

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	recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview, and record review, the facility failed to develop and implement a care plan for dialysis, for Resident 17, and for bowel and bladder incontinence for Residents 28 and 49, for 3 of 24 residents reviewed for care plan development. Findings include: 1. Resident 17's record was reviewed on 5/19/21 at 10:02 a.m. The record indicated Resident 17 had diagnoses that included, but were not limited to, end stage renal disease. A Quarterly Minimum Data Set (MDS) assessment, dated 2/27/21, indicated Resident 17 was cognitively intact, and received dialysis while a resident. Current physician's orders included, but were not limited to, 1500 ml fluid restriction daily, started 4/23/2020, weight on Monday, Wednesday,	F 0656	**F656 Develop/Implement Comprehensive Care Plan.** **The facility request paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:** Resident #17, #28, and #49 care plans were reviewed and revised.	06/10/2021

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	Friday, for dialysis weight before and upon returning from dialysis, started 2/19/2021; hold blood pressure meds and insulin before dialysis one time a day every Monday, Wednesday, Friday, started 1/22/2021; and Lidocaine Cream 4%, apply to dialysis access site topically before dialysis every Monday, Wednesday, Friday for pain, started 10/19/20. Review of care plans indicated there was no care plan for dialysis that included observations or monitoring of the shunt site, the type of dialysis, or when, where, and who transports the resident to dialysis. On 5/21/21 at 10:59 a.m., the Director of Nursing indicated she wasn't seeing a care plan for dialysis. 2. During an interview, on 5/17/21 at 01:20 p.m., Resident 28 said he sometimes soils himself waiting for staff to take him to the bathroom, he has to wait awhile for them to take him. Resident 28's record was reviewed on 5/19/21 at 12:17 p.m. The record indicated Resident 28 had diagnoses that included, but were not limited to, type 2 diabetes mellitus, abnormalities of gait and mobility, and lack of coordination. A Quarterly MDS assessment, dated 3/31/21, indicated Resident 28 was moderately impaired in cognitive skills for daily decision making, required extensive assist of 2 for most activities of daily living, was frequently incontinent of bowel and bladder, and has not had a bowl or bladder training program. A bowel and bladder assessment, dated 10/2/2020,		**2) How the facility identified other residents:** The facility has determined that any current resident residing in the facility had the potential to be affected. Facility audit was conducted to determine those residents that are incontinent, and residents receiving dialysis have care plans that are current and reflective of resident's needs. **3) Measures put into place/ System changes:** In-service conducted by Director of Nursing/MDS Coordinator for the interdisciplinary team to review procedures for development of a comprehensive care plans. New admissions will be reviewed within 24-48 hours of admission to ensure diagnosis are reflective of resident condition and person-centered care plans are initiated. Additionally, all new admissions are reviewed in scheduled daily clinical meetings to ensure the development of person care plans are reflective of resident condition. **4) How the corrective actions will be monitored:** The Director of Nursing and MDS Coordinator will randomly review three residents' records weekly ensuring that care plans have been developed that accurately reflect resident status MDS coordinator will review during scheduled care plan meetings to ensure care plans are reflective of	

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	indicated Resident 28 uses a bed pan and commode, wears incontinent briefs, and is frequently incontinent of bowel and bladder. He is able to tell staff when he needs to go. On 5/21/21 at 10:10 a.m., the Director of Nursing indicated she doesn't think he was ever on a bowel and bladder training program. She said he was continent prior to going on hospice, so she doesn't think he was on a bowel and bladder program. She said they toilet him as he puts his light on, after meals, and at bedtime. He was at the hospital in 9/2020, had a catheter, and they removed it after he came here. Then he went on hospice and they transitioned the care over to hospice. Now he wears incontinent briefs. He prefers to go to the shower room bathroom and he takes himself down to that room. She said the only careplan she found was "toilet use: assist as needed" and had looked through the care plans to see if there was a careplan for incontinence, and that was the only careplan she could find for bowel and bladder incontinence. 3. During an interview, on 5/17/21 at 1:39 a.m. Resident 49 indicated she has to wait so long for her call light to be answered that she had already gone (had been incontinent) when they answer her call light, that it happens on every shift, even at night, and said she would be continent if they got to her in time because she was continent when she came in here. Resident 49's record was reviewed on 5/20/21 at 2:36 PM. The record indicate Resident 49 had diagnoses that included, but was not limited to, left lower leg fracture, chronic kidney disease, right hip pain, generalized muscle weakness, and right knee pain.		resident's status. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction. **5) Date of compliance: 6-10-21**	

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	155704	A. BUILDING 00 B. WING	05/21/2021

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	A Quarterly MDS assessment, dated 5/3/21, indicated Resident 49 was cognitively intact, required extensive assist of one for toilet use, was occasionally incontinent of urine, always incontinent of bowel, and has not had a trial of a toileting program for bowel or bladder. During an interview on 5/20/21 at 12:20 a.m. Resident 49 was observed seated in her wheelchair and said everything is still the same, that she still doesn't get to the bathroom in time. She was not observed incontinent at that time and did not have any odors. During an interview, on 5/21/21 at 11:08 a.m., the Director of Nursing indicated Resident 49's care plan is missing the initial comprehensive care plan and it wasn't complete. She said it didn't look like Resident 49 was on a toileting program and Resident 49 would be more continent if she was toileted regularly. A policy for "Care Plans Protocol" was provided by the Director of Nursing on 5/21/21 at 2:08 p.m. The policy included, but was not limited to, "...The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool the comprehensive care plan must include measurable objectives and time frames, and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care...Care Plans needed to be completed in Point Click Care (Electronic Health Records). Upon completion of the Admission MDS, the			

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	MDS Coordinator and in disciplinary team will ensure that all triggered items are care planned and that any additional care needs are care planned...." 3.1-35(a) 3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure an ortho boot was applied as ordered, failed to ensure the application of Unna Boots and/or compression stockings per physician orders, and failed to ensure documentation of discoloration to a resident's skin for 2 of 8 residents reviewed for skin integrity and 1 of 1 resident reviewed for range of motion (Resident 32 and Resident 41) Findings include: 1. The clinical record for Resident 32 was reviewed on 5/19/21 at 9:16 a.m. The diagnoses included, but were not limited to, right femur fracture, cognitive communication deficit and vascular dementia. A Quarterly Minimum Data Set (MDS)	F 0684	**F 684 Quality of Care** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:**	06/10/2021

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	assessment, dated 4/9/21, indicated no skin impairments noted for Resident 32. A physician order, dated 10/6/20, indicated the application of compression stockings daily and remove at bedtime. A physician order, dated 4/28/21, indicated the application of Unna Boots to bilateral lower extremities evening shift on Wednesdays. An observation conducted of Resident 32's skin with Licensed Practical Nurse (LPN) 6, on 5/19/21 at 9:55 a.m., noted no Unna Boots or compression stockings on Resident 32's bilateral lower extremities. LPN 6 commented his bilateral lower extremeites were swollen and he needed his compression stockings. The electronic medication administration record (EMAR) for May of 2021, noted nursing staff signing off on the application of Resident 32's compression stockings for 5/19/21 at 8:00 a.m. The EMAR of May 2021, also noted nursing staff signing off on the application of Unna Boots to Resident 32's bilateral lower extremities on 5/12/21. 2a. The clinical record for Resident 41 was reviewed on 5/20/21 at 11:23 a.m. The diagnoses included, but were not limited to, left fibula fracture, pain in left leg and abnormalities of gait and mobility. A Quarterly MDS assessment, dated 2/9/21, indicated Resident 41 had impairment on one side for his lower extremity and he was cognitively intact. A physician order, dated 3/12/21, indicated for Resident 41 to wear a walking boot to left foot.		Resident # 32 and #41 care plan was reviewed and revised to reflect their status. Resident orders reviewed, and primary care physician assessed residents. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Skin sweep was completed to identify any unidentified bruises or skin conditions. Orders were reviewed for those residents using Una Boots, compression stockings, or Walking Boots. Care Plans were updated as needed. Any new identified issues were reported to primary physician for review. **3) Measures put into place/ System changes:** Licensed Nursing staff educated on the completion of Weekly Skin assessments, notification of changes to Nurse practitioner and Primary Care Physician. Education provided on following physician orders and documentation of those residents that utilize Una Boots, Compression stockings, and or Walking Boots. Documentation of those residents that refuse to follow orders and physician notification as well. **4) How the corrective actions will be monitored:** Director of Nursing is the responsible party for this Plan of Correction.	

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	An observation was conducted, on 5/17/21 at 11:48 a.m., to where no ortho boot was observed to Resident 41's left foot. Resident 41 interviewed during observation and indicated the nursing staff never apply the boot on a daily basis. He fractured his leg in the past and that was why he utilized the ortho boot. The ortho boot was located under his bedside table. There was no care plan related to Resident 41 having a history of a fracture and/or the use of the ortho boot. Observations were conducted on 5/18/21 at 9:52 a.m. and 5/19/21 at 11:20 a.m., to where Resident 41 had his ortho boot in place to the left lower extremity. An interview conducted with the Director of Nursing (DON), on 5/19/21 at 1:34 p.m., indicated Resident 41 still utilizes an ortho boot to his left leg and will continue to wear it until the fracture is healed. 2b. An observation was conducted on 5/17/21 at 11:43 a.m., of Resident 41. There were 3 quarter sized reddish/purple discoloration areas to his left upper extremity and purple discoloration that covered the entire top of his left hand. He indicated nursing staff have not come in to measure or observe the discoloration. There was no documentation of an assessment, measurements, and/or a root cause for the bruising to Resident 41's left upper extremity. Another interview conducted with Resident 41, on 5/20/21 at 10:55 a.m., indicated he didn't have the discoloration to his left arm prior to admitting to		Director of Nursing/designee will Audit 3 resident records weekly to ensure weekly skin assessments have been completed and documented. Any resident utilizing adaptive equipment such as compression stockings, una boots and or walking boots etc. will have documentation of use or refusal noted on MAR/TAR. Care Plans will be updated to reflect resident's current status and or changes in resident condition. Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)** **Date of compliance: 6-10-21.**	

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the facility. He believes his left arm might have made contact with his night stand while he was moving or attempting to transfer from bed. His left upper extremity was observed and the purple discoloration to his left hand had faded and went from the size to the entire top of his hand to the size of a half-dollar. The 3 quarter sized reddish/purple discoloration to his left arm had turned a darker purple and appeared smaller in size. Resident 41 stated "they look like they are getting smaller".

A care plan for skin, revised 2/3/21, indicated the following, "...I have a potential for impairment to skin integrity r/t [related to] DM [diabetes mellitus] PAD [peripheral arterial disease]...Interventions...Assess/record changes in skin status...Report pertinent changes in skin status to physician...."

A care plan for anticoagulat use, revised 2/3/21, indicated the following, "...I am on anticoagulant therapy Coumadin...Interventions...Monitor/document/report PRN [as needed] adverse reactions of ANTICOAGULANT therapy...bruising...."

An interview conducted with the DON, on 5/19/21 at 1:34 p.m., indicated Resident 41 should have a diagnosis of age-related purpura and if he didn't we will add it to his diagnoses. The discoloration was not bruising. It was discussed during a care plan meeting a few weeks ago and it must not have gotten added at that time.

A diagnosis of other nonthrombocytopenic purpura was added to Resident 41's list of diagnoses on 5/19/21.

An interview conducted with the DON, on 5/21/21

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	at 12:00 p.m., indicated physician orders should be followed as written and Resident 41's skin was discussed with the Nurse Practitioner and believed he had age-related purpura. That would account for the discoloration to his arm and hand. He is also on a blood thinner. A policy titled "Administrative Physician's Orders", undated, was provided by the DON on 5/20/21 at 2:19 p.m. The policy indicated the following, "...5. Following a physician visit, a licensed nurse will...Check for any orders that require verification. The orders will be verified by the nurse and the instructions for the order will be completed...6. Document in progress notes new medication/treatment and why it was initiated...7. Initiate a care plan if applicable...." 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, interview and record review the facility failed to implement a physician	F 0686	**F 686 Treatment to prevent/Heal pressure ulcer.**	06/10/2021

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	order for a stage 3 pressure ulcer (full thickness tissue loss) and failed to provide a treatment for a stage 3 pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident 36). Finding include: During an interview with Resident 36 on 5/17/21 at 11:09 a.m., indicated he had a "sore" on his bottom. The resident indicated the staff did not always do the treatment on the sore every day. The resident indicated he had reported it to "everyone" but did not know the staff's names. The resident indicated that this issue was his main concern about the facility because it needed to be treated every day as the physician ordered. Review of the record of Resident 36 on 5/19/21 at 10:57 a.m., indicated the resident's diagnoses included, but were not limited to, cerebral infarction, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, morbid obesity, pressure ulcer stage three, obstructive sleep apnea, diabetes mellitus type 2, arteriosclerosis, chronic kidney disease and hypertension. The Admission Minimum Data Set (MDS) for Resident 36, dated 4/21/21, indicated the resident indicated the resident was admitted to the facility on 4/15/21. The resident was independent with daily decision decision making and was reasonable/consistent. The resident was at risk for pressure ulcers. The resident was admitted with a stage 3 pressure ulcer. The hospital discharge plan for Resident 36, dated 4/15/21, indicated a treatment of dakin moist 2 x 2 foam dressing daily to the stage three pressure ulcer.		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified: Resident #36 no longer resides in facility.** **2.How the facility identified other residents:** **Any resident residing in the facility had the potential to be affected. Audit all resident to ensure has weekly skin assessments in place. Any identified issues were reported to primary care physician and care plan updated.** **3. Measures put into place/ System changes:** Nursing staff educated on the completion of Weekly Skin assessments, new orders,	

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	The wound assessment for Resident 36, dated 4/16/21, indicated the resident had a stage 3 pressure ulcer that measured 7 centimeters (cm) by 7 cm on the left buttock. The wound assessment for Resident 36, dated 5/13/21, indicated the resident had a stage 3 pressure ulcer that had improved. The wound had a moderate amount of exudate that was red/brown. The would had a large amount of granulation 67-100%. The assessment did not have measurements documented. Resident 36's Treatment Administration Record (TAR) electronic health record indicated the facility did not provide a treatment for the stage 3 pressure ulcer from 4/16/21 to 4/20/21 (5 days). The facility did not obtain a physician order for a pressure ulcer treatment and dressing change until 4/21/21. During an interview with Resident 36 on 5/20/21 at 11:45 a.m., Resident 36 indicated he did not get his pressure ulcer dressing change again yesterday (5/20/21). The resident's TAR ,dated 5/20/21, indicated the dressing change was not signed as provided. During an observation on 5/21/21 at 10:.30 a.m., RN 7 completed Resident 36 pressure ulcer dressing change. The pressure ulcer wound was located on the left buttock and was approximately 3 centimeters (cm) by 3 cm pink with dark edges. The old dressing had brown, black and yellow drainage on it. During an interview with the Director Of Nursing (DON) on 5/20/21 at 3:34 p.m., verified Resident 36 did not have a treatment in place or provided for		completion of treatment as ordered. Director of Nursing/designee will review three residents records weekly that will include new admission to ensure skin assessments and interventions have been completed, documented and changes have been relayed to primary care physician, and responsible parties to ensure compliance.. Care Plans will be updated to reflect skin changes and or changes in resident condition. **4.How the corrective actions will be monitored** **Director of Nursing/Designee is responsible for this Plan of Correction. Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of compliance: 06/10/2021**	

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	his stage 3 pressure ulcer from 4/16/21 to 4/20/21. The DON also verified the resident's record indicated his pressure ulcer treatment was not documented for 5/20/21. The DON indicated it would of been the admitting nurses responsibility to ensure the resident had a treatment in place for his pressure ulcer and the floor nurses responsibility to ensure the treatments were completed as ordered by the physician. The pressure injury and skin condition assessment policy provided by the DON on 5/20/21 at 9:35 a.m., indicated the purpose was to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Dressings would be checked daily for for placement, cleanliness, and signs and symptoms of infection. The treatments would be signed by the staff in the residents electronic Treatment Administration record. 3.1-40(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview and record review the facility failed to investigate the root	F 0689	**F689D Free of Accidents Hazards/Supervision/Devices This Plan of Correction is the**	06/10/2021

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	cause of falls, implement interventions to prevent further falls and failed to conduct an assessment and neurological assessment after a fall for 2 of 3 residents reviewed for accidents (Resident 26 and Resident 41). Findings include: 1. During an interview with Resident 26 on 5/18/21 at 1:06 p.m., indicated he had a fall out of bed and had to go to the hospital. The resident indicated he had reported to the facility that he was fearful of falling out of bed because he tossed and turned a lot, but there was nothing done about it. Observation at this time, the resident was a large man sitting in a recliner, the resident's bed was average size. Review of the record of Resident 26 on 5/20/21 at 11:23 a.m., indicated the resident's diagnoses included, but were not limited to, osteomyelitis of the vertebra, diabetes, bursitis of the right shoulder, body mass index (BMI) 40.0-44.9, anxiety disorder and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment for Resident 26 dated 3/23/21, indicated the resident was independent with daily decision making and was reasonable and consistent. The progress note for Resident 26, dated 3/21/21 at 2:40 p.m., indicated the nurse found the resident on the floor between the bed and the nightstand. The resident reported falling out of bed and had neck pain and stiffness. The resident was kept in the same position until Emergency Medical Services (EMS) arrived and transported the resident to the hospital. The documentation indicated no assessment or neurological		**center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate corrective action(s) for those residents affected by the deficient practice:** Resident #26 no longer resides within facility. Resident #26 was re-assessed, care plan reviewed and modified to reflect root cause and interventions updated. **2) Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** An audit will be completed to identify residents with a fall since 4-1-21 to ensure root cause analysis and updated interventions were present. Any identified issues resulted in re-assessment, with care plan updates with focus on root cause and interventions. **3)Facility measures and systemic changes to ensure the deficient practice does not recur:**	

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	assessment was performed. The progress note for Resident 26, dated 3/21/21 at 3:52 p.m., indicated the resident arrived back to the facility. The documentation indicated no assessment or neurological assessment was performed. The local hospital note for Resident 26, dated 3/21/21 (no time), indicated the resident was being seen for a fall out of bed with head and neck injury. The resident presented with pain down the back of his head and neck. The resident was stable and improved at time of discharge. The resident had a head and cervical spine imaging and they were negative. The record of Resident 26 indicated there were no assessments or neurological assessments performed until 3/24/21. The Interdisciplinary Team (IDT) note for Resident 26, dated 4/20/21, (as a late entry for 3/22/21) indicated the resident was observed to be on floor at bedside. The root cause was "behavior" and the intervention was "educate on call light use for assistance. The plan of care for Resident 26, dated 3/18/21, indicated the resident was at risk for falls related to decreased activity participation. The intervention included, (3/18/21) encourage my participation in activities that will increase strength and mobility to reduce falls. The plan of care had no other fall interventions documented. During an interview with Resident 26 on 5/20/21 at 2:30 p.m., indicated the reason he fell out of bed on 3/21/21 was because his bed was too small and he needed a bariatric bed. The resident had		Licensed nurses will be re-educated on the fall policy, care plan updates, neuro policy/assessments. Licensed nurses will be re-educated on documentation of falls in the electronic health record. **4)Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** DON/designee will complete an audit of all falls on the next business day after the fall to ensure care plans are updated to reflect interventions to prevent falls and neuro checks are initiated as required. Review of those residents that have a fall will be reviewed in daily scheduled stand-up meeting for 72 hours. Director of Nursing/Designee will be responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of Compliance: 6-10-21**	

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requested a bariatric bed from the facility several times prior to falling on 3/21/21. The resident had told staff he was fearful of falling out of bed because it was too small. The resident indicated he hit his head on the night stand or floor when he fell out of bed and that he couldn't remember which one because he was "foggy" headed after the fall. The resident indicated the facility had done "absolutely nothing" to prevent him from falling again. The resident indicated he now slept in his recliner because the bed was too small for him.

During an interview with the Director Of Nursing (DON) on 5/20/21 at 3:12 p.m., indicated she was unable to find any documentation that Resident 26 had an assessment or neurological assessment after his fall on 3/21/21 until 3/24/21. The DON indicated the charge nurse would be responsible to complete an assessment and a neurological assessment after a fall. The DON indicated she thought the resident had a bariatric bed and therapy would be responsible to evaluate residents for bariatric beds. We observed Resident 26's bed at this time and the DON indicated she agreed he did not have a bariatric bed and the resident should have a bariatric bed.

During an interview with the Therapy Manager on 5/20/21 at 3:25 p.m., indicated therapy did not typically evaluate residents for bariatric beds.

The Neurological assessment policy provided by the DON on 5/21/21 at 2:10 p.m., indicated the purpose was to recognize neurological trends and changes in the resident's condition. Neurological assessments may be preformed for 72 hours and/or unless otherwise ordered by the attending physician.

2. The clinical record for Resident 41 was reviewed

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on 5/20/21 at 3:17 p.m. The diagnoses included, but was not limited to, left fibula fracture, lack of coordination and abnormalities of gait and mobility.

A Quarterly Minimum Data Set (MDS) assessment, dated 5/20/21, indicated Resident 41 was cognitively intact.

An interview conducted with Resident 41 on 5/17/21 at 11:44 a.m., indicated he had fallen a few times since he's been here and he fractured his left lower extremity.

A fall care plan, revised 2/3/21, indicated the following, "...I am at risk for falls r/t [related to] decreased mobility, hx [history] of falls, meds, demenita...." Interventions included, but were not limited to, the following:

- Be sure Resident 41's call light in within reach and encourage resident to use it for assistance as needed
- Educate patient on use of call light
- Follow facility fall protocol

A Fall IDT (interdisciplinary team) note, dated 1/11/21, indicated the following, "...Resident was trying to get his flashlight that fell between wall and bed...Root cause of fall: Resident lost balance when he was trying to move bed to retrieve his flashlight...Intervention and care plan updated...Resident educated on use of call light for assistance and to not move furniture, instead ask for assistance...."

The fall care plan was not updated with such intervention until 1/25/21. Resident 41's fall event occured on 1/9/21.

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A progress note, dated 1/31/21, indicated Resident 41 had a witnessed fall in attempt to reach for clothing while on the toilet. Resident 41 proceeded to fall forward and landed on his knees.

A Fall IDT note, dated 2/1/21, indicated the following, "...Resident witnessed falling from toilet onto knees...Root cause of fall: Responding to toileting needs unassisted...Intervention and care plan updated: X-rays 2 view of L [left] knee, L lower leg, and foot per NP [nurse practitioner]...."

There was no specific intervention related to the root cause of Resident 41's fall event on 1/31/21. The fall care plan was not revised with new interventions on, or around, 1/31/21.

A "Fall-Initial Occurrence Note", dated 4/19/21, indicated Resident 41 was found sitting on his bottom beside his bed sitting on his sheets and blanket. He stated he slid off of the bed. The immediate intervention put into place were to educate Resident 41 on not sitting on his linens.

A Fall IDT note, dated 4/20/21, indicated the following, "...Resident observed to be on floor of room at bedside...Root cause of fall: Poor safety awareness...Intervention and care plan updated: Educate and demonstrate use of call light...."

There was no specific interventions added to Resident 41's fall care plan on, or around, 4/19/21. The root cause analysis wasn't specific to what the resident was doing in the event leading up to the fall and determine possible and causative factors.

A policy titled "Falls", revised 2/19/21, was provided by the DON on 5/21/21 at 10:00 a.m. The policy indicated the following, "...Observed or

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	unobserved and reported by staff member. Licensed nurse shall conduct assessment immediately, including events leading up to the fall to determine when possible and causative factors...Document all assessment findings and observations, physician and family notifications in the resident's clinical record in accordance with the assessment guidelines...." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure 2 residents had a bowel and bladder program (Resident 28 and 49), and failed to ensure a resident's catheter drainage bag didn't make contact with the floor and change a suprapubic catheter per physician orders for 1 of 2 residents reviewed for urinary catheter (Resident 18). This affected 3 of 4 residents reviewed for bowel or bladder services. Findings included: 1. During an interview, on 5/17/21 at 01:20 p.m., Resident 28 said he sometimes soils himself waiting for staff to take him to the bathroom, he has to wait awhile for them to take him. Resident 28's record was reviewed on 5/19/21 at 12:17 p.m. The record indicated Resident 28 had diagnoses that included, but were not limited to, type 2 diabetes mellitus, abnormalities of gait and mobility, and lack of coordination. A Quarterly MDS assessment, dated 3/31/21, indicated Resident 28 was moderately impaired in cognitive skills for daily decision making, required extensive assist of 2 for most activities of daily living, was frequently incontinent of bowel and bladder, and has not had a bowl or bladder training program.	F 0690	**F 690D Bowel and Bladder Incontinence** **The facility requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1.) Immediate actions taken for those residents identified:** Residents # 18, #28, and #49were assessed for appropriate toileting program, orders reviewed, and care plans reviewed. Tubing to res#18 was removed from the	06/10/2021

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	A bowel and bladder assessment, dated 10/2/2020, indicated Resident 28 uses a bed pan and commode, wears incontinent briefs, and is frequently incontinent of bowel and bladder. He is able to tell staff when he needs to go. On 5/21/21 at 10:10 a.m., the Director of Nursing indicated she doesn't think he was ever on a bowel and bladder training program. She said he was continent prior to going on hospice, so she doesn't think he was on a bowel and bladder program. She said they toilet him as he puts his light on, after meals, and at bedtime. He was at the hospital in 9/2020, had a catheter, and they removed it after he came here. Then he went on hospice and they transitioned the care over to hospice. Now he wears incontinent briefs. He prefers to go to the shower room bathroom and he takes himself down to that room. She said the only careplan she found was "toilet use: assist as needed" and had looked through the care plans to see if there was a careplan for incontinence, and that was the only careplan she could find for bowel and bladder incontinence. 2. During an interview, on 5/17/21 at 1:39 a.m. Resident 49 indicated she has to wait so long for her call light to be answered that she had already gone (had been incontinent) when they answer her call light, that it happens on every shift, even at night, and said she would be continent if they got to her in time because she was continent when she came in here. Resident 49's record was reviewed on 5/20/21 at 2:36 PM. The record indicate Resident 49 had diagnoses that included, but was not limited to, left lower leg fracture, chronic kidney disease, right hip pain, generalized muscle weakness, and right knee pain.		floor. Supra pubic catheter was changed. **2.) How the facility identified other residents:** Any resident that has an order for catheters for has the potential to be affected. Audit was conducted to identify those residents that currently utilized a catheter, orders reviewed, and care plan updated. Audit completed to identify any resident that is incontinent, assessments completed to determine appropriate toileting programs. No resident was identified to have been adversely affected. **3.) Measures put into place/ System changes:** Facility licensed nursing staff were educated on following physician orders, (changing supra pubic catheter) infection control related to catheter bags on floor and bowel and bladder assessments for those residents identified to be incontinent and appropriate toileting programs. **4.) How the corrective actions will be monitored:** The Director of Nursing / Designee will be the responsible party for this plan of correction. Audits will be conducted 3 times weekly to	

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	A Quarterly MDS assessment, dated 5/3/21, indicated Resident 49 was cognitively intact, required extensive assist of one for toilet use, was occasionally incontinent of urine, always incontinent of bowel, and has not had a trial of a toileting program for bowel or bladder. During an interview on 5/20/21 at 12:20 a.m. Resident 49 was observed seated in her wheelchair and said everything is still the same, that she still doesn't get to the bathroom in time. She was not observed incontinent at that time and did not have any odors. During an interview, on 5/21/21 at 11:08 a.m., the Director of Nursing indicated Resident 49's care plan is missing the initial comprehensive care plan and it wasn't complete. She said it didn't look like Resident 49 was on a toileting program and Resident 49 would be more continent if she was toileted regularly. A policy for "Bowel & Bladder - Assessment & Toileting Programs" was provided by the Director of Nursing on 5/20/21 at 11:00 a.m. The policy included, but was not limited to, "Purpose: Based on the resident's comprehensive assessment the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible...Toileting Programs: To reduce resident incontinence episodes and restore as much bowel and bladder incontinence as possible by trying to identify a voiding pattern and implement a toileting program...." 3a. The clinical record for Resident 18 was reviewed on 5/20/21 at 8:49 a.m. The diagnoses		include all shifts for documentation of ordered catheter care, bowel and bladder assessments completed, and correct placement of catheter tubing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5.) Date of compliance: 6-10-21**	

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included, but were not limited to, neuromuscular dysfunction of bladder, chronic kidney disease and difficulty in walking.

A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/21, noted Resident 18 with moderate cognitive impairment and the use of an indwelling catheter.

An observation conducted on 5/17/21 at 11:29 a.m., noted Resident 18 lying in bed with her catheter drainage bag making contact with the floor.

An observation conducted on 5/20/21 at 8:43 a.m., noted Resident 18 lying in bed with her catheter drainage bag making contact with the floor.

3b. A physician order noted for the changing on Resident 18's suprapubic catheter monthly.

The electronic treatment administration record (ETAR), dated May of 2021, indicated Resident 18's suprapubic catheter was not signed off, as changed, on 5/14/21.

A care plan for catheter use, revised on 6/1/20, indicated the following, "...High Risk for Urinary Tract Infection due to: Suprapubic Catheter r/t [related to] neurogenic bladder...Interventions...Change catheter and drainage bag per MD [medical director] orders...Change catheter per orders...Ensure catheter tubing and drainage bag are properly positioned to prevent urinary back-flow or contamination...."

An interview conducted with the Director of Nursing (DON), on 5/21/21 at 12:00 p.m., indicated physician orders should be followed as written.

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	Resident 18 doesn't like to have her catheter drainage bag in a dignity bag. A policy titled "Urinary Catheter Care", revised 2/14/19, was provided by the DON on 5/20/21 at 11:00 a.m. The policy indicated the following, "...7. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directory. May place drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with the floor or other surfaces...." 3.1-41(a)(1) 3.1-41(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on record review and interview, the facility failed to ensure a resident had a physician's order for dialysis for 1 of 3 residents reviewed for dialysis services. (Resident 17) Findings included: Resident #17's record was reviewed on 5/19/21 at 10:02 a.m. and indicated diagnoses that included, but were not limited, type 2 diabetes mellitus and end stage renal disease. A Quarterly Minimum Data Set (MDS) assessment, dated 2/27/21, indicated Resident 17	F 0698	**F 698 D Dialysis** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared**	06/10/2021

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	was cognitively intact, and received dialysis while a resident. Current physician's orders included, but were not limited to, 1500 ml fluid restriction daily, started 4/23/2020, weight on Monday, Wednesday, Friday, for dialysis weight before and upon returning from dialysis, started 2/19/2021; hold blood pressure meds and insulin before dialysis one time a day every Monday, Wednesday, Friday, started 1/22/2021; and Lidocaine Cream 4%, apply to dialysis access site topically before dialysis every Monday, Wednesday, Friday for pain, started 10/19/20. There was no order for the type of dialysis, nor the dates and times and place the resident would go to dialysis. On 5/21/21 at 10:31 a.m., the Director of Nursing indicated she couldn't find where the order for dialysis was carried over, that 7/11/2020 was the date of the first day of dialysis, and said it just didn't get carried over. A policy for "Physician Orders - Electronic Signing, Confirming and Monthly Review", was provided by the Director of Nursing on 5/21/21 at 2:08 p.m., and included but was not limited to, "...Each month the primary physician or his assigned designee, either a nurse practitioner or a physician assistant, will review the physician orders and diagnoses, and make any corrections prior to electronically signing and dating the monthly recaps...." 3.1-37(a)		**and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:** Residents # 17 had order written for dialysis therapy. Resident #17 has been assessed by primary care physician, and care plan revisions made. **2) How the facility identified other residents:** Any resident that receives dialysis had the potential to be affected. No other resident has been identified. Audit was completed on those residents receiving dialysis, orders were present. **3) Measures put into place/ System changes:** Educated Licensed nursing staff on components/requirements of dialysis orders Residents receiving dialysis will be reviewed during scheduled clinical meetings to determine accuracy and completion of dialysis orders. **4) How the corrective actions will be monitored:** Oversight of this plan of correction is the facility Director of Nursing/designee who will conduct audits on new admissions/readmissions. A daily review of orders conducted during scheduled clinical meetings to determine accuracy. Dialysis resident orders will be reviewed 3 times weekly to determine they	

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			are complete. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of Compliance :6-10-21**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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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
	dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure completion of temperature logs for the monitoring of 1 of 2 medication storage refrigerators. Findings include: An observation was conducted of a medication storage room located off of the main dining room on 5/18/21 at 3:15 p.m. The refrigerator was noted with multiple insulin pens and purified protein derivative (PPD) solution. The temperature of the refrigerator registered at 50 degrees F (Fahrenheit) on the thermostat. The Maintenance Director was notified of such and he wasn't aware of any concerns with the medication storage refrigerator. The Maintenance Director obtained a new thermometer and the temperature was then registering at 39 degrees F when observed at 3:23 p.m. The temperature log was reviewed with the following documentation: 5/1/21- 42 degrees F, No temperature obtained from 5/2/21 to 5/10/21, 5/11/21- 39 degrees F, 5/12/21- no temperature obtained, 5/13/21- 40 degrees F, 5/14/21- 38 degrees F, 5/15/21- 48 degrees F & No temperatures obtained from 5/16/21 to 5/18/21. An interview conducted with the Director of Nursing, on 5/21/21 at 12:00 p.m., indicated the temperature logs should be completed and the staff should alert someone if there were any abnormal findings. A policy titled "Food-Resident Pantry-Safe	F 0761	**F 761 D Storage of Drugs/Biologicals** **The facility respectively requests a desk review for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the practice. **2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Any resident that received medication stored in front medication room refrigerator had the potential to be affected. None were identified. New thermometer was placed, temperature logs	06/10/2021

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	Storage", dated 3/29/21, was provided by the Director of Nursing on 5/20/21 at 9:35 a.m. The policy indicated the following, "...Guidelines...Nursing staff is responsible for daily documentation of temperatures and cleaning of specimen refrigerators and medication room refrigerators...Refrigerators shall be maintained between 33-41 degrees...." 3.1-25(m)		placed, and accurate documentation noted. Medications destroyed in front medication refrigerator. Pharmacy notified. Nursing staff educated on storage of drugs and documentation of medication refrigerator temperatures. 3)**What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:** Education on med storage policy (components of F761) and accurate temperature log documentation was completed by 6-10-21 per the Director of Nursing. Immediate notification to Administrator/Director of Nursing should temps fall below standard. **4)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:** An ongoing audit will be conducted by Director of Nursing/designee on all med room refrigerator temps 3 times per weekly to include all shifts for 6 months until 100% compliance has been met for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of Correction 6-10-21**	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview and record review, the facility failed to ensure communication with staff when an issue occurred to where a high-temperature dish machine was not meeting temperature requirements, dietary staff not having knowledge of the type of dish machine in use, utilizing a dish machine without monitoring temperature based on the dish machine temperature logs, and not initiating a secondary plan to serve meals when the dish machine was identified as not meeting temperature requirements. The facility failed to ensure food was stored properly related to undated and unlabeled food and not covering food items that	F 0812	**F812 F Food Procurement, Store/Prepare/Serve-Sanitary** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	06/10/2021

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	were being served to residents in their rooms. This had the potential to affect all 54 residents that receive food from the kitchen. Findings include: 1. An observation of the kitchen was conducted on 5/16/21 at 11:45 a.m. Dietary Staff 2 and Dietary Staff 4 were present. Dietary Staff 2 indicated he wasn't sure if the dish machine was a high-temperature or a chemical dish machine. Dietary Staff 2 proceeded to ask Dietary Staff 4 about the type of dish machine, and she was unable to verify the type of dish machine as well. Dietary Staff 2 proceeded to run the dish machine to where a wash temperature of 154 degrees and a rinse temperature of 93 degrees was noted. When the machine was running, again, the wash temperature was 151, degrees and the rinse temperature was 100 degrees. The temperature log for the dish machine was reviewed during the observation and indicated below normal temperatures had started on 5/3/21 at lunch time when the wash temperature was 160 degrees, and the rinse temperature was 132 degrees. The temperatures for the rinse cycle remained abnormal until the date of 5/16/21. Dietary Staff 2 indicated himself and Dietary Staff 4 were working double shifts this weekend and it's only the two of them for staffing the kitchen. Dietary Staff 4 was finishing up serving lunch on dishes to all the residents during observation. The dish machine temperature log showed no temperature documented on the following date(s)/time(s): 5/13/21- lunch time, 5/13/21- dinner time, 5/14/21- breakfast time,		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified:** No resident was identified to have been affected. Dish machine was repaired. Temperatures per required standard degrees noted and documented on temperature log. Education provided to dietary staff on dish machine operation, monitoring and documentation of temperatures, implementation of secondary plan to serve meals should temperatures drop below required standards, and food labeling, dating, and covering of food items. **2)How the facility identified other residents:** Any resident residing in the facility had the potential to be affected, however no resident was identified. **3)Measures put into place/ System changes:** Facility staff was educated on the components of F 812. Food Procurement Store/Prep/Serve-Sanitary; and Policy for Food-Resident Pantry-Safe Storage. Dietary staff instructed on dish machine	

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	5/14/21- lunch time, 5/14/21- dinner time, 5/15/21- breakfast time, 5/15/21- lunch time, 5/16/21- breakfast time & 5/16/21- lunch time. Another observation of the kitchen was conducted on 5/16/21 at 1:50 p.m., with Dietary Staff 4. She indicated the Maintenance Director instructed her to finish cleaning all the dishes from lunch and then start the utilization of paper products "because the rinse is too low". Dietary Staff 4 was still unable to clarify what type of dish machine was utilized in the kitchen. The dish machine was observed with a wash temperature of 150 degrees and a rinse temperature of 116 degrees. The machine ran through another cycle to where the wash temperature was 150, degrees and the rinse temperature was 117 degrees. An interview conducted with the Executive Director (ED), on 5/16/21 at 2:00 p.m., indicated the dish machine manufacture company was coming in to fix the machine as soon as possible. They have conducted in-servicing of all kitchen staff about proper temperatures. He reviewed the temperature logs and indicated there appeared to be a concern about the temperatures of the dish machine prior to 5/16/21 but he was not aware of it. He instructed the dietary staff to start utilizing paper products and clarified the dish machine is a high-temperature dish machine. An interview conducted with the Maintenance Director on 5/16/21 at 2:22 p.m., indicated the Dietary Manager made him aware of the "booster pump" not getting as hot as it should but he didn't observe the temperatures when he went to check on it. This occurred on Monday, 5/10/21.		operation, monitoring of temps, and secondary plan to serve meals should dish machine temp out below required standards. Dietary staff will immediately notify the Executive Director/Maintenance director should dish machine temperatures fall below required standards. **4)How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director/designee. Kitchen observation audits will be conducted 2 times weekly per Executive Director designee to include correct labeling, dating, and covering of food items; and correct monitoring/documentation of dish machine temperatures. Identified issues will be corrected immediately with 1-1 education provided as required. Audits will be conducted daily to include all shifts per dietary to determine kitchen sanitation, temperatures of dish machine remain within normal range, and labeling, dating, and covering of food is accomplished. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	The dietary staff utilize the digital temperature monitor because it is calibrated. He brought up an idea to place a meat thermometer in the dish machine to see if it registers at a different temperature. He reached out to the Corporate Director of Maintenance on 5/10/21 about the dish machine concern but the dish machine manufacture company could not make it out to the facility. They asked for the manufacture company to come out on 5/10/21, 5/14/21 or 5/16/21 and they were unable to make it out to the facility. The dish machine manufacture company will be here on 5/17/21. Maintenance Director indicated he was unable to explain why he didn't check the temperature of the dish machine when made aware of the concern from the Dietary Manager, on 5/10/21. An interview with the Maintenance Director, on 5/16/21 at 2:50 p.m., indicated he attempted to utilize the meat thermometer to obtain a temperature of the dish machine and he could only get it to register at 163 degrees. That was for the whole dish machine cycles of wash and rinse. The dish machine has 3 elements and possibly one was out and not making the dish machine reach temperature as it should. He observed the machine on 5/10/21 and there were no leaks or other concerns that he could see first-hand. That was why he contacted the name of the manufacture company for the dish machine due to the parts needed to be supplied by the name of the manufacture company. An "In-Service Sign in Sheet" was provided by the ED on 5/16/21 at 2:12 p.m. The document indicated the following, "...5/16/21...Dishwasher temp [temperature] logs...High temp dishwasher: wash 160 or higher...Rinse 180 or higher...Check temp at each meal...Use paper products until repair		plan of correction as indicated. **5)Date of compliance**: 6-10-21	

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of dishwasher is complete...." The sign-in sheet was signed by Dietary Staff 2 and Dietary Staff 4.

A "Service Order Receipt", dated 1/5/21 was provided by the Maintenance Director on 5/16/21 at 2:22 p.m. The receipt indicated the dish machine manufacture company came to the facility to address a "temperature problem" with the dish machine. There was a bad tank element, and it was replaced with appropriate temperatures after the repair.

Another "Service Order Receipt", dated 2/10/21, indicated the dish machine was leaking and had a "temperature problem". The booster pressure relief valve leaked water. The thermostat and pressure relief valve were replaced with the dish machine operating properly after the repair.

A policy titled "EQUIPMENT AND UTENSIL CLEANLINESS AND SANITATION", undated, was provided by the ED on 5/16/21 at 4:18 p.m. The policy indicated the following, "...To establish guidelines to prevent the spread of infection...12. Temperature control is to be maintained between 120 degrees and 150 degrees F, if machine is low-temperature model. If high temperature model, the temperatures will be maintained as follows...Wash... 155 - 170 degrees F...Power rinse...165 - 180 degrees F...Final rinse...180 - 195 degrees F...13. Dishwashing temperatures will be monitored three times a day by the operator before and during the washing process...."

410 IAC 7-24-285 Warewashing machine; hot water sanitization temperatures
Sec. 285. (a) Except as specified in subsection (b), in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the

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manifold may be not more than one hundred ninety-four (194) degrees Fahrenheit or less than:
(1) for a stationary rack, single temperature machine, one hundred sixty-five (165) degrees Fahrenheit; or
(2) for all other machines, one hundred eighty (180) degrees Fahrenheit.

2a. An observation conducted of hall trays, on 5/16/21 at 11:28 a.m., noted 8 trays stacked on a hall cart with no covering present over the cart itself. There were no lids on the drinks or covering to the piece of pie located on each tray.

On 5/16/21 at 11:43 a.m., an observation of 2 trays were located on a stacked cart just inside the dining room. There was a total of 12 pieces of pie on that cart without a covering over the cart or a covering over the pieces of pie. The same issue was observed on 5/16/21 at 12:05 p.m. with 4 slices of pie remaining on that same cart without a covering.

2b. A kitchen tour was conducted on 5/16/21 at 11:45 a.m., with Dietary Staff 2. The storage refrigerator was observed with 2 bags of a partial onion with no date present, 3 bags of prepared sandwiches with no date present, and 2 cups of cottage cheese, uncovered, with no date. The 2 bags of a partial onion and the 3 bags of prepared sandwiches were discarded. The 2 cups of cottage cheese were removed from the refrigerator and placed on 2 resident trays for consumption.

A policy titled "Food-Resident Pantry-Safe Storage", dated 3/29/21, was provided by the Director of Nursing (DON) on 5/20/21 at 9:35 a.m. The policy indicated the following, ""...Food or beverages used for multiple residents will have "date opened" written on the container...Food

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	items, condiments and liquids that are NOT in the original container shall be discarded 3 days after the date labeled on the container...."" 3.1-21(i)(1) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in			

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	compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure an inventory of a resident's	F 0842	**F 842 Resident record** **The facility requests paper**	06/10/2021

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	personal belongings was signed and dated on admission and discharge by the resident or his representative and a facility staff member. This affected 1 of 3 residents reviewed for closed records. (Resident B) Findings include: Resident B's record was reviewed on 5/18/21 at 2:23 p.m. The record indicated Resident B was admitted on 4/20/21 and was discharged on 5/4/21. Resident B had diagnoses that included, but were not limited to, gait and mobility abnormalities, lack of coordination, chronic respiratory failure with hypoxia, and generalized abdominal pain. Review of the record failed to indicate an inventory of the resident's personal belongings was documented, signed, and dated upon admission or discharge by the resident or a representative, and a staff member. On 5/18/21 at 7:47 p.m., a family member indicated they did not have an inventory list, they were given items from his room and they didn't know what he had brought in. The family member said there was nothing to sign that they had received all the items he had brought in with him or took when he left. During an interview, on 5/21/21 at 9:59 a.m., the Director of Nursing indicated the "Personal Effects Inventory" is a new form that activities has been using and they will have to update it with a place for staff and residents to sign and date. She said she doesn't know how many residents have had this form used for them. During an interview, on 5/21/21 at 1:39 p.m., the Director of Nursing indicated they didn't have a		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.Immediate actions taken for those residents identified: Resident B no longer reside in the facility. Audit will be completed on all residents to ensure an inventory of resident belongings will be done upon admission, discharge or edited when items are brought in or sent home.** **2.How the facility identified other residents:** **All residents belongings will be checked for accuracy and discrepancy items will be added to inventory sheets and it will signed by resident or family per facility policy.** **3. Measures put into place/ System changes:**	

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	policy for filling out an inventory sheet, and going forward they are using a form that they can put the signatures and dates on. This Federal tag relates to Complaint IN00353375. 3.1-50(a)(1)		Nursing staff will be educated on completion of inventory sheets upon admission, discharge or when there is change in inventory. Director of Nursing/designee will review three residents records weekly x 6 months that will include new admissions discharges and readmission to ensure compliance. **4)How the corrective actions will be monitored:** Director of Nursing/Designee is responsible for this Plan of Correction. Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5.Date of compliance: 06/10/2021**	
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			

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	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; §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			

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	155704	A. BUILDING 00 B. WING	05/21/2021

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	(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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to disinfect glucometers with an EPA (Environmental Protection Agency) approved disinfectant for 2 of 9 residents reviewed for medication administration. (Resident 17 and Resident 24) Findings include: A medication administration observation was conducted on 5/16/21 at 4:22 p.m. with Licensed Practical Nurse (LPN) 5. LPN 5 proceeded to check	F 0880	**F880 D Infection Prevention and Control** **The facility respectfully requests paper compliance.** Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth, or the facts alleged, or the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the	06/10/2021

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	Resident 17's blood glucose with the glucometer. He then removed his gloves and pumped alcohol-based hand sanitizer into his hand and rubbed it all over the glucometer. He indicated he allows the alcohol-based hand sanitizer to dry before utilizing the glucometer on another resident. Continued observation of LPN 5 conducted, on 5/16/21 at 4:40 p.m., to where he took the same glucometer and obtained Resident 24's blood glucose. LPN 5, again, removed gloves and placed alcohol-based hand sanitizer on his hands and applied all over the glucometer. LPN 5 indicated he would utilize Sani Wipes or bleach wipes but did not have any available during medication administration. An interview conducted with Qualified Medication Aide (QMA) 10, on 5/17/21 at 11:30 a.m., indicated she has utilized alcohol prep wipes before to clean the glucometers when she was out of Sani Wipes or bleach wipes. A policy titled "Glucometer Cleaning", dated 4/21/21, was provided by the Director of Nursing (DON) on 5/20/21 at 9:35 a.m. The policy indicated the following, "...To prevent the growth and spread of microorganisms and bloodborne pathogens...The blood glucose monitor should be cleaned and disinfected between each use...Procedure...3. Clean and disinfect meter using pre-moistened wipe of 1ml [milliliter] or 5-6% sodium hypochlorite solution [household bleach] and 9ml water to achieve a 1:10 dilution concentration...4. Wipe meter with 1:10 solution bleach wipe until all surfaces of the glucometer are visibly wet. DO NOT wipe inside battery compartment...5. Discard bleach wipe...6. Place meter on clean surface such as a paper towel and allow to air dry for no les [sic] than 3 minutes or according to manufacturer instructions...."		health and safety code section 1280 and 42CFR 483. This plan of correction constitutes the facility's written credible allegation of compliance. **1)What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** LPN #5 identified in the cited practice were re-educated per Director of Nursing on cleaning/disinfecting glucometers prior to and after use. Residents #17 and # 24 had no adverse effects identified. Director of Nursing/designee will ensure that Sani Wipes/Bleach wipes are always available on medication carts for cleaning/disinfecting purposes. **2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Any resident receiving accu-checks had the potential to be affected, none were identified. **3.) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Facility licensed nursing staff members received directed in servicing by the Director of	

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	The manufacturer guidelines, undated, was provided for the glucometer the facility utilizes by the DON on 5/20/21 at 11:03 a.m. The guidelines indicated the following, "...Cleaning and Disinfecting Procedures...Step 1... Wear appropriate protective gear such as disposable gloves...Step 2...Open the cap of the disinfectant container and pull out 1 towelette and close the cap...Step 3...Wipe surface of the meter to clean blood and other body fluids...Step 5...Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens...Step 6...Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions...." The EPA's "Registered Antimicrobial Products Effective Against Human HIV-1 and Hepatitis B Virus", dated 2/22/2021, did not include alcohol-based hand sanitizer and/or the use of alcohol prep pads for proper disinfectanting of surfaces. 3.1-18(b)		Nursing on cleaning and disinfecting glucometers. Individual glucometers were provided for each resident that requires accu-checks. Education (IC) will occur upon hire, quarterly, annually, and as needed. DON/Designee will complete daily visual rounds of glucometer cleaning throughout the facility to include all shifts, to ensure staff are practicing appropriate Infection Control Practices and remain compliant. This will continue for 6 weeks to determine compliance has been maintained thereafter random bi-weekly observations to include all shifts will be implemented. Review of observations will be discussed during daily stand-up meetings to address concerns. Identified issues will be corrected immediately upon identification with 1-1 education and or disciplinary measures. **4.) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The responsible party for this plan of correction will be the Director of Nursing/Designee with Executive Director oversight. The results of audits/observations will be reviewed in Quality Assurance Meeting for 6 months or until	

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			100% compliance has been maintained. The facility through the QAPI program, will review, update, and make changes as needed for sustaining substantial compliance for no less than 6 months. **5.) DOC** 6-10-21	