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
	155289	A. BUILDING 00 B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL OAKS HEALTH CARE CENTER	4725 S COLONIAL OAKS DR MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 13, 14,15, 16, and 17, 2022 Facility number: 000186 Provider number: 155289 AIM number: 100266300 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 28 Medicaid: 48 Other: 15 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 22, 2022.	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance. ="" p="">	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in			

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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	a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:			

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	(i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.			

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	§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to provide notification of transfer or discharge to a resident or the resident's representative and failed to provide notification to the Long Term Care Ombudsman for 1 of 5 residents reviewed for hospitalizations (Resident 66). Findings include: Resident 66's clinical record was reviewed on 6/15/22 at 9:12 a.m. Her nurses notes indicated, but was not limited to the following: On 4/27/22 at 9:20 a.m., she had a leave of absence to a hospital for surgery. On 4/28/22 at 8:03 p.m., she returned to the facility by ambulance. On 5/30/22 at 4:45 a.m., she had increased confusion, an order was received to send her to the emergency room. On 6/2/22 at 10:36 p.m., she returned to the facility by ambulance.	F 0623	Resident #66 had no adverse reactions as a result of this deficient practice. Resident #66's transfer or discharge notification forms for both hospitalizations were completed and placed in the residents electronic medical record. The local Long Term Care Ombudsman was made aware of the facility-initiated transfers. All other residents residing in the facility that have facility-initiated transfer and/or discharges have the potential to be affected by this deficient practice. Facility initiated transfers and/or discharges for the previous thirty days have been reviewed. The facility policy and procedure for Notice of Transfer or Discharge was reviewed and no changes were indicated. Facility staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for Notice of Transfer or Discharge. The SSD and/or designee will complete the Transfer/Discharge audit form (Attachment A). The	07/14/2022

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	Her clinical record lacked a transfer or discharge notification for both hospitalizations. During an interview, on 6/17/22 at 9:03 a.m., the Social Service Director indicated when residents were discharged to home or another facility, she completed the transfer or discharge notification form and it was included in the discharge packet. For residents who were sent to the hospital she ran a report at the end of the month and completed a transfer or discharge form was sent to the Ombudsman. She was observed running a hospitalization report for both hospitalizations for Resident 66 and neither hospitalizations were on the report. She indicated it maybe something they need to figure out and the Ombudsman had not been notified for either hospitalizations. During an interview with the Interact Nurse, on 6/17/22 at 11:23 a.m., she indicated when a resident was sent to the hospital the resident's code status, medication list, last physician notes, recent labs and x-rays, and the transfer/discharge and bedhold policy was sent with the resident. A current policy, titled "Notice of Transfer or Discharge," provided by the DON, on 6/17/22 at 1:28 p.m., indicated the following: "...Procedure...8. The nursing facility must place a copy of the notice in the resident's medical record and transmit/provide a copy to the following: a. The resident/resident representative; b. A family member of the resident, if known; c. The resident's legal representative, if known; d. The local Long Term Care Ombudsman program for any facility-initiated transfer...." 3.1-12(a)(6)(A)		random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the SSD and/or designee will randomly complete the Transfer/Discharge audit form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on observation, interview, and record review, the facility failed to ensure residents did not receive psychotropic medications without indication for use for 1 of 5 residents reviewed for unnecessary medications (Resident 67). Findings include: On 6/14/22 at 2:07 p.m., Resident 67 was observed in bed. On 6/15/22 at 9:31 a.m., she was in bed. During a wound observation, on 6/15/22 at 10:51 a.m., she asked the nurse for a pain pill for pain in her bottom and her shoulder. On 6/15/22 at 1:12 p.m., she was standing up at the side of her bed holding onto her overbed table talking with roommate. On 6/16/22 at 9:51 a.m., she was in bed. On 6/17/22 at 10:56 a.m., she was in bed. Resident 67's clinical record was reviewed on 6/14/22 at 1:59 p.m. Diagnoses included, but was not limited to, major depressive disorder single episode, anxiety disorder, cognitive communication deficit, unspecified dementia	F 0758	Resident #67 has had no adverse reactions as a result of this deficient practice. Resident #67's medication was reviewed by the facility Psychiatric Nurse Practitioner and reduced accordingly. All other residents residing in the facility that receive psychoactive medication have the potential to be affected by this deficient practice. All residents on psychoactive medication have been reviewed to ensure there is a schedule for gradual dose reduction in place unless clinically contraindicated by the Psychiatrist or Physician. The facility Psychiatric Nurse Practitioner will continue with monthly review and management of residents receiving psychoactive medication. The facility policy and procedure for Psychoactive Medications/Gradual Dose Reduction was reviewed and no changes were indicated. Facility staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for Psychoactive Medications/Gradual	07/14/2022

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	without behavioral disturbance, other malaise, abnormal weight loss, low back pain and chronic pain syndrome. She admitted to the facility on 9/30/21. Her orders included but, were not limited to, sertraline (anti-depressant) 75 mg (milligram) daily for major depressive disorder single episode (9/30/21) and mirtazapine (anti-depressant) 30 mg daily for major depressive disorder single episode (9/30/21). A quarterly MDS (Minimum Data Set), dated 5/18/22, indicated she was moderately cognitively impaired. A resident mood interview indicated she felt tired or having little energy two to six days and she had a poor appetite or overeating seven to eleven days (half or more of the days). She did not exhibit behaviors. Her PHQ9 (Patient Health Questionnaire) score indicated she had normal or minimal depression. She received an anti-depressant. A 10/1/21 revised care plan indicated she had a diagnosis of depression and presented with signs/symptoms of depression such as poor appetite. Depression may be related to loss of loved one and/or disease process. Her goal was she would not display major depressive signs/symptoms such as self isolation; crying/tearful revised on 5/5/22. Her interventions were initiated on 10/1/21 and included, she would receive her medications as ordered, she would receive psychiatric services as needed, family involvement would be encouraged, emotional support and assistance would be provided as needed. A 10/4/21 revised care plan indicated she had		Dose Reduction. The SSD and/or designee will complete the Behavior and Psychoactive medication review form (Attachment B) The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the SSD and/or designee will randomly complete the Behavior and Psychoactive medication review form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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anxiety as evidenced by history of anxiety, depression; change in environment and health status. Her goal was that her care plan interventions would maintain her anxiety as evidenced by her PHQ-9 score of five or less revised on 5/5/22. Her interventions were initiated on 10/1/21 and included medications as ordered and mental health services.

A 3/18/22 revised care plan, indicated she had behavioral symptoms such as asking my roommate to feed her, repetitive verbalizations, delusions, yelling/screaming, cursing, related to cognitive deficit and major depression. Her goal was her behavioral symptoms would be managed through her care plan interventions as evidenced by three or less episodes through her care plan interventions revised on 5/5/22. Her interventions were initiated on 2/14/22 and included, allow her to express her feelings, approach her from the front and make sure you had her attention, encourage her family to actively participate with her behavior plan and medications as ordered

Her interdisciplinary psychopharmacological reviews, nurses notes and behavioral sheets included the following:

An interdisciplinary psychopharmacological review, dated 10/25/21 at 3:50 p.m., indicated she received mirtazapine 30 mg at bedtime for depression and sertraline HCL (Hydrochloride) 75 mg one time daily for depression. Her behavior target(s) to quantify was adjustment to new environment. Her antidepressant criteria was she was withdrawn to self. The IDT (Interdisplinary Team) reviewed her medications and did not recommend a GDR (Gradual Dose Reduction) at that time. She was new to the facility and was still trying to adjust to her long term stay at the

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facility.

An interdisciplinary psychopharmacological review, dated 11/30/21 at 4:23 p.m., indicated she received mirtazapine 30 mg at bedtime for depression and sertraline HCL 75 mg one time daily for depression. Her behavior target(s) to quantify was adjustment to new environment and poor appetite. Her antidepressant criteria was she was withdrawn from interests and withdrawn to self. The IDT team reviewed her medications and did not recommend a GDR at that time. She was still trying to adjust to her long term stay in the facility.

On 12/31/21 at 4:20 a.m., she had been sleeping throughout the night. No depression noted but the nurse had noted some crying off and on during the day.

On 1/2/22 at 9:06 a.m., she remained on alert charting due to monitoring for signs and symptoms of depression. She remained in bed and slept most of the day.

On 1/3/22 at 3:11 a.m., she remained on alert charting for signs of depression. She had slept through the night without difficulty. She remained friendly and cooperative with staff, and showed no signs of depression at that time.

On 1/4/22 at 1:35 p.m., she stayed in room and mostly in bed. She lacked motivation to get up and made frequent negative statements. (nobody cares, why should I do anything, i.e.)

On 1/5/22 at 1:37 p.m., she stayed in bed most of day, did not have any interest in doing anything, she said what was the point, there was nothing she wanted to do.

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	On 1/21/22 at 1:30 p.m., Resident 67's sister telephoned the facility because Resident 67's roommate called her and told her that Resident 67 was very ill. The nurse explained the conversation that was had at the noon med pass. Resident 67's sister stated that she believed Resident 67 was depressed because she had not been able to visit and that her sister would be coming that afternoon to see Resident 67. No further concerns were voiced. The nurse would alert social services of the issue with roommate calling Resident 67's family member. A behavior sheet, dated 1/27/22 at 1:02 p.m., roommate was found feeding Resident 67 in their room and said she couldn't feed herself because her bottom hurt too much. Staff offered to feed her and she said her roommate would feed her. The roommate finished feeding her but she said she might want staff to feed her more later. She tried to get others to do things she was able to do herself. On 2/21/22 at 2:32 p.m., the pharmacy recommended a GDR of sertraline and was denied by the nurse practitioner. An interdisciplinary psychopharmacological review, dated 2/21/22 at 2:42 p.m., indicated she received mirtazapine 30 mg at bedtime for depression and sertraline HCL 75 mg one time daily for depression. Her behavior target(s) to quantify was adjustment to new environment and poor appetite. Her antidepressant criteria was withdrawn from interests and withdrawn to self. The IDT team reviewed resident's medications and a GDR was not indicated at that time. She struggled with being in the facility and not at home. She has had some attention seeking behaviors.			

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A behavior sheet, dated 3/5/2022 at 8:23 a.m., indicated upon giving resident medication that a.m., she became very aggressive, yelling "Why are you holding me hostage? Why have you kidnapped me? Are you broke? What's wrong with you? I had to pi-- in the bucket over there because you are keeping me here! I hope you all get the electric chair and they fry your a----!" The writer calmly explained to her, she was here currently for wound healing and the writer had some medications for her to take. She was resistive and she insisted staff was trying to poison her.

A behavior sheet, dated 3/6/22 at 12:31 p.m., indicated she walked around her room unassisted and unsteady on feet. Her roommate alerted staff to the situation. Staff entered the room to assist her to bed. She yelled at staff members, proclaiming "Why are you holding me hostage? Are you broke? Why are you keeping me here?" Unable to reorient resident at that time, but was able to assist her safely to bed.

On 3/16/22 at 1:42 p.m., she took off her wound vac that a.m. She said she did not know what it was for and it was replaced by the wound nurse. It was reiterated to her how important it was to keep it on. She was very confused and argumentative.

A social service behavior note, dated 3/18/22 at 12:31 p.m., indicated as per behavior sheet written on 3/5 at 8:23 a.m. and 3/6 at 12:31 p.m.; she had repetitive questions, delusions, yelling/screaming, cursing - on 3/5 she became aggressive during a.m. med pass, yelled "why are you holding me hostage? why have you kidnapped me?, what's wrong with you?, are you broke?, I had to pi-- in the bucket over there because you were keeping

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	me here!" and numerous other accusations. (see behavior note). On 3/6 she walked around unassisted and unsteady on her feet. Staff alerted to room by roommate. When staff entered room to assist her to her bed she yelled at them, "why are you holding me hostage, why are keeping me here, are you broke?". Staff unable to be reoriented but was able to assist her safely to bed. Interventions used for both behaviors; approached in calm manner, identified self, established eye contact, called her by name, explained what they were going to do, used simple sentences, tasks broken down in small steps, non-verbal cues given, didn't argue or confront, offer fluids, offered a snack, changed a position, talk with her, validated her feelings, left alone and re-approached, medication was given. The outcome and prevention was the interventions were tried and the behavior was unchanged, her behaviors were care planned. She was to be seen by the nurse practitioner. On 3/20/22 at 5:02 a.m., she remained on alert charting for behaviors, for pulling off wound vac. No behaviors noted at that time. She asked about the wound vac, but it was causing some minor discomfort from her brief being bunched up in the back. The wound vac was in place and functioned at that time. An interdisciplinary psychopharmacological review, dated 3/28/22 at 2:27 p.m., indicated she received mirtazapine 30 mg at bedtime for depression and sertraline HCL 75 mg one time daily for depression. Her behavior target(s) to quantify was adjustment to new environment and poor appetite. Her antidepressant criteria was she was withdrawn from interests and withdrawn to self. The IDT team reviewed her medications and a GDR was not indicated at that time. She			

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continued to adjust to the nursing home. A GDR would cause emotional harm to her.

On 3/29/22 at 1:39 p.m., the pharmacy recommendation for GDR of mirtazapine was denied by the nurse practitioner. The reason being that a GDR was not indicated at that time. She continued to adjust to the nursing home. A GDR would cause emotional harm to the resident.

An interdisciplinary psychopharmacological review, dated 5/31/22 at 5:45 p.m., indicated she received mirtazapine 30 mg at bedtime for depression and sertraline HCL 75 mg one time daily for depression. Her behavior target(s) to quantify was adjustment to new environment and poor appetite. Her antidepressant criteria was she was withdrawn from interests and withdrawn to self. The IDT team reviewed her current medications and did not recommend a GDR at that time.

During an interview with the SSD (Social Service Director), on 6/17/22 at 9:14 a.m., she indicated Resident 67 had not had any behaviors since March when she was agitated. She had two behaviors in March and one in January, yelled at staff that she was kidnapped and why was she at the facility. She came to facility on the antidepressants.

During an interview with the SSA (Social Service Assistant), on 6/17/22 at 9:22 a.m., she indicated she thought she was on remeron for appetite but she was on it for depression, she should had been on it for appetite. Her appetite was poor and couldn't get hungry. She still struggled with being at the facility and her family says she still wanted to go home. She liked to lay in bed. The behaviors since she had been at the facility was on 1/27/22,

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3/5/22 and 3/6/22. She would be looked at again for GDR in August. The new psychiatric provider may see her sooner. She was not wanting to eat and not motivated and did not socialize, family brought in snacks that she liked and she liked her cokes. She self isolated. Her previous stay at the facility she was friendly, carried on conversations and talked to others. Since she readmitted she was not very happy that she was at the facility.

During and interview with the DON, ADON, SSD and SSA, on 6/17/22 at 11:41 a.m., the SSA indicated Resident 67 slept a lot and was hard to stir, she stopped into see her but it was hard to stir around and wake her up. The DON thought she was depressed and she wanted to stay in bed all the time, loss of her role and was not going home. Her family and activities had tried to get her out of the room. SSA indicated she believed Resident 67 was depressed and had not adapted to the facility, for along time she said she wanted to go back home and felt like she just lost her will. Her appetite was almost non existent.

A current policy titled, "Psychoactive Medications/Gradual Dose Reduction Policy," provided by the DON, on 6/17/22 at 11:34 a.m., indicated the following: "Policy: It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status. To ensure the resident is receiving the necessary medication at the lowest effective dose with an appropriate diagnosis. To ensure gradual dose reduction attempts are made unless contraindicated...."

3.1-48(a)(1)
3.1-48(a)(4)

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 ensure a urinary catheter was managed in a hygienic manner for 1 of 1 residents reviewed with a urinary catheter (Resident 33). Findings include:	F 0880	Resident #33 had no adverse reactions as a result of this deficient practice. Resident #33's catheter tubing was adjusted to prevent the urinary catheter tubing from touching the floor. All other residents residing in the facility that require a catheter for urinary	07/14/2022

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	On 6/13/22 at 10:04 a.m., he was in the hallway, in his wheelchair. His urinary catheter tubing was coming from the leg of his pants and the urinary catheter tubing was lying on the floor On 6/13/22 at 11:02 a.m., he sat in his room, in his wheelchair. His urinary catheter tubing was coming from the leg of his pants and the urinary catheter tubing was lying on the floor, he indicated his catheter leaks at night. On 6/16/22 at 9:48 a.m., he sat in his room, in his wheelchair. His tubing from his urinary catheter was coming from the leg of his pants. His urinary catheter drainage bag was partially lying on the floor. On 6/16/22 at 2:10 p.m., he sat in his room in his wheelchair. His tubing from his catheter was coming from the bottom of his pant leg and his urinary catheter tubing was lying on the floor. On 6/16/22 at 2:18 p.m., Nursing Assistant 22 indicated she would lift his tubing up a little higher and it was not supposed to be on the floor. On 6/16/22 at 2:51 p.m., he sat in his room, in his wheelchair. His urinary catheter tubing was coming from the bottom of his pant leg and his left foot was on top of the urinary catheter tubing lying on the floor. On 6/16/22 at 3:31 p.m., LPN 14 was taking his blood pressure as he sat in his wheelchair in his room. His urinary catheter tubing was lying on the floor. She indicated he just wiggles and she would take care of it. Resident 33's clinical record was reviewed on 6/15/22 at 10:23 a.m. Diagnoses included, but was		elimination have the potential to be affected by this deficient practice. All residents residing in the facility that require a catheter for urinary elimination have been reviewed to ensure appropriate catheter tubing placement. The facility policy and procedure for Catheter Use Care was reviewed and no changes were indicated. Nursing staff were reinserviced by the Director of Nursing regarding the facility policy and procedure for Catheter Use Care. The DON and/or designee will complete the Urinary Catheter Review form (Attachment C). The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Urinary Catheter Review form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	

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	not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease stage 3, malignant neoplasm of prostate, hematuria and other obstructive and reflux uropathy. His current orders included, but were not limited to, cleanse area of supra pubic placement daily and cover with fenestrated boarder dressing daily and as needed, maintain suprapubic catheter and to be changed by doctor monthly and change catheter collection bag every 30 days and as needed. A quarterly MDS (Minimum Data Set) dated 4/27/22, indicated he was moderately cognitively impaired. He was totally dependent with toileting. He required extensive assistance with one staff member for personal care. He had an indwelling catheter. A 1/27/22, revised care plan indicated he had a suprapubic catheter related to diagnosis of malignant neoplasm of prostate. His interventions included, but was not limited to, catheter care every shift, change catheter system when clinically indicated or ordered, he would receive teaching on how to care for my catheter and personal hygiene needs, proper positioning of the drainage bag dated 4/14/2022. A current policy titled, "Catheter use care policy," provided by the Interact Nurse, on 6/17/22 at 11:31 a.m., indicated the following: "...General Considerations...6. The drainage bag and tubing should not touch the floor at any time...." 3.1-18(a)		The facility will ensure this requirement is met through application of the following Directed Plan of Correction. No residents were negatively affected by this practice. All residents who reside in the facility that require a catheter for urinary elimination have the potential to be affected by this practice. Root cause analysis Findings: During the facility visit for Recertification and State Licensure Survey, the surveyors noted the facility staff failed to ensure that a resident’s urinary catheter tubing was managed in a hygienic manner. What: • Staff to ensure indwelling catheters are cared for in a manner to prevent the possibility of infection. • Staff to ensure indwelling catheters are placed below the level of the bladder and catheter drainage bag and tubing are positioned off the floor at all times. Why: • Urinary catheter tubing was lying/touching the floor • Staff not ensuring that urinary catheter tubing is managed in a hygienic manner • Staff failing to provide resident with teaching/education regarding catheter care. Immediate Corrective Action: Nursing staff were inserviced	

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			regarding facility Catheter Use Care policy and procedure. Root Cause Analysis (RCA) and LTC infection control self-assessment reviewed and completed as indicated. Corrective Measures: • Reeducation and inservice with staff/resident including: o Facility Policy and Procedure for Catheter Use Care o Resident teaching/education regarding catheter care. Summary: • Root cause analysis determined the need for Facility IP nurse and/or DON to ensure a persistent increase in frequency of reeducation and auditing to assure the appropriate utilization and management of urinary catheter devices in a hygienic manner. The DON and/or designee will complete the Urinary Catheter Review form (Attachment C). The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Urinary Catheter Review form to ascertain continued compliance at least	

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			biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. Survey findings, root cause analysis reviewed with corporate IP, Medical Director, Administrator, Facility IP nurse, and Facility Director of Nursing. The plan of action was agreed upon.	
F 9999 Bldg. 00	3.1-14 Personnel (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure CNA certification was current and active for 1 of 41 Certified Nurse Aides' (CNA) reviewed (CNA 39). Findings include: Review of Employee Records was completed on 6/14/22 at 9:00 a.m. CNA 39's nurse aide certification had expired on 3/31/22 and had not been renewed.	F 9999	Employee #39's expired nurse aide certification had no adverse effects towards resident care. All residents receiving care/assistance have a potential to be affected by this deficient practice. Facility staff were reinserviced by the Director of Nursing regarding process for certification/license renewal. The Human Resource Director (HR) will randomly audit 5 employees weekly for four weeks, every other week for four weeks, then monthly thereafter utilizing the Employee Certification/License audit form (Attachment D). Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as	07/14/2022

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	During an interview, on 6/15/22 at 9:37 a.m., the Human Resources Director indicated certification renewals were the responsibility of the employee. She completed periodic checks for CNA and QMA certifications expiration. She was not aware CNA 39's certification had expired. The CNA worked full time, primarily on Hickory Lane. Review of CNA 39's time sheet for May 15- June 15, 2022 indicated she had worked 124.75 hours over the one-month period.		determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the HR and/or designee will randomly complete the Employee Certification/License audit form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The HR report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly.	