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
	155650	A. BUILDING 00 B. WING	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00395090, IN00395441, IN00400848 and IN00401857. Unrelated deficiencies are cited. Survey dates: February 28 and March 1, 2023 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 16 Medicaid: 49 Other: 11 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/6/23.	F 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully request a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a resident had a Physician's Order and an assessment to	F 0554	**F554** **What corrective action(s) will be accomplished for those residents found to have been**	03/17/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Gatson	Administrator	03/17/2023

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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	self-administer their own medications for 1 of 1 resident rooms observed for medications at the bedside. (Resident C) Finding includes: During an observation on 2/28/23 at 5:28 a.m., LPN 6 entered the room to answer the call light that had been activated. Resident C indicated he needed incontinence care. LPN 6 informed him she would inform his CNA. During an observation on 2/28/23 at 5:32 a.m., Resident C was lying in bed. There were two pills in a plastic cup next to a half glass of water sitting out of reach from the resident on the over the bed table. The resident indicated the medications were brought into the room at around 5 a.m. and no one had awakened him to take the medications. Incontinence care was then provided to the resident by CNA 1 and CNA 2. At 5:57 a.m. on 2/28/23, CNA 2 placed the over the bed table within reach of the resident. The resident then placed the medication in his mouth followed by a drink of water. During an interview on 2/28/23 at 6:02 a.m., LPN 6 indicated medication was not to be left at the bedside. The medications in the cup were Kepra (seizure medication) and levothyroxine. Resident C's record was reviewed on 2/28/23 at 1:39 p.m. The diagnoses included, but were not limited to morbid obesity and colostomy. A Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated an intact cognitive status.		**affected by the deficient practice;** L.P.N #6 was immediately re-educated not to leave medications at the bedside. Resident C – did not have any adverse effects from the medication. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nursing staff were re-educated on: · Self-administration and Medication Storage policy including items needed such as an assessment and physician's order. · Not leaving medications at the bedside. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will conduct random observations of medication pass for 5 residents on alternate	

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	The Physician's Orders, dated 8/28/22, indicated Kepra 750 milligrams and levothyroxine 25 micrograms were to be administered between 4 a.m. and 7 a.m. There was no self-administration of medication assessment or order in the record. A self-administration of medication policy, dated 10/2014 and received as current from the Corporate RN, indicated residents who chose to self administer medications would be assessed for the ability to self administer medications. A medication administration policy, dated 10/2014 and received as current from the Corporate RN, indicated, residents were allowed to self-administer medications when specifically authorized by the physician and in accordance with the procedures for self-administration medication. The resident was to always be observed for the medication administration. 3.1-25(m)		shifts 3 times weekly for 6 months to ensure medications are not left at the bedside without following the self-administration of medication policy. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure extensive to dependent residents received necessary care and services in a timely manner, related to activities of daily living (ADLs) of incontinent care and repositioning for 2 of 5 residents reviewed for incontinent care and repositioning. (Residents C	F 0677	**F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C – Incontinent care was	03/17/2023

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	and G) Findings include: 1. During an observation on 2/28/23 from 5:32 a.m. through 6:00 a.m., CNA 1 and CNA 2 entered Resident C's room and began incontinence care and colostomy care. The resident was wearing a brief and inside the brief there were two urine saturated bath towels and the creases of the groin had a dried caked white substance. The scrotum and penis were pinkish/red in color, and there was a strong urine odor in the room. CNA 2 indicated the resident chose to have the bath towels in the brief. CNA 1 indicated the the last time incontinence care had been completed was at 1:00 a.m. The resident indicated the last time he had incontinence care was around 9 or 10 p.m. the last evening. CNA 1 informed the resident he had not waken the resident up when incontinence care was given at 1 a.m. CNA 2 indicated she had not assisted in the 1 a.m. incontinence care. The resident required both CNA 1 and CNA 2 to assist the resident to onto his right side. CNA 1 placed a new plastic bag around the end of the colostomy bag and emptied the contents of the colostomy into the plastic bag. When finished emptying the bag, the opening of the colostomy bag was wiped with a towel then clamped shut There had been no drainage from the colostomy bag prior to the emptying of the bag. The back of the brief was saturated with dark brown liquid, and the incontinent pad under the resident had dried beige color stains/rings and the bottom sheet of the bed had dried beige color stains/rings with some red drainage on the sheet. CNA 1 indicated the drainage on the pad and sheet was from the colostomy. The brief, incontinent pad, and bottom sheet were changed with effort from both CNA's required to turn the resident from side to side in		provided immediately. Resident G – Incontinent care was provided immediately and resident was repositioned. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-educated on providing residents assistance with ADL care including timely incontinence care and repositioning dependent residents. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly observe 6 residents weekly for 6 months with a focus on dependent residents to ensure assistance with ADL care including timely incontinence care and repositioning is completed. Nurse manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

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	the bed. Resident C's record was reviewed on 2/28/23 at 1:39 p.m. The diagnoses included, but were not limited to morbid obesity and colostomy. A Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated an intact cognitive status, required extensive assistance of two or more staff for bed mobility, was incontinent of urine, and had a ostomy for bowel movements. The Care Plans indicated: On 3/15/22, had increased excoriation. The interventions included, the skin and linens were to be kept clean and dry and the excoriation was to be treated per the Physician's Orders. On 4/9/21, required assistance with toileting. The interventions included incontinence care would be provided as needed. On 9/20/21, bladder incontinence was present. The interventions included incontinence care would be provided after each incontinent episode. A Physician's Order, dated 1/9/23, indicated Triad Paste (zinc oxide based paste) was to be applied to the groin every evening shift. 2. Observations of Resident G on 2/28/23 were as follows: At 5:25 a.m. and 6:02 a.m., Resident G was lying on her back. The bed was flat, and she was asleep. At 7:28 a.m., she remained asleep and lying on her back. CNA 3 entered the room, then walked out without any care provided. At 8:27 a.m., the breakfast tray was delivered to		Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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the room. The head of the bed was elevated by CNA 3, the breakfast tray was set up, and the resident remained on her back.

At 8:55 a.m., she remained in a sitting position in the bed with her head of the bed up and was feeding herself small bites of breakfast.

At 9:12 a.m., she remained on her back in a sitting position in bed. She indicated she was done with the breakfast.

At 9:21 a.m., she remained on her back in a sitting position in bed. The Unit Manager entered the room and removed the breakfast tray from the room.

At 9:30 a.m., she remained on her back in a sitting position in bed.

At 9:40 a.m., her eyes were closed, she remained on her back. The head of the bed remained elevated. CNA 3 entered the room and assisted the resident's roommate.

At 10:06 a.m., LPN 4 and LPN 5 entered the room. LPN 5 indicated they were not in the room to provide incontinence care and were just going to reposition her. LPN 4 and LPN 5 then lowered the head of the bed and turned the resident to the right side. The brief was saturated. The brief was removed and there was a dried white substance on the buttocks. The buttocks was pink in color. The incontinent pad underneath the brief had a dried brown ring, which was acknowledged by LPN 5. Incontinence care and a linen change was then completed by LPN 4 and LPN 5.

The Wound Nurse was interviewed on 2/28/22 at 10:29 a.m. and indicated the resident had MASD

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	(moisture associated skin damage) and the treatment of zinc oxide paste for the MASD had not been completed yet. Resident G's record was reviewed on 2/28/23 at 9:41 a.m. The diagnoses included, but were not limited to dementia and spinal stenosis. A Quarterly MDS assessment, dated 2/9/23, indicated a severely impaired cognitive status, required extensive assistance of one staff for bed mobility and toileting. Was always incontinent of urine and had an ostomy for bowel movements. A Care Plan, dated 2/23/23, indicated MASD was present. The interventions included the skin was to be kept clean and dry and toileting assistance was to be provided. A Care Plan, dated 8/30/21, indicated a limited functional status for toileting. The interventions included she would be observed for incontinence every two hours and as needed and incontinent care would be provided. This Federal tag relates to Complaints IN00395090, IN00395441, and IN00400848. 3.1-38(a)(3) 3.1-38(a)(3)(A) 3.1-38(a)(3)(D)			
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			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards, related to open skin areas observed during care not being reported to the Nurse by the CNA's, for 1 of 2 residents observed for quality of care. (Resident C) Finding includes: During an observation of care on 2/28/23 at 5:32 a.m., CNA 1 and CNA 2 provided incontinence care and a bed linen change to Resident C. CNA 1 was on the left side of the bed and CNA 2 was on the right side of the bed and assisted the resident to turn onto his right side. While lying on his right side, an opened area on the skin was observed on his left upper side and was an approximate size of a quarter. Resident C's record was reviewed on 2/28/23 at 1:39 p.m. The diagnoses included, but were not limited to, morbid obesity and colostomy. A Care Plan, dated 9/20/21, indicated bladder incontinence was present. The interventions included skin breakdown would be reported. The Nurses' Progress Notes, dated 2/28/23, had one entry timed at 12:33 p.m. There was no documentation of an assessment or Physician notification of the skin open area on the left upper side. The Director of Nursing (DON), indicated in an interview on 2/28/23 at 2:58 p.m., the CNA's were	F 0684	**F684** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** CNA 1 was immediately re-educated on reporting any new open areas to the nurse/wound nurse immediately. Resident C – was assessed by the wound nurse. Order for treatment received from MD. Family notification was completed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-educated on reporting any new open areas to the nurse/wound nurse immediately when noted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	03/17/2023

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	to report any skin openings to the Nurse when they were found. The Wound Nurse Progress Note, dated 2/28/23 at 4:43 p.m., indicated an assessment of the skin had been completed and there were two skin open areas found. The left lateral breast was measured at 1 cm (centimeter) by 2 cm with a depth of 0.1 cm and the left lateral back was 2 cm x 3.5 cm with a depth of 0.1 cm, and had a small amount of bloody drainage. The Physician was notified and a treatment order was obtained. The Responsible Party and the resident were notified of the new orders. The Wound Nurse was interviewed on 3/1/23 at 9:20 a.m. and indicated the DON had informed her of the skin open areas on the afternoon of 2/28/23. An investigation and assessment of the areas was initiated. The areas were found as stage 2 areas (superficial pressure area). The CNA's had not reported the areas. A written statement from CNA 1, dated 2/28/23 and provided by the Wound Nurse, indicated CNA 1 had forgotten to inform the Nurse about the skin open areas. The Prevention of Pressure Wounds, facility policy, dated 6/2017, and received from the Corporate RN as current, indicated , "...The facility should have a system/procedure to assure assessments are timely and and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed...Immediately report any signs of a developing pressure injury..." This Federal tag relates to Complaint IN00395441.		**assurance programs will be put into place;** DON/designee will observe 6 resident's weekly for 6 months to ensure any new open areas have been reported to the nurse/wound nurse. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	3.1-37			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status, related to residents care-planned as a nutritional risk did not have the meal consumption records completed to ensure there was dietary intakes at each meal, for 2 of 3 residents reviewed for dietary intakes. (Residents F and D) Findings include: 1. Resident F's closed record was reviewed on 3/1/23 at 9:53 a.m. The diagnoses included, but	F 0692	**F692** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F – is no longer at the facility. Resident D – is no longer at the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	03/17/2023

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	were not limited to, stroke and dementia. The admission date was 12/19/22. A Care Plan, dated 12/25/22, indicated a regular diet, left more than 25% or more uneaten, and had a low body mass index (BMI) (Body fat based on height and weight). The interventions included, a diet was to be served as ordered and the amount of intake of the diet was to be recorded. A Physician's Order, dated 12/22/22, indicated a regular diet. The Weight Record, dated 12/21/22, indicated a weight of 87.5 with a BMI of 15.52 (underweight is less than 18.2). There were no meal intakes documented on the meal intake record or the Nurses' Progress Notes on 12/19/22 for dinner, 12/21/22 for breakfast, lunch, or dinner, 12/23/22 for breakfast, lunch, or dinner, 12/24/22 for breakfast and lunch, and 12/25/22 for breakfast and lunch.2. The closed record for Resident D was reviewed on 2/28/23 at 1:15 p.m. Diagnoses included, but were not limited to, dementia, hypertension and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 9/21/22, indicated the resident was cognitively impaired and required an extensive assist of one with eating. A dietary care plan indicated the resident received a regular diet and had pressure ulcers. The interventions included to record oral intake. A Nutritional Observation, dated 9/29/22, indicated the resident had pressure injuries and required staff assistance with eating.		**what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-educated on documenting food consumption for residents. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 8 residents weekly for 6 months to ensure documentation of food consumption is completed. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

The Meal Consumption Intake for November 2022 lacked documentation of the following meals:
- Breakfast on 11/4/22
- Lunch on 11/4/22
- Dinner on 11/2/22

There was no documentation for any meals on 11/1/22 and 11/3/22.

The Meal Consumption Intake for October 2022 lacked documentation of the following meals:
- Breakfast on 10/5/22, 10/6/22, 10/10/22, 10/11/22, 10/22/22, 10/25/22, and 10/28/22.
- Lunch on 10/5/22, 10/6/22, 10/10/22, 10/11/22, 10/21/22, 10/22/22, 10/25/22, and 10/28/22.
- Dinner on 10/7/22, 10/12/22, 10/13/22, and 10/26/22.

There was no documentation for any meals on 10/1/22, 10/2/22, 10/3/22, 10/4/22, 10/8/22, 10/9/22, 10/14/22, 10/15/22, 10/16/22, 10/18/22, 10/23/22, 10/27/22, 10/29/22, 10/30/22, and 10/31/22.

Interview with the Director of Nursing (DON) on 3/1/23 at 1:17 p.m., indicated the food consumption logs were incomplete. She was unable to provide any further documentation.

This Federal tag relates to Complaints IN00395441 and IN00401857.

3.1-46(a)(1)
3.1-46(a)(2)

F 0757
SS=D
Bldg. 00

483.45(d)(1)-(6)
Drug Regimen is Free from Unnecessary Drugs
§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free

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	155650	A. BUILDING 00 B. WING	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

(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
	from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on observation, record review, and interview, the facility failed to ensure a resident's medication regimen was managed and monitored related to a Physician's Order for the application and removal of a lidocaine pain patch not followed or clarified for where the patch was to be placed, for 1 of 1 residents reviewed for unnecessary medications. (Resident G) Finding includes: During an observation on 2/28/23 at 10:06 a.m., LPN 4 and LPN 5 provided Resident G with incontinence care. During the care, LPN 4 removed a patch, dated 2/27/23, from the left frontal thigh. LPN 4 identified the patch as the lidocaine patch. Resident G's record was reviewed on 2/28/23 at	F 0757	**F757** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G – pain patch was removed immediately. MD was notified and order was clarified to include the site. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice.	03/17/2023

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	9:41 a.m. The diagnoses included, but were not limited to, dementia and spinal stenosis. A Care Plan, dated 8/30/23, indicated a risk for for pain. the interventions included medications would be administered per orders. A Physician's Order, dated 8/23/21, indicated a lidocaine 4% patch was to be applied at 9 a.m. and taken off at 9 p.m. The location of where the patch was to be placed was not included in the order. The February 2023 Medication Administration Record indicated the lidocaine patch had been applied at 9 a.m. on 2/28/23. During an interview on 2/28/23 at 12:02 p.m., LPN 5 indicated he had placed the lidocaine patch on the resident's back this morning. The resident had stenosis so he placed the patch on her lower back. The Physician's Order had not indicated where to place the patch. He had been unaware the other patch had not been removed from 2/27/23. A medication administration policy, dated 10/2014 and received from the Corporate RN as current, indicated medications were to be administered as prescribed. 3.1-48(a) 3.1-48(a)(1)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed staff were re-educated on ensuring pain patches are applied and removed according to physician's order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will observe 3 residents with orders for pain patches weekly for 6 months to ensure pain patches are applied and removed according to physician's orders. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
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			

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	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 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(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 and interview, the facility failed to ensure infection control practices and standards were maintained related to glove usage and handwashing, for 1 of 2 observations of infection control practices during incontinence care. (CNA 1 and Resident C) Finding includes: During an observation on 2/28/23 from 5:32 a.m. through 6 a.m., CNA 1 provided colostomy and incontinence care, with the assistance of CNA 2, for Resident C. CNA applied gloves upon entering the resident's room. CNA 1 emptied the colostomy bag into a plastic bag, wiped the end of the bag	F 0880	**F880 Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C – suffered no ill effects. C.N.A. 1 was immediately re-educated on changing gloves and performing hand hygiene during and after care. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	03/17/2023

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	and clamped the bag. CNA 1 then removed the soiled brief with two urine saturated towels and used wipes to clean the resident. CNA then exited the room without removing the gloves and returned to the room with clean linen to change the bed. The gloves had not been changed during the procedure nor had handwashing taken place throughout the incontinence care and changing of the bed linen. CNA 1 used the bed controls to lower the bed and raise the head of the bed with the same gloves used to provide care. CNA 1 then removed the gloves and entered the hall to place the linens and trash in the barrels in the hallway. The Corporate RN reminded CNA 1 once in the hallway to use the alcohol gel hand sanitizer. A hand-washing policy, dated 3/2020, indicated, when hands were not visibly soiled, an alcohol based hand rub was to be used after direct contact with a resident, before donning gloves, before moving to a contaminated body site to a clean body site during resident care, after contact with potentially infectious material, and after removing gloves. 3.1-18(b)		**what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on infection control practices and maintaining standards of infection control related to glove usage and handwashing. Nursing staff were re-educated changing gloves and performing hand hygiene during and after care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will conduct daily random surveillance observations x 6 weeks and then of 8 staff members weekly for 6 months to ensure infection control practices are being followed including changing gloves and performing hand hygiene during and after care. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality	

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

FORM APPROVED
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			Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	