STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00389104. Complaint IN00389104 - Substantiated. Federal/State deficiency related to the allegation is cited at F677. Unrelated deficiency cited. Survey dates: September 6 and 7, 2022 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 3 Medicaid: 53 Other: 6 Total: These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 14, 2022.	F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 10/05/22	
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;			

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

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	Based on observation, interview, and record review, the facility failed to carry out activities of daily living (ADLs) necessary to maintain personal hygiene for 2 of 3 residents reviewed for ADL care. (Residents D and E) Findings include: 1. During an observation and interview on 9/6/22 at 11:04 a.m., Resident D was observed in the main dining room in her wheelchair, her black pants were wet in the upper leg creases, there was a strong urine and stool odor. The clinical record for Resident D was reviewed on 9/6/22 at 1:18 p.m. Her diagnoses included, but were not limited to, dementia, severe protein calorie malnutrition, morbid obesity, nutritional deficiency, need for assistance with personal care, and diabetic. A Quarterly Minimum Data Set (MDS) assessment, dated 7/15/22, indicated the resident was severely cognitively impaired. She required the extensive assistance of two staff members for mobility and transfer. She required the extensive assistance of one staff member for Activities of Daily Living (ADLs). She was always incontinent of bladder and bowel. The resident had no skin issues documented. During an observation and interview on 9/6/22 at 1:25 p.m., Certified Nurse Aide (CNA) 2 entered Resident D's room and she donned gloves. CNA 3 entered the resident's room and donned gloves. Resident D's black pants were observed to be wet from the waist to the knees, and there was an odor of urine and stool. The CNAs transferred the resident from the wheelchair to the bed. When the pants were removed there was a copious amount	F 0677	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 10/05/2 **F 677** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · All certified and licensed staff were reeducated on appropriate handwashing and peri care by DNS/designee. · All staff reeducated on standard of care related to incontinence. · Routine skills validations on all certified and licensed staff to include peri care and handwashing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · The DNS/Designee will provide education and training to all certified and licensed staff on handwashing and peri care. · The DNS/Designee will reeducate all staff on standard of	10/05/2022

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	of stool on the resident's left posterior leg to the knee. When the brief was removed the resident's skin was noted to be bright red. CNA 3 took a wet wash cloth and wiped the resident's lower abdomen, folded the wash cloth and wiped stool from the resident's right leg fold from the peri area to the upper thigh. She folded the wash cloth and wiped stool from the resident's left leg fold from the peri area toward the upper thigh. CNA 3 took a clean wet wash cloth and wiped the peri area from the center downward, folded the wash cloth and wiped the resident's right labia, folded the wash cloth, and wiped the resident's left labia. There was stool left on the skin of lower abdomen and in the leg folds. The resident was rolled to the right side and the skin fold between the legs and buttocks was bright red, the resident's skin from the anus to the lower back was bright red. CNA 3 used a wet wash cloth to remove stool from the resident's left leg fold from the peri area toward the lower back, she folded the wash cloth, wiped the anus area from the peri area to the lower back, folded the wash cloth, and wiped the resident's right leg fold from the thigh toward the peri area. There was stool left in the resident's folds between the legs and buttocks bilateral. There was dried stool left on the skin of the right thigh and abdomen. The resident was screaming during the process. CNA 3 removed her gloves and left the room without hand washing. CNA 3 reentered the room and donned gloves; no hand hygiene was observed. The Unit Manager entered the room, donned gloves and instructed the resident to calm down. CNA 2 only put a small quarter sized amount of cream on the resident's peri area. No cream was applied to any other area for the resident. The unit manager removed her gloves and exited the room. No hand hygiene was observed.		care related to incontinence. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A Root Cause Analysis will be conducted with IDT team and reviewed by QA committee for findings and recommendations. · All staff will be in-serviced by DNS/designee by 10/05/22 on handwashing and peri care. · All staff reeducated on standard of care related to incontinence by DNS/ Designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The DNS/Designee will monitor each solution/systemic change identified in the RCA 5 days a week or more often as necessary for 6 weeks and until compliance is maintained. · The DNS/designee will be responsible for the completion of the hand hygiene QA tool weekly X4, monthly X3 and quarterly thereafter until such time QA committee feels resolution has been achieved. · If a threshold of 95% is not	

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	During an interview on 9/6/22 at 1:30 p.m.., the Unit Manager indicated she had received a shower sheet that morning from the CNA and had not looked at the resident's skin. During an observation and Interview on 9/6/22 at 1:31 p.m., after questioning the CNA's if they checked for stool left in the resident's folds, CNA 2 used a wet wash cloth and wiped the resident's right thigh, folded the wash cloth, wiped the resident's lower abdomen, folded the washcloth, and wiped the resident's right skin fold. During an observation, on 9/6/22 at 1:34 p.m., Licensed Practical Nurse (LPN) 4 entered the resident's room with pain medication, no hand hygiene was observed, and she was not wearing gloves. LPN 4 went to the bathroom and gathered a paper towel for the resident to spit into, she donned gloves and disposed of the paper towel. LPN 4 indicated she had not seen the resident's skin and did not want to look at her skin until the resident had time to calm down. All three staff removed their gloves and washed their hands prior to exiting the room. On 9/6/22 at 1:47 p.m., the Unit Manager provided a shower sheet for Resident D, dated 9/5/22. The sheet indicated the resident was raw between her legs. During an interview on 9/6/22 at 2:08 p.m., CNAs 2 and 3 indicated they did two-hour bed checks, and even if a resident was in distress while cleaning stool from their body, it was not okay to leave stool in the skin folds. They indicated if a skin issue was observed, they would report it to the nurse.		achieved, an action plan will be developed to ensure compliance. · The DNS/designee will be responsible for the completion of routine auditing using perineal care skills validation. Minimum of 10 perineal care skills validation to be completed weekly X 1 month, then 5 X's weekly for a period of no less than 3 months by DNS/designee with results proved to QA committee for review and recommendations. **By what date the systemic changes will be completed:** Completion Date: 10/05/22	

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	During an observation and interview on 9/6/22 at 2:59 p.m., LPN 4 entered Resident D's room and donned gloves. CNAs 5 and 6 entered the resident's room and donned gloves. LPN 4 indicated there was an open area (top layer of skin missing) on the left upper leg in the skin fold. The LPN observed stool on the resident's right buttock and in the skin folds. CNA 5 took a wet wash cloth, wiped the peri area center, and removed stool, folded the rag, wiped the right-side labia, folded the rag, and wiped the left labia. LPN 4 indicated there was an open area near the resident's anus, there was an open area on the left proximal labia, and an open area on the left lower buttocks. LPN 4 removed her gloves and washed her hands. CNA 6 removed her gloves, without washing her hands removed clean clothes from the resident's closet, and laid them on the resident's bed. Both CNAs donned clean gloves, dressed the resident, transferred the resident to the wheelchair, removed their gloves, and washed their hands with soap and water. During an interview on 9/7/22 at 10:37 a.m., Registered Nurse (RN) 7 indicated if a skin issue was reported she would assess the resident as soon as possible, measure the area, and dress the area. She would notify the Nurse Practitioner (NP) and wound nurse to get a course of treatment, document the event, notify the doctor and family. During an interview on 9/7/22 at 10:38 a.m., the Unit Manager indicated she had assessed Resident D while she was in the room on 9/6/22, by just looking over, even though she did not touch anything. She indicated her nurse had assessed the resident, notified the NP, wound nurse, and obtained treatment orders. A Skin Event Report was provided by the DON on			

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	9/7/22 at 10:43 a.m. The Event, dated 9/6/22, indicated Resident D had three open areas noted to the peri area: 1) pinpoint left proximal labia. 2) 1 cm x 1 cm left proximal labia. 3) pinpoint superior anus surround tissue excoriated. A Skin Event Report was provided by the DON on 9/7/22 at 10:43 a.m. The Event, dated 9/5/22, indicated Resident D had no skin issues. During an interview on 9/7/22 at 1:23 p.m., CNA 5 indicated in order to provided care she just knows what each resident needs because she has taken care of them for a little over a year. She can also look in the computer. During an interview on 9/7/22 at 1:25 p.m., the Unit Manager indicated CNAs can look at the shower sheet binder for shower days, they can look in the kiosk for care needs, and there was a profile binder on each hall that indicated care needed. 2. During an observation on 9/6/22 at 11:07 a.m., Resident E was observed in his room in his wheelchair wearing a t-shirt and shorts. During an interview on 9/6/22 at 2:45 p.m., CNAs 5 and 6 entered Resident E's room, donned gloves, dropped a clean brief on the floor. picked it up and it placed on the resident's bed, and removed the resident's pants. CNA 6 donned gloves, went into the bathroom, cleaned the resident's bed pan, removed her gloves, without washing her hands she donned new gloves, and placed the resident on the bed pan. Both CNAs removed their gloves and did not wash their hands with soap and water. CNA 5 gathered the soiled linen and trash, opened the door and exited the resident's room. CNA 6 removed the wheelchair from the resident's room.			

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	During an observation on 9/6/22 at 3:29 p.m., CNAs 5 and 6 entered Resident E's room, washed their hands with soap and water, donned gloves, rolled the resident to the left side, and removed the bed pan. CNA 5 wiped the resident from his scrotum upwards toward his lower back, folded the wash cloth, wiped stool from her own right glove, and placed a brief under the resident. CNA 5 with her right gloved hand moved the resident's personal items around on his bed side tray table, opened the top drawer of the resident's bedside table looking for a barrier cream to apply. The resident's skin folds between his upper legs and lower buttocks were observed to be red. The resident was rolled to his back and CNA 5 used a wet wash cloth to wipe the head of the penis and the front of the scrotum. The scrotum was observed to be bright red, and there was a scabbed area on the left buttock. CNA 5 removed her gloves and washed her hands. CNA 6 moved the resident's tray table and call light to within reach of the resident without wiping the tray off. She then removed her gloves and washed her hands with soap and water. During an interview on 9/6/22 at 3:59 p.m., CNAs 5 and 6 indicated they did two-hour check and change. They indicated the policy was when entering a resident's room you should first wash you're hands with soap and water, don gloves, provide care, remove gloves, wash you're hands with soap and water, and then place the call light and tray table within the resident's reach. During an interview on 9/7/22 at 2:43 p.m., CNA 8 indicated when two-hour check and change was completed it should be documented in the computer.			

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	During an interview on 9/7/22 at 2:47 p.m., the Director of Nursing (DON) indicated there was no documentation of the two-hour check and change in the computer, that was just a standard of care. The current facility policy titled " Skin Check" and with a revised date of 4/2012, was provided by the DON on 9/6/22 at 2:19 p.m. The Policy indicated, "Procedure Steps: 7. Check friction areas ...between buttocks, groin, thighs, skin folds ...8. During checks observe for redness, tenderness, ...discoloration, irritation, ...moisture, and/or pain ...12. Document and report pertinent information to nurse ..." The current facility policy titled " Perineal Care" and with a revised date of 3/2012, was provided by the DON on 9/6/22 at 2:19 p.m. The Policy indicated, "Purpose ...Hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees ...Definitions: Hand hygiene - a general term that applies to hand washing, antiseptic hand wash and alcohol-based hand rub ...hand washing - the vigorous, brief rubbing together of all surfaces of hands with soap and water, followed by rinsing under a stream of water ...5 Moments of hand hygiene - a term that describes the hand hygiene opportunities that prevention infection transmission linked to healthcare activities. Before touching a resident ...After body fluid exposure. After touching a resident. After touching resident surroundings ..."Procedure Steps: ...3. Wash hands. 4 Put on gloves ...7. Fill wash basin with warm water ...9. Wet and soap folded wash cloth ...11. Obtain clean wash cloth. Wet, soap and fold wash cloth ...Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14 alternate from side to side - wipe from front to back and from center			

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	of perineum outward ...20. Change water in basin. With a clean washcloth, rinse area, thoroughly ...21. Gently pat area dry ...24. Clean anal area from front to back ...28 Remove gloves. 29. Wash hands. 30 Report any unusual findings to nurse ...31. Document procedure. This Federal tag relates to Complaints IN00389104. 3.1-38 (a)(3)			
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			

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

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	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 don the appropriate personal protective equipment in an isolation room while providing care for 3 of 6 staff observed for infection control. (Housekeeper 9, CNA 10, CNA 11) Findings include: 1. During an observation and interview on 9/6/22 at 10:50 a.m., Housekeeper 9 was inside of Resident G's room. She was not wearing a gown or gloves. An interview on 9/6/22 at 10:50 a.m., with Housekeeper 9, she indicated she was not wearing a gown or gloves in the resident's room. Upon entering an isolation room you should have on a gown, gloves, mask, and eye wear. 2. During an observation and interview on 9/6/22 at 10:59 a.m., Certified Nursing Aide (CNA) 10 entered Resident G's isolation room without donning a gown or gloves. CNA 11 exited the room without a gown or gloves. Both CNAs indicated they did not have on a gown or gloves. They indicated the policy was when they entered an isolation room staff must don a gown, gloves, mask, and eyewear. An interview, on 9/6/22 at 10:51 a.m., with the Director of Nursing (DON), she indicated there was a sign on the door, so all staff were aware of an isolation room. At 2:58 p.m., the DON indicated Resident G was in isolation due to having candidiasis (fungal infection) in her lungs. The current facility policy "Infection Prevention	F 0880	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 10/05/2 **F 880** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Signage defining appropriate PPE for contact isolation rooms was added to all alleged deficient room. · All staff encountering residents were reeducated on appropriate PPE use for contact isolation areas by DNS/designee. · Compliance rounds to be completed on alleged deficient room daily until compliance is maintained by the IP/designee using the Infection Control observational rounds tool to observe for proper use of PPE in contact isolation room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the	10/05/2022

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	and Control Program" and with a revision date of 3/2022, indicated, " ...The facility shall establish and maintain infection prevention ...designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections ..." The current facility "Stop Sign," "Isolation Droplet/Contact Precautions" and not dated, indicated the sign indicated, " ...wear all PPE listed below ...Gown, N95, Eye Protection, and Gloves ..." 3.1-18(b)		potential to be affected by the alleged deficient practice. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation, and QA tools. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. · The IP Consultant will provide education and training to the IP/DNS/ED and IDT including providing all education, in-service materials, observation, and QA tools. · All staff will be in-serviced by DNS/designee by 10/05/22 on infection control practices to include signage for appropriate PPE in contact isolation rooms, proper use of PPE in contact isolation rooms. · The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to	

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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
			determine accuracy · Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the Infection Control observational rounds tool to observe for use of proper PPE in contact isolation rooms, signage defining appropriate PPE for contact isolation room. · The consultant IP will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. · Infection Control Observation QA tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. · The IP/designee will be responsible for the completion of the Infection Control Observation QA Tool weekly x 4, monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	09/07/2022

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			months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update, and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed:** Completion Date: 10/05/22	