STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING 00 B. WING	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00444843 Complaint IN00444843- No deficiencies related to the allegations are cited. Survey dates: November 22, 25, and 26, 2024 Facility number: 000343 Provider number: 155486 AIM number: 100289600 Census Bed Type: SNF/NF: 12 Total: 12 Census Payor Type: Medicare: 2 Medicaid: 5 Other: 5 Total: 12 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 27, 2024.	F 0000		
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to maintain the stove hood in a cleanly manner. This had the potential to affect 12 of 12 residents in the facility.	F 0812	**Tag F 812** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerrod Moore	Administrator	12/12/2024

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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	Findings include: A tour of the kitchen was conducted with the Dietary Manager (DM) on 11/22/24 at 12:00 p.m. During the tour, an observation of the stove hood was made. There were several intricate looking cobwebs strung between the gaps in the vent covers on the left side of the hood. The cobwebs were brown in color. There was fuzzy debris built up on the right side of the hood. These areas were directly above the stove. An interview was conducted with Dietary Aide 5 during observation of the stove hood. She indicated a separate company was responsible for cleaning the stove hood, and it had been a couple of months since they came. On 11/22/24 at 12:56 p.m., an interview was conducted with the DM, who provided the, 3/4/24, service report from the company who cleaned the facility's stove hood. The service report indicated the exhaust hood was cleaned on 3/4/24. The DM indicated the Maintenance Director provided her with the, 3/4/24, service report as verification of the last time the stove hood was cleaned. She was unsure how often it was supposed to be cleaned, but the stove hood was "pretty bad" during the tour. On 11/22/24 at 12:45 p.m., the DM provided verification of a, 10/1/24, semi-annual kitchen hood suppression inspection and the, 10/23/24, wet and dry fire sprinkler system inspection reports. None of them referenced cleaning of the stove hood. An interview was conducted with the DM on 11/22/24 at 1:17 p.m. She indicated there was no		**practice:** All residents have the potential to be affected by dirty kitchen equipment. The noticeable cobwebs were removed immediately. The kitchen hood is cleaned bi-annually by Nelbud; it was cleaned in March of 2024, and then again November 27, 2024. In between the 8 months, the kitchen experienced a fire that destroyed the hood on May 3, 2024. The repair of the hood served as a cleaning and kept us in compliance for bi-annual cleaning. In between bi-annual cleaning, the kitchen staff have been re-educated on proper kitchen sanitation. **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:** The Maintenance Director and Dietary Manager have created a check-off sheet that will have the dietary staff at the end of the day to ensure all areas of the kitchen are cleaned (see attachment). With this system in place it will help to ensure all food remains uncontaminated and all residents and staff have a clean eating and working environment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Monday thru Friday, the Dietary Manager	

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	facility policy on cleaning the stove hood, but they were due for a cleaning this month. 3.1-21(i)(3)		will inspect the kitchen, and kitchen cleaning check-off sheet to ensure everything is being cleaned properly. Food safety as well as a clean working area is top priority for kitchen staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** To ensure the deficient practices will not recur the Maintenance Director and Dietary Manager will monitor that all dietary staff are following proper cleaning procedures. **By what date the systemic changes for each deficiency will be completed:** Systemic changes will be completed by December 12, 2024.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure the use of enhanced barrier precautions (EBP) for 3 of 3 residents reviewed for EBP (Resident 3, Resident 11, and Resident 2), and failed to ensure a feeding tube piston syringe was dated for 1 of 1 resident reviewed for enteral feeding management (Resident 11). 1. The clinical record for Resident 3 was reviewed on 11/25/2024 at 11:30 a.m. The medical diagnoses included chronic kidney disease. A Quarterly Minimum Data Set Assessment, dated 11/13/2024, indicated Resident 3 had an	F 0880	TAG F 880 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**100% of resident's medical records have been reviewed. Resident 2, Resident 3, and Resident 11 are the three who have the necessity for the use of enhanced barrier precautions (EBP). Resident 2, Resident 3, and Resident 11 have a care plan indicating that they have the necessity for the use of enhanced barrier precautions (EBP).	12/12/2024

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	indwelling urinary catheter. A physician order, dated 5/16/2024, indicated Resident 3 utilized an indwelling urinary catheter. A urinary care plan, last revised 11/15/2024, indicated Resident 3 utilized an indwelling urinary catheter. The care plan did not indicate the use of EBP. During an interview on 11/22/2024 at 12:29 p.m., Certified Nursing Assistant (CNA) 2 indicated she did not know what EBP was. When she provided care to residents with indwelling medical devices, such as catheters and feeding tubes, she only utilized gloves, but not a gown or other personal protective equipment. During an interview on 11/22/2024 at 12:45 p.m., the Director of Nursing (DON) indicated the facility did not have anyone on EBP and they did not utilize it currently. 2. The clinical record for Resident 2 was reviewed on 11/26/24 at 10:12 a.m. The diagnoses included, but were not limited to, congestive heart failure, pleural effusions, and acute and chronic respiratory failure with hypoxia. A physician's order, dated 8/2/24, indicated Resident 2 received catheter care every shift and an order, dated 8/5/24, indicated Resident 2 was to have the hospice provider complete pleural drain care two times per week. An observation conducted, on 11/22/24 at 11:10 a.m., indicated no enhanced barrier precaution signage was in Resident 2's room or any personal protective equipment (PPE) was located in or near the resident's room. 3. During an observation on 11/22/24 at 11:56 a.m.,		Resident 2, 3 and 11 have signage in their room indicating the need for EBP. Resident 2, 3, and 11 have a banner on the home page of Point Click Care indicating that staff must use EBP when performing high-contact care with each of them. Resident 2, 3 and 11 have a physician order for EBP. The CNA assignment sheets indicate that Resident 2, Resident 3 and Resident 11 have the necessity for EBP. All nursing staff and all environmental services staff have been educated on the use of EBP and the facilities policy and procedure regarding infection control and EBP (see attachment). All licensed nurses have been educated on the use of dating and proper storage of piston syringes for Resident 11. Resident 2, Resident 3, and Resident 11 have gowns and gloves; washable gowns will be stored at the nurse's station, and exchanged every shift. **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:** The DoN and IP nurse have created an action plan form for the ongoing issues (see attachment). All nursing staff and housekeeping staff have been educated on the use of enhanced barrier precautions (EBP). With this	

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	Resident 11 was sitting in her recliner. The resident had a bottle of formula for a gastrostomy tube (feeding tube) hanging on a pole with a piston (syringe for administering formula, medication, and water into the gastrostomy tube and checking placement of the gastrostomy tube) hanging next to the formula bottle in a bag with no date. Observation of the resident's room and bathroom indicated there was no PPE visible. During an interview on 11/22/24 at 12:55 p.m., the DON verified the piston syringe was not dated. The DON indicated the nurse was responsible to date the piston syringe when it was opened. The DON verified there was no PPE located in Resident 11's room. The clinical record for Resident 11 was reviewed on 11/25/24 at 11:10 a.m. The diagnoses included, but were not limited to, dementia, gastrostomy status, congestive heart failure, hypertension, anxiety and diabetes. The physician recapitulation for Resident 11, dated November 2024, indicated the resident was to have the peg-tube (artificial nutrition through a tube into the stomach) flushed with 60 milliliters (ml) of water, check tube placement and residual prior to administration of formula or flushing of the feeding tube. During an interview on 11/25/24 at 11:40 a.m., Registered Nurse (RN) 1 indicated the facility does not have a policy for enhanced barrier precautions (EBP). The enteral nutrition policy was provided by RN 1 on 11/25/24 at 1:30 p.m. The policy indicated the staff caring for residents with feeding tubes would be trained on potential adverse effects of tube		system in place, this will help to ensure that residents currently not using EBP will be better protected from the potential MDRO transmissions in the future. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** To ensure the current deficiencies are corrected, the DoN and/or the IP nurse will audit each resident weekly for 4 weeks, then every 2 weeks for 2 months, and then monthly for the next 4 months for compliance of use of EBP and use of dating and proper storage of position syringes. (see attachment) While this monitoring/auditing is being conducted, the facility will also add these two issues cited in F880 to QAPI (attachment). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** To ensure the deficient practices will not recur the DoN and/or the IP nurse will monitor that all nursing staff and housekeeping staff are following proper procedure of wearing EBP when performing high-contact care of Residents 2, 3, and 11 and any resident with the necessity for the use of EBP in the future. This monitoring will occur weekly for 4	

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	feeding, such as feeding-tube complications. 3.1-18(b)(1) 3.1-18(b)(2)		weeks, then every 2 weeks for 2 months, and then monthly x 4 months to ensure that staff are wearing EBP when performing high-contact care of Resident 2, Resident 3 and Resident 11 currently and any other resident with the necessity for the use of EBP in the future. **By what date the systemic changes for each deficiency will be completed:** Systemic changes have been made as of December 12, 2024. That includes the placement of gowns, but finishing all in-service staff training.	