STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING 00 B. WING	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAROLETON HEALTHCARE CENTER	2500 IOWA AVE CONNERSVILLE, IN 47331

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 26, 27, 28, 29, & March 1, 2024 Facility number: 000318 Provider number: 155387 AIM number: 100266550 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 10 Medicaid: 34 Other: 3 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 7, 2024	F 0000	**F-0000** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the on-site annual survey/quality review/licensure review conducted 02/26/2024 through 03/01/2024.Please accept this plan of correction as the provider's credible allegation of compliance.The facility would like to respectfully request a desk review.Tonya James, LHFA**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

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

Tonya James., LHFA | Executive Director | 03/20/2024

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	adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to implement a fall intervention of a reacher to assist the resident with picking items off the floor for a resident who had a history of falls and was at risk for falls for 1 of 2 residents reviewed for accidents (Resident 20). Finding include: During an observation and interview with Resident 20 on 2/27/24 at 10:49 a.m., indicated he had a fall recently due to something slick on the floor. The resident had no reacher visible in his room. During an observation and interview on 2/27/24 at 12:59 p.m., the resident indicated he use to have a reacher to use to pick items up off the floor, but he had not seen it for awhile and was unsure where it was. The resident had no reacher visible in his room. During an observation on 2/28/24 at 10:35 a.m., Resident 20 did not have a reacher visible in his room. During an observation and interview with LPN 1 on 2/28/24 at 11:19 a.m., looked for Resident 20's reacher in his room and was unable to locate it. LPN 1 indicated she would request a reacher from therapy for the resident. Review of the record of Resident 20 on 2/27/24 at 1:01 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, diabetes, major depressive disorder, chronic pain disorder, chronic inflammatory	F 0689	F689 1. Resident 20 received full assessment and fall care plan reviewed by IDT team to ensure all interventions appropriate and in place. 2. All residents have the potential to be affected by the issues cited in the statement of deficiencies. 3. DON or designee will provide education related to “Fall Management” am ensuring interventions to prevent falls were in place for residents. 4. The Director of Nursing and/or designee will audit fall interventions for 6 residents at least five (5) times per week for four (4) weeks, then 6 residents at least 3 times per week for four (4) weeks, and then 6 residents at least 1 time a week for four (4) weeks and continue no less than two (2) additional months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	03/20/2024

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	demyelinating polyneuritis, muscle weakness and benign prostatic hyperplasia with lower urinary tract symptoms. The fall risk assessment for Resident 20, dated 12/21/23, indicated the resident was diminished safety awareness, used a walker for ambulation, impaired walking with difficulty rising from chair, head down, grasps furniture, minimal assist with gait belt, the resident had balance problems while walking, instability while turning. The resident had 3 or more predisposing conditions for risk of falls. The resident was identified as a fall risk. The care plan for Resident 20, dated 3/2/23, indicated the resident was at risk for falls related to gait/balance problems, history of falls, medications, safety awareness and weakness. The interventions included, but were not limited to, therapy to get me a reacher so that I can pick up items on the floor. The Annual Minimum Data Set (MDS) assessment for Resident 20, dated 2/13/24, indicated the resident was moderately impaired for daily decision making. The resident utilized a walker for mobility device. The State Optional MDS assessment for Resident 20, dated 2/13/24, indicated the resident required extensive assistance of one person for transfers and extensive assistance of two people for toileting needs. The resident was on a scheduled pain medication regimen, received PRN (as needed), did not receive non medication interventions for pain, The progress note for Resident 20, dated 2/22/24 at 7:15 a.m., indicated the nurse was called to the resident's room by a CNA. The resident was			

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	observed laying on the floor in front of his lift chair beside his bed. The resident had candy wrappers all over the floor by his feet. The resident indicated he stood up to go to his bed and slipped. The Interdisciplinary Team (IDT) progress note for Resident 20, dated 2/23/24 at 12:31 p.m., indicated the resident had an unwitnessed fall. The root cause of the incident was the resident was up without assistance and the floor was cluttered. During an interview with the Director Of Nursing (DON) on 2/28/24 at 1:25 p.m., indicated all nursing staff were responsible to ensure Resident 20's fall intervention of a reacher was in place. The fall policy provided by the DON on 2/29/24 at 10:00 a.m., indicated the facility would provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Fall prevention and management was the process of identifying risk factors that minimize the potential for falls and also a process to manage a resident's care if a fall occurs. The facility would attempt to put an intervention in place to prevent further falls. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such			

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	that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observations, interview, and record review, the facility failed to promote a resident's dignity by ensuring the use of a catheter drainage bag and have an order for the use of an indwelling urinary catheter for 1 of 3 residents reviewed for urinary catheters. (Resident 43) Findings include: The clinical record for Resident 43 was reviewed	F 0690	**F690** 1. Resident 43's orders were reviewed and updated on 2/29/2024. Resident 43 was 2. All residents with catheters have the potential to be affected by the issues cited in the statement of deficiencies.	03/20/2024

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	on 2/27/2024. The medical diagnosis included muscle weakness. An Admission Minimum Data Set Assessment, dated 12/13/2023, indicated that Resident 43 utilized an indwelling urinary catheter. Physician orders did not reflect the size of urinary catheter for Resident 43. A urinary catheter care plan, dated 12/15/2023, indicated to provide a privacy bag to Resident 43's drainage bag and he utilized a 16 Fr (French) catheter with a 10-milliliter balloon anchor. During an observation on 2/27/2024 at 10:39 a.m., Resident 43 was sitting in his wheelchair in the dining room with his urinary catheter drainage bag hanging under his wheelchair. A moderate amount of yellow urine was visible in the bag. During an observation on 2/27/2024 at 10:43 a.m., Resident 43 was sitting in his wheelchair in the dining room with his urinary catheter drainage bag hanging under his wheelchair. A moderate amount of yellow urine was visible in the bag. During an observation on 2/27/2024 at 1:20 p.m., Resident 43 was laying in bed and his catheter was noted to be a 22 Fr with a 30 mL balloon anchor. During an interview on 3/1/2024 at 11:20 a.m. with the Director of Nursing, she indicated that the size of his catheter had been changed to the 22 Fr with a 30 ml balloon after a recent surgical procedure. It was the expectation of the facility to utilize privacy bags and to have orders for the correct sizing and/or indication for use for urinary catheters. A physician's order for Resident 43's		3. DON or designee will provide education related to dignity and privacy bags as well as catheter orders. 4. The Director of Nursing and/or designee will audit catheter orders and observe for catheters for privacy bags for all residents with catheters at least five (5) times per week for four (4) weeks, then 6 residents at least 3 times per week for four (4) weeks, and then 6 residents at least 1 time a week for four (4) weeks and continue no less than two (2) additional months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	

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	catheter size and indication of use was added to the clinical record on 2/29/2024. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to ensure Resident 13's portable oxygen tubing and storage bag was dated for 1 of 1 resident reviewed for respiratory care (Resident 13). Finding include; During an observation on 2/26/24 at 1:05 p.m., Resident 13's storage bag and tubing was not dated on portable oxygen. During an observation on 2/27/24 at 12:54 p.m., Resident 13's storage bag and tubing was not dated on portable oxygen. During an observation on 2/29/24 at 12:57 p.m., Resident 13's portable oxygen tubing/storage bag was not dated. During an observation and interview with CNA 2 on 2/29/24 at 2:22 p.m., verified Resident 13's	F 0695	**F695** 1. Resident 13's O2 storage bag and tubing was changed for portable oxygen. Resident 13 received a full assessment. 2. All residents with oxygen use have the potential to be affected by the issues cited in the statement of deficiencies. 3. DON or designee will provide education related to changing oxygen, tubing labeling and storage. 4. The Director of Nursing and/or designee will audit changing of oxygen tubing, labeling, and storage for 6 residents at least five (5) times per week for four (4)	03/20/2024

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	portable oxygen tank tubing and storage bag was not dated. During an interview with the Director Of Nursing (DON) on 3/1/24 at 11:21 a.m., indicated Resident 13's portable oxygen tubing and storage bag should have been dated. Review of the record of Resident 13 on 3/1/24 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, acute respiratory failure with hypoxia and dependence ion supplemental oxygen. The physician order for Resident 13, dated March 2024, the resident was ordered oxygen 2 liters via nasal cannula to keep oxygen saturation above 90%. 3.1-47(a)(6)		weeks, then 6 residents at least 3 times per week for four (4) weeks, and then 6 residents at least 1 time a week for four (4) weeks and continue no less than two (2) additional months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was kept at safe holding temperatures on the steam table, and failed to ensure dishes were stored dry for 2 of 4 observations and had the potential to affect all 47 residents in the facility. Findings include: On 2/26/24, at 9:14 a.m., Cook 3 was observed as she removed a tray of dishes from the dish machine, removed the dishes from the tray and immediately put them away while still wet. On 2/26/24 at 10:50 a.m., food temperatures were observed as taken, by Cook 3. The mashed potatoes were 117, then when rechecked were 115.8. The hamburgers were 131.8, and the hot dogs were 131.3. Cook 3 indicated foods are "served at 130 (degrees) once they are on the steam table." Cook 3 began to plate the food for the noon meal and was stopped by the surveyor due to the low food temperatures of the mashed potatoes, hamburgers, and hot dogs. Cook 3 removed the steam table pans of mashed potatoes, hamburgers and hot dogs and reheated them on the range until the mashed potatoes reached 142, the hamburgers reached 137 and the hot dogs reached	F 0812	F812 1. Cook 3 received education regarding dish storage procedures. Cook 3 received education regarding food procurement and temperatures. 2. All residents have the potential to be affected by the issues cited in the statement of deficiencies. 3. District Manager will provide education to ED and culinary team related to food procurement and temperatures. District Manager will provide education to ED and culinary team related to dish storage. 4. ED and/or designee will audit food temperatures five (5) times per week for four (4) weeks, then at least 3 times per week for four (4) weeks, at least 1 time a week for four (4) weeks and continue no less than two (2) additional months. ED and/or designee will observe dish storage five (5) times per week for four (4) weeks, then at least 3 times per week for four (4) weeks, at least 1 time a week for four (4) weeks and continue no	03/20/2024

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	137.5. Cook 3 said she took the food temperatures when the food was brought out and placed on the steam table, and the food sat, about 15 minutes on the steam table, before the temperatures were taken with the surveyor. On 2/28/24 at 1:30 p.m., with the Dietary Manager dishes were observed stored as clean. In 3 stacks of 19 total, 7 monkey dishes (small bowls) had moisture inside the bowls. On 2 trays, one with 10 cups and one with 15 cups, 3 had moisture inside the cups. In a stack of 7 plates, 1 had moisture. The Dietary Manager indicated they should let the dishes set and air dry before putting them away. A policy for "Food: Preparation" was provided by the Dietitian, on 3/1/24 at 10:31 a.m. The policy included, but was not limited to, "Policy Statement: All foods are prepared in accordance with the FDA Food Code. Procedures: 4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 [degrees] F (Fahrenheit) and/or less than 135 [degrees] F, or per state regulation...." A policy titled "Warewashing" was provided by the Dietitian, on 3/1/24 at 19:31 a.m., and included, but was not limited to, "Policy statement: All dishware, serviceware, and utensils will be cleaned and sanitized after each use...4. All dishware will be air dried and properly stored." 3.1-21(i)(3)		less than two (2) additional months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee. !--[if="" !supportannotations]--="">	