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| | 155432 | A. BUILDING 00<br>B. WING | 12/14/2021 |

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| ALBANY HEALTH CARE & REHABILITATION CENTER | 910 W WALNUT ST<br>ALBANY, IN 47320 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: December 8, 9, 10, 13 and 14, 2021,<br><br>Facility number: 000309<br>Provider number: 155432<br>AIM number: 100288960<br><br>Census Bed Type:<br>SNF/NF: 71<br>Total: 71<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 51<br>Other: 11<br>Total: 71<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 22, 2021. | F 0000 | **The completion of this plan of correction does not constitute an admission that the alleged deficiencies exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.** | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or | | | |

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

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| | enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. | | | |
| | Based on observation and interview, the facility failed to provide privacy to a resident during wound care for 1 of 5 wound observations (Resident 21).<br><br>Findings include:<br><br>During Resident 21's wound care observation, on 12/13/21 at 2:33 p.m., the Wound Care Nurse, explained what he was going to be doing to the | F 0550 | F550 Privacy/dignity<br>Plan of Correction<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>*RN 55 immediately closed door to room and educated Wounds Care Nurse on practice providing resident with privacy and dignity.* | 01/17/2022 |

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| | resident, he performed hand hygiene and donned gloves and assisted the resident to turn onto her left side, he pulled her pants down to expose her buttocks, he removed the dressing from her coccyx, he cleansed the area and indicated he needed latex gloves to be able to apply the new dressing and could not find any latex gloves in her room. He exited the room, the privacy curtain was not pulled and her buttocks was exposed to the hallway. The resident was observed for approximately 20 seconds in this position and a gentleman had walked by her room and glanced into her room. After the 20 second observation, the resident was observed from the hallway into the resident's room, anyone walking down the hall would be able to observe her buttocks from the hallway. RN 55 walked by the resident's room, shut the door and indicated to the Wound Nurse that he should had closed the door.<br><br>On 12/13/21 at 3:05 p.m., RN 55 indicated it was a dignity concern for the Wound Nurse to leave the door opened with her buttocks exposed.<br><br>A current policy titled, "Resident Rights," provided by the Administrator, on 12/14/21 at 2:44 p.m., indicated the following: "Nursing Home Resident Rights...Visits Privacy-Confidentiality...Privacy in your room during bathing, medical treatment, and personal care...."<br><br>3.1-3(t) | | 2. 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?<br>*All residents requiring care per Wound Care Nurse (WCN) have the potential to be affected. Interviews conducted with interviewable residents receiving wound care per WCN to determine if dignity and privacy are maintained during care.*<br>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?<br>*Interview by DON/designee of 2 residents receiving wound care per WCN weekly to ensure privacy and dignity are maintained with treatment performance.*<br>*Unplanned rounding to be performed 3 times weekly by DON/designee during WCN hours to ensure compliance with privacy and that dignity is maintained.*<br>*1:1 education with WCN per CEC regarding resident's right to privacy and maintaining dignity.*<br>*All staff educated on topics of dignity and providing privacy during care.*<br>*DON/designee will perform audits 3 times weekly during WCN hours for 4 weeks, then weekly for 8 weeks, then monthly for 2 months, then quarterly. Audits to be completed for no less than 6 months.* | |

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| | | | 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.<br>*Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.* | |
| F 0580<br>SS=D<br>Bldg. 00 | 483.10(g)(14)(i)-(iv)(15)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse | | | |

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| | consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). | | | |
| | Based on record review and interview, the facility failed to notify a resident's representative of an examination of the residents vaginal area performed by the Nurse Practitioner, after a potential sexual interaction with a male resident (Resident 72). | F 0580 | **F580 Notify of Changes ( injury/Decline/Room, etc.)**<br>**Plan of Correction**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been** | 01/17/2022 |

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| | Findings include:<br><br>On 12/9/21 at 9:23 a.m., Resident 72 indicated she did not know where she was or how long she had been at the facility.<br><br>On 12/9/21 at 2:53 p.m., she was wandering in the dining room.<br><br>Resident 72's clinical record was reviewed on 12/9/21 at 2:27 p.m. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, cognitive communication deficit, anxiety disorder and other recurrent depressive disorders.<br><br>A annual MDS (Minimum Data Set), dated 11/30/21, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility, transfers and dressing. She required limited assistance of one staff member for walking in room, corridor and locomotion on the unit.<br><br>An initial non-pressure skin report, dated 11/30/21 at 11:28 p.m., indicated a head to toe assessment was completed with no new areas found.<br><br>A nurse practitioner progress note, dated 12/1/21, indicated Resident 72 was seen for a potential sexual abuse incident. The resident was unable to verbalize details of the incident due to dementia. Staff had reported Resident 72 was found in an empty room without clothes on, in a bed. Another resident was also noted to be in the room without clothing, in another bed. Staff unsure of the amount of time the residents were alone together or any possible interactions between the two residents. A vaginal exam was completed with no signs of trauma, swelling or discharge. Vulva | | **affected by the deficient practice?**<br>DON verified with the Nurse Practitioner that a vaginal exam was not performed on Resident 72, only a visual assessment of the perineum was completed and no invasive procedure was performed. DON informed Resident 72's daughter that the Nurse Practitioner had completed a perineal skin assessment on Resident 72 and not a vaginal examination. 1:1 education was provided to the family friend, a CNA, that they are to refer family members to the nurse to receive/review any clinical information.<br><br>**2. 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?**<br>A thirty-day lookback audit was performed on all resident changes, and unusual occurrences that involve residents that meets the criteria for notification to ensure that proper notification was performed.<br>The Nurse Practitioner was not asked to complete a skin assessment on any other residents. No other residents were affected by the alleged deficient practice. | |

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| | appeared within normal limits and age appropriate with no visual signs of molestation. Diagnosis for the visit was vascular dementia with behavioral disturbance and encounter for gynecological examination (general) (routine) without abnormal findings.<br><br>During an telephone interview with Resident 72's family member, on 12/9/21 at 11:08 a.m., she indicated her mother did not know her anymore and was confused. She was not aware of the vaginal examination that was performed on her mother on 12/1/21. On 11/30/21, between 9:30 p.m. and 10:00 p.m., a nurse from the facility called to inform her that her mother and a male resident was found naked in separate beds in the male resident's room. A family friend that worked at the facility had told her that she had sat in on the vaginal examination that was performed by the nurse practitioner. She was angry that the facility did not contact her regarding the exam and felt like they were trying to hide it. She wondered why they were not watching the residents and wished she were told about the exam.<br><br>During an interview with the Nurse Consultant with the DON present, on 12/13/21 at 10:20 a.m., she indicated anytime they would find a male and female resident together they would do a thorough examination on both the residents. They would not contact the family, because it was just a skin assessment that was performed by the nurse practitioner to check for swelling or bruising. It was not a vaginal exam, it was a thorough skin assessment because he was naked also and to make sure no penetration occurred. The Nurse Practitioner just happened to be in the building the following day and she had asked her to do the assessment. | | **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?**<br><br>Federal tag F580 and facility policy Physician/ Clinician/Family/Responsible Party Notification of Change in Condition were reviewed.<br>Facility staff were educated to allow clinical questions or information to be addressed by the nurse.<br>NP clarified that a skin assessment and not a vaginal exam, as previously documented was completed of the perineal area for Resident 72.<br><br>DON/designee will audit orders for vaginal exams to ensure the family/responsible party are notified daily during department head meeting X4 weeks, then weekly X8 weeks, then monthly X2, then quarterly. Audits will be completed for no less than 6 months.<br><br>**4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**ie: what QA program will be put into place and by what date will they be completed.**<br><br>Audits/findings will be forwarded to | |

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| | During an interview, with the Nurse Practitioner that performed the exam, on 12/13/21 at 10:25 a.m., indicated she observed the outside of the resident's vaginal area and examined for bruising and discharge, but did not do a PAP smear.<br><br>A current policy titled, "PHYSICIAN/CLINICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION," provided by the Nurse Consultant, on 12/13/21 at 11:18 a.m., indicated the following: "Purpose: To ensure that medical/psychological care problems are communicated to the attending physician/clinician and family/resident representative in a timely, efficient and effective manner... 1. The facility must immediately inform the resident; consult with the resident's physician/clinician; and notify, consistent with his or her authority, the resident representative(s) when there is: An accident involving the resident which results injury and has the potential for requiring physician/clinician interventions... 3. The facility must also promptly notify the resident and the resident representative, if any, when there is: ...A change in resident rights under Federal or State law or regulations...."<br><br>3.1-5(a)(1)<br>3.1-5(b)(2) | | QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives | | | |

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| | adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent potential sexual interactions between residents with dementia for 1 of 1 resident to resident interactions (Resident 72 and Resident 123).<br><br>Findings include:<br><br>1. On 12/9/21 at 9:23 a.m., Resident 72 indicated she did not know where she was or how long she had been at the facility.<br><br>On 12/9/21 at 2:53 p.m., she was wandering in the dining room.<br><br>Resident 72's clinical record was reviewed on 12/9/21 at 2:27 p.m. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, cognitive communication deficit, anxiety disorder and other recurrent depressive disorders.<br><br>Her medications included, but was not limited to, citalopram hydrobromide (antidepressant) 15 mg (milligram) daily and hydrocodone-acetaminophen (pain reliever) 5-325 mg three times daily.<br><br>A annual MDS (Minimum Data Set), dated 11/30/21, indicated she was severely cognitively impaired. She required extensive assistance of one staff member for bed mobility, transfers and dressing. She required limited assistance of one staff member for walking in room, corridor and locomotion on the unit.<br><br>The clinical record lacked a careplan related to the incident. | F 0689 | F689 Accidents/hazards<br>Plan of Correction<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>*A progress note was placed and care plan was updated for Resident 72.*<br>*Resident 123 was placed on 1:1 supervision and sent to inpatient geri-psych at first facility acceptance for treatment.*<br>*Permanent transfer referrals were initiated.*<br>2. 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?<br>*Residents residing on the secured dementia unit had the potential to be affected.*<br>*Behavior assessments over the past 30 days to be reviewed to determine if sexual behaviors occurred for those residents residing on the secured dementia uni.*<br>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?<br>*Resident 123 will receive 1:1 care until permanent transfer from facility.*<br>*All staff educated on when to initiate 1:1 supervision, abuse* | 01/17/2022 |

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| | The clinical record lacked nurses notes related to the incident.<br><br>An initial non-pressure skin report, dated 11/30/21 at 11:28 p.m., indicated a head to toe assessment was completed with no new areas found.<br><br>A nurse practitioner progress note, located in the scanned document section of the clinical record, dated 12/1/21, indicated Resident 72 was seen for a potential sexual abuse incident. The resident was unable to verbalize details of the incident due to dementia. Staff had reported Resident 72 was found in an empty room without clothes on, in a bed. Another resident was also noted to be in the room without clothing, in another bed. Staff unsure of the amount of time the residents were alone together or any possible interactions between the two residents. A vaginal exam was completed with no signs of trauma, swelling or discharge. Diagnosis for the visit was vascular dementia with behavioral disturbance and encounter for gynecological examination (general) (routine) without abnormal findings.<br><br>2. Resident 123's clinical record was reviewed on 12/10/21 at 9:19 a.m. Diagnoses included, but was not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere with behavioral disturbance and anxiety disorder.<br><br>His medications included, but were not limited to, quetiapine fumarate (antipsychotic) 0.5 mg daily and donepezil hydrochloride (dementia) 5 mg daily.<br><br>An occupational therapy assessment, dated 11/30/21, indicated the resident was severely cognitively impaired. | | *policy, rounding/monitoring of secured dementia unit, and proper notification of behaviors.*<br>*Education on above topics will be provided to new hires and agency staff along with other policies and education.*<br>*Social Services/designee will audit behavior assessments daily for 4 weeks, then weekly for 8 weeks, then monthly for 2 months, then quarterly to identify any sexual behaviors. This audit will also ensure completion/initiation of care plans and documentation for each resident involved.*<br>*Audits will be completed for no less than 6 months.*<br>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.<br>*Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.* | |

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| | A discharge MDS, dated 12/1/21, indicated he required extensive assistance for bed mobility. He required limited assistance for transfers. He had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and the behavior occurred one to three days.<br><br>A behavior sheet, dated 11/29/21, indicated a report was received from previous shift QMA that resident had made multiple sexual remarks and pulled his penis out and was stroking it in front of the CNA. He was severely wandering without purpose and severely sexually inappropriate. more than 3 times. Interventions that were made were he was approached in calm manner, identified self, established eye contact, called resident by name, (behaviors unchanged), offered fluids and Used distraction (behavior improved). The comment section indicated the resident was noted with pants and underwear off in presence of CNA. Making sexual gestures and remarks to CNA. Occurred in the hallway and resident's room. Resident noted with pants and underwear off stroking his penis and telling the CNA he needs help getting off. Resident was redirected with interventions including snacks and fluids and assisted to lay down in room.<br><br>A behavior sheet, dated 11/30/21 at 11:32 p.m., indicated the resident continuously was having severe sexually inappropriate behavior and exit seeking. Interventions approached in a calm manner, identified self, established eye contact, called resident by name, explained what they were going to do, didn't ague or confront, offered fluids and snack (behaviors unchanged). The comment section indicated the resident was aggressively exit seeking. Resident did get out of locked unit | | | |

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| | and was not easily redirected to return to locked unit. Resident later in evening was found naked in his room with a female resident who was also naked. The residents were in separate beds at the time. He had been exit seeking all evening, sexually inappropriate behavior started at approximately 10:45 a.m. Resident was sent to local hospital emergency room for psychiatric evaluation.<br><br>He had a focused careplan, initiated on 11/30/21, that indicated he had behavioral symptoms such as sexual acts such as fondling/exposing self in public areas. Sexual behaviors such as touching, feeling, pinching and grabbing. His goal was his behavioral symptoms would be managed through his care plan interventions as evidenced by (specify number) episodes (specify frequency i.e. daily, weekly) through his careplan interventions. His interventions were allow me to express my feelings, medications as ordered and redirect his behavior by offering snacks and fluids.<br><br>A social service note, dated 11/30/21 at 2:00 a.m. indicated he had spoke with residents daughter, regarding trying to send the resident out due to behaviors. She informed social service that her sister was working on becoming POA (Power of Attorney) and she was going to take the resident home with her in Oklahoma but was not able to as he was being sexual towards her and her daughter.<br><br>A nurses note, dated 11/30/21 at 11:51 a.m. , indicated the following behavior of being sexually inappropriate the SSD (Social Service Director) called a psychiatric hospital and they could not accept the resident due to payer type.<br><br>A social service note, dated 11/30/21 at 12:01 p.m. | | | |

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| | indicated a referral was sent to another psychiatric hospital related to the behavior and was informed they would not accept resident due to behavior stated he was easily redirected with snacks and fluids.<br><br>A nurses note, dated 11/30/21 at 11:00 p.m. indicated a new order was received to send the resident to a local hospital for psychiatric eval and complete work-up or possible infection. Ativan 1 (mg) milligram (IM) intramuscular but recommended not to give unless absolutely necessary.<br><br>A nurses note, dated 11/30/21 at 11:38 p.m., indicated EMS was at the facility to take resident for evaluation at local hospital.<br><br>A nurses note, date 12/1/21 at 6:39 a.m., indicated the resident was medically cleared. Psychiatric services would evaluate the resident and would notify the facility with a plan.<br><br>A nurses note, dated 12/1/21 at 1:30 p.m., indicated the resident returned from local hospital by ambulance with no clothes on and his watch was missing. He was alert to self and able to follow simple instructions. Able to make wants and needs known. He was placed on one on one care immediately.<br><br>A nurses note, dated 12/1/21 at 4:22 p.m., the resident was being transferred to a psychiatric hospital emergency room for evaluation and treatment.<br><br>A social service note, dated 12/1/21 at 4:36 p.m., indicated the daughter was informed her the facility was trying to find alternate placement. Daughter understood and was okay with alternate | | | |

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| | placement. Psychiatric hospital agreed to accept resident due to behaviors through emergency room and would then hold for 72 hour evaluation.<br><br>During an interview with LPN 33, on 12/9/21 at 4:12 p.m., he indicated he was called to the dementia unit, QMA 39 indicated to him that she had walked into Resident 123's room and found Resident 72 and Resident 123 naked sitting on opposite beds. He had heard Resident 123 was being sexually inappropriate with staff on his recent days off of work. He had never known Resident 72 or 123 to be sexually inappropriate before. Resident 72 wandered into other resident's rooms. He completed a head to toe assessment on both residents and no evidence was found of sexual intercourse. Resident 123 was sent to a local emergency room for psychiatric hospital placement. Resident 72's daughter was notified of incident and she had indicated it was uncharacteristic of her mother to do that.<br><br>During an interview with QMA 39, on 12/13/21 at 10:37 a.m., she indicated Resident 72 normally sat at a table in the corner in the dining room and she wasn't there. She went to her room and wasn't there, so she went room to room to look for her and the first room she checked, Resident 72 and Resident 123 were both sitting on the opposite beds naked. She got Resident 72 up and started to get her dressed and charge nurse came in and did a head to toe assessment and checked the beds. Resident 123 kept saying that was where she is supposed to sleep and they were getting ready go to bed. He did not normally act that way with other residents. He had said something sexual to a staff member but she didn't know what it was. Resident 72 acted normal after the incident and did not act like anything had happened and he did not either. He just kept saying they were going to | | | |

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| | bed and she was to sleep over there pointing to the other bed.<br><br>During an interview with the SSD, on 12/13/21 at 1:51 p.m., he indicated Resident 123 was sent out after the first behavior with staff and at the time they wouldn't except him because he was easily redirected with snacks and fluids and it was just one behavior. After the second behavior he was put on one on ones. He did not develop a careplan after the first incident and probably should had. He had followed up with Resident 72 for 2 days after the incident, she had no distress or sexually inappropriate behaviors and was documented in the facility investigation. Resident 123 also did not have any inappropriate behaviors until the one with the staff members.<br><br>A current policy titled, "Abuse, Neglect and Misappropriation of Resident Property," provided by the Administrator at entrance to the facility, on 12/8/21, indicated the following: "...Policy Interpretation and Implementation... 5. The facility shall prevent abuse by providing residents, families and staff with information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; provide feedback regarding the concerns that have been expressed. And identify, correct and intervene in situations in which abuse, neglect or misappropriation of resident is property is likely to occur such as: ...Having sufficient staff on each shift to meet residents' needs and assuring that the assigned staff know assigned residents' individual care needs...."<br><br>3.1-45(a) | | | |
| F 0761 SS=D | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals | | | |

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| Bldg. 00 | §483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation and interview, the facility failed to lock a medication cart and properly label and date medications for 2 of 3 medication cart observations (200 and 300 hall carts).<br><br>Findings include:<br><br>1. During a random observation, on 12/8/21 at 12:33 p.m., two medication carts sat outside of the Administrators office across from the nurses station. The 200 hall medication cart was unlocked and unattended. | F 0761 | F761 Labeling/storage of drugs<br>Plan of Correction<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>*Cart was immediately locked upon completion of IDH inspection per DON. All unmarked items were removed from the cart and re-ordered when necessary on 12/8/2021*<br>*All unmarked items were removed* | 01/17/2022 |

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| | On 12/08/21 at 12:34 p.m., an agency nurse approached the other cart and indicated the cart was not hers and she was unsure where the nurse was that worked the cart.<br><br>On 12/08/21 at 12:35 p.m., during an observation of the inside of the cart with the DON present, the cart contained, but was not limited to, insulin vials, lidocaine vials, pills, breathing treatments, powder and liquid medications and also included the following:<br><br>a. Two opened insulin vials with no opened date on them.<br><br>b. Two opened lidocaine (numbing medication) vials, both with no opened date on them and one with no resident identifier on it.<br><br>c. Ipratropium Bromide with Albuterol (breathing treatment) opened package with no opened date or resident identifier on it.<br><br>d. A partial bottle of 7up with no identification on it.<br><br>The DON indicated during the observation, they would normally date and label the medications and she didn't know who the 7up belonged to.<br><br>2. An observation of the 300 hall cart with LPN 42, on 12/14/21 at 11:34 a.m., an opened vial of insulin was observed with no open date on it. LPN 42 indicated they would normally date them after being opened.<br><br>A current policy titled, "GUIDELINES FOR MEDICATION STORAGE AND LABELING," provided by the Administrator, on 12/14/21 at 2:44 p.m., indicated the following: "Purpose: | | *from the cart and re-ordered when necessary on 12/14/2021*<br>2. 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?<br>*All residents residing on 200 and 300 halls had the potential to be affected by alleged deficient practice.*<br>*All medication carts were audited for med storage compliance including labeling of medications and date opened.*<br>3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?<br>*Med storage audits to be performed by unit manager/designee and/or pharmacy to monitor for appropriate labeling and date opened.*<br>*Nursing licensed staff educated on medication storage policy.*<br>*DON/designee will perform random audits* to include weekends and all three shifts, 3 times weekly for 4 weeks and until 100% compliance is achieved, then weekly for 8 weeks and until 100% compliance is achieved, then monthly for 6 months until 100% compliance is maintained to ensure that medication carts are properly locked and that medication is properly labeled and dated.<br>4. How will the corrective action(s) | |

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| | Medications and biologicals are stored safely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. General Guidelines: 1. Medication and biologicals in medication rooms, cart, and refrigerators are maintained within: a. Secured (locked) locations, accessible only to designated staff... 9. Multi-dose vials that have been opened or accessed (e.g., needle-punctured) should be dated when the vial is first accessed and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial...."<br><br>3.1-25(j)<br>3.1-25(m) | | be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.<br>*Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.* | |
| F 0886<br>SS=D<br>Bldg. 00 | 483.80 (h)(1)-(6)<br>COVID-19 Testing-Residents & Staff<br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including<br>individuals providing services under arrangement and volunteers, for COVID-19. At a minimum,<br>for all residents and facility staff, including individuals providing services under arrangement<br>and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with | | | |

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| | COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for<br>conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate<br>to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing<br>services under arrangement and volunteers, | | | |

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| | who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>Based on observation and interview the facility failed to monitor COVID-19 self testing for staff for 1 of 1 random observations of COVID-19 self testing.<br><br>Findings include:<br><br>During a random observation, on 12/13/21 at 1:33 p.m., at entrance to the facility, the COVID-19 screener was sitting at the table. On the table for self testing for staff members to the left of the screener was a test card with CNA 25's name was on it, the card did not indicate a date or time it was completed or when to be read. The test indicated negative. The screener indicated the staff test themselves, she did not know when the staff member tested or who she was and thought she was agency staff. They normally wrote the date and time on the card and she double checked when the staff had tested. Agency normally sits in the dining for 15 minutes and the tests should be read within 15 minutes to a half hour.<br><br>On 12/13/21 at 1:35 p.m., CNA 25 indicated she had tested herself at 11:15 a.m., when she went to lunch and and had not made it back to the table to read it.<br><br>On 12/13/21 at 2:55 p.m., the Administrator indicated the screener would monitor the testing cards. She had spoke with CNA 25 and reminded | F 0886 | **F886 COVID-19 Testing Residents & Staff**<br>**Plan of Correction**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>HFA re-educated CNA 25 to write the time on her test card and re-educated the screener to ensure staff placed times on their test cards.<br>CNA 25 retested upon notification of error. Supervised to ensure accuracy of labeling and reading.<br><br>**2. 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?**<br>A review of other test cards was completed to ensure times were placed and timely reading completed. | 01/13/2022 |

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| | her to write the time on the card and re-educated the screener to make sure staff had put the times on the cards. The screener monitored testing during the day and second shift monitor their own.<br><br>A current policy titled, "COVID-19 TESTING OF STAFF AND RESIDENTS," provided by the Administrator, on 12/12/21 at 2:44 p.m., indicated the following: Policy: It is the policy/procedure of this facility to provide testing for staff and residents to identify those individuals that are exhibiting signs/symptoms of COVID infection or those identified as being exposed according to CDC guidelines. Purpose: According to CDC's QSO-20-38-NH, CMS's recommendation to test with authorized nucleic acid or antigen detection assays is an important addition to other infection prevention and control (IPC) recommendations aimed at: Preventing COVID-19 from entering nursing homes, detecting cases quickly, and stopping transmission. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff...." | | **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?**<br><br>Staff educated to the following procedure for self-testing:<br>After test completed, write time of test on their test card, highlight name on testing list for test tracking. Take test and place at scheduled workstation. Activate timer on charting phone, personal phone, or kitchen timer provided for 15 minutes. When timer sounds, check test result and discard test. Any positive test warrants staff leaving facility and test to be reported to nurse manager immediately for further instructions.<br>If an employee has any symptoms or has reason to believe that their COVID test could result as positive, they must wait to report to work a minimum of 15 minutes until the COVID test results are read. All asymptomatic employees may report to work while awaiting the results of their COVID test.<br>Inservice/education placed at agency table.<br>DON/designee will perform random audits daily to ensure times are placed on test cards located at workstations and are being read timely X4 weeks, then weekly X8 weeks, then monthly X2 months, | |

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| | | | then quarterly. Audits will be completed for no less than 6 months.<br><br>**4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**ie: what QA program will be put into place and by what date will they be completed.**<br><br>Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. | |