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	155145	A. BUILDING 00 B. WING	07/21/2022

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, 21, 2022 Facility number: 000068 Provider number: 155145 AIM number: 100275980 Census Bed Type: SNF/NF: 38 Total: 38 Census Payor Type: Medicare: 4 Medicaid: 30 Other: 4 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2022.	F 0000	**F000** The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this *CMS-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 August 15, 2022.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a			

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

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	resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure behavioral health services were provided to maintain resident's highest practicable well-being. Residents that required behavioral health monitoring were not evaluated for these services at admission, and not monitored for behaviors for 1 of 1 residents reviewed for abuse. (Resident 240) Findings include: On 07/20/22 at 2:33 P.M., Resident 240's clinical record was reviewed. Diagnosis included, but were not limited to, unspecified dementia with behavioral disturbance, cognitive communication deficit, and unspecified symptoms and signs involving cognitive functions and awareness. The most recent admission MDS (minimum data set) Assessment, dated 12/28/21, indicated Resident 240's cognitive status was unable to be assessed. Resident 240 was admitted from a behavioral health unit at the hospital, after being a resident at another long term care facility. A progress note from the admitting behavioral health unit, dated 12/21/21, indicated Resident 240 presented to that facility "...due to being easily agitated, angered, impulsive, yells/curses at staff-becomes combative with care and hits staff. She will hit other patients and is verbally/physically threatening and confrontational. Is argumentative with medication, wanders, restless, anxious, paces and is very intrusive entering other rooms. Has verbal	F 0740	**F740 (D)** It is the practice of this provider to ensure that behavioral health services are provided to maintain the resident's highest practicable well-being. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Resident #240 no longer resides at the facility *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?* Any resident with behaviors has the potential to be affected by this alleged deficient practice. An IDT Meeting was held to identify all current residents with behaviors. Care Plans were updated as needed, residents were added to the behavior monitoring/tracking book as needed and residents to be followed by psyche/behavioral services as needed.	08/15/2022

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	outbursts..." A fax cover sheet indicated the behavioral health notes were faxed to the facility on 12/22/21. Resident 240's admission assessment, dated 12/21/21, indicated "...Resident is anxious...Resident is currently experiencing unwanted behavior(s). New repetitive behavior(s) noted. New disruptive behavior noted. New wandering behavior noted..." Resident 240's current orders included, but were not limited to, "May be seen by Psychologist PRN [as needed]," dated 12/21/21. Resident 240's orders lacked behavioral monitoring. A baseline careplan, dated 12/21/21, indicated resident was confused. Careplan did not address Resident 240's behaviors. On 1/6/22 Resident 240's care plans were updated and included "Resident presents with diagnosis of dementia with behaviors, and may exhibit any or all of the following moods and behaviors: aggression toward others, refusing care, and difficult with redirecting." During an interview on 7/18/22 at 2:44 P.M., Resident 5 indicated Resident 240 tried to suffocate her in December of 2021. Resident 240's progress notes failed to document the incident between Resident 5 and Resident 240. Resident 240's progress notes included the following: 12/31/21 5:59 P.M. "Resident wanders building, entering non community areas, requires frequent redirections. Will reach out and touch other people without permission, this resident doesn't understand personal space, easily redirected but requires frequent redirection."		*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* MDSC in-serviced by Regional MDS Coordinator regarding ensuring care plans are up to date and in a timely manner. All Department in serviced by the Administrator regarding monitoring/tracking/documenting behaviors and ensuring appropriate behavioral health services are offered. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center F740-20220721 Audit Tool*. Progress will be monitored on various shifts and to include some weekend days/shifts to ensure that the required supervision and education is provided five days weekly for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on	

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	1/5/22 6:24 P.M., "This resident got close to another resident and other resident ask [asked] resident to move back, this resident slapped other resident..." 1/8/22 10:30 A.M., "This resident entered another residents room. The resident began yelling at this resident and this resident became agitated in which she swung her arms at the other resident and smacked her in the face..." On 7/19/22 at 8:00 A.M., the Administrator provided an incident report involving Resident 240 and Resident 5. The incident report included the following: "Incident date: 12/28/2021. Incident Time: 11:01 P.M....Nurse was making rounds and when passing Resident 5's room, Resident 5 began yelling for the nurse. When nurse entered room, Resident 240 was standing next to Resident 5's bed. Resident 5 started to yell for the nurse to get Resident 240 out of her room, Resident 240 slapped her [Resident 5]. Resident's immediately separated...stop sign placed on Resident 5's door as a preventative..." During an interview on 7/20/22 at 2:22 P.M., the Administrator indicated Resident 5 started yelling for staff to help get Resident 240 out of her room. Resident 240 had been on a behavioral health unit at the hospital before admitting to the facility. The Administrator indicated at that time that she did not recall Resident 240 having any behaviors, but Resident 240 often wandered into other resident rooms. Resident 240 was discharged to a different long term facility on the dementia unit not long after the incident. During an interview on 7/21/22 at 8:08 A.M., CNA (certified nurses aide) 5 indicated Resident 240 wandered around a lot and was rude to the other		business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* August 15, 2022-2 -	

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	residents. During an interview on 7/21/22 at 8:12 A.M., QMA (qualified medication aide) 21 indicated Resident 240 was aggressive toward other residents and would wander into residents rooms often. QMA 21 further indicated that a stop sign was put on one Resident's door due to an incident that happened to keep Resident 240 out of the room. On 7/21/22 at 8:50 A.M., a current Behavior Management policy, revised December 2015, indicated "Each resident with identified behaviors...will be monitored for episodes of behaviors..." 3.1-43(a)(1)			
F 0880 SS=E 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			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 1 of 3 residents observed for medication administration, 1 of 3 residents observed for care, and 1 of 1 resident reviewed for urinary catheters. Gloves were not worn during administration of an insulin injection, gloves were not changed and hand washing was not completed appropriately during resident care, and a urinary catheter bag was touching the floor. (Resident 3, Resident 16, Resident 236, Resident 138, LPN 9, CNA 3, CNA 5) Findings include: 1. On 7/18/22 at 11:19 A.M., LPN 9 was observed to enter Resident 16's room. LPN 9 was holding a small syringe, and an alcohol wipe and asked Resident 16 if she could give her an insulin injection. LPN 9 was observed to raise Resident 16's shirt, and inject the resident without wiping with an alcohol swab. LPN 9 was not wearing gloves. On 7/19/22 at 11:00 A.M., medication administration was observed. LPN 9 was observed to draw up Resident 16's insulin, then carried the uncapped insulin syringe from the medication cart across the hall and into the resident's room. LPN wiped Resident 16's	F 0880	**F880 (E)** It is the practice of this provider to ensure that infection control practices are followed appropriately. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* Resident 16 now receives insulin injections with appropriate infection control practices (i.e. wiping with an alcohol pad and the staff do wear gloves) Staff now practice appropriate infection control measures while caring for resident #138 (including changing gloves and handwashing) Resident #236's catheter tubing and bag are maintained following appropriate infection control practices (i.e. tubing is maintained in the catheter bag) Resident #3 no longer receives	08/15/2022

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	injection site with an alcohol swab, then injected the resident. LPN 9 was not wearing gloves. 2. On 7/21/22 at 8:43 A.M., CNA 3 and CNA 5 were observed to provide care for Resident 138. After providing peri care, CNA 3 washed her hands with a 16 second soap lather before rinsing. CNA 5 obtained soap, then rubbed her hands under running water. After washing her hands, CNA 3 put on gloves, assisted CNA 5 to place a lift pad under Resident 138, attached the lift pad to the lift, then used the controls to assist the resident from the bed to a shower chair. CNA 3 then pushed Resident 138 in the shower chair to the shower room and provided a shower without changing gloves. After the shower, CNA 3 exited the room with Resident 138, then turned around and entered the shower room again to take the gloves off, and wash her hands. After taking Resident 138 back to her room, CNA 3 put on a new pair of gloves then using the lift controls, assisted the resident from the shower chair to her bed using a mechanical lift. CNA 3 then pushed the lift to the other side of the room, came back to the resident's bed, closed the privacy curtain on the left and the right side, then assisted CNA 5 to further dry the resident with towels. CNA 3 then held the resident's hand while turning her side to side to place a clean incontinence brief on her. CNA 3 then used her gloved left hand to apply a skin protectant cream on Resident 138's buttocks, and took the gloves off. CNA 3 had the same gloves on from the time she entered the resident's room until after the cream was applied. 3. On 7/18/22 at 12:04 P.M., Resident 236 was observed sitting in his wheelchair. Resident 236's catheter tubing was resting on the right wheel of the wheelchair. On 7/19/22 at 1:18 P.M., Resident 236's catheter		medication that has "dropped" onto any surface prior to placing in the medication cup. *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 in the facility have the potential to be affected by the same alleged deficient practice. Nursing Department staff in serviced on Infection prevention and control protocols, including, but not limited to: hand hygiene, gloving protocols, proper insulin administration procedures, proper medication administration procedure and indwelling catheter infection control protocol. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Nursing Department staff will be in serviced by DON/Designee on Infection prevention and control protocols, including, but not limited to: hand hygiene, gloving protocols, proper insulin administration procedures, proper medication administration procedure and indwelling catheter infection control protocol.	

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	bag was observed touching the wheelchair brace that holds the right front wheel on. The catheter bag was half full. The catheter bag cover was bunched up with the exposed catheter bag touching the outside portion of the wheelchair pedal. On 7/19/21 at 1:21 P.M., the Administrator walked by Resident 236's room and did not fix the catheter bag. On 7/20/22 at 10:24 A.M. Resident 236's catheter tubing was observed resting on the right front wheel of the wheelchair. On 7/20/22 at 3:23 P.M., Resident 236's catheter bag was resting on the right outside portion of the wheelchair. At that time, the catheter bag cover was bunched up exposing the catheter bag. At that time, LPN (licensed practical nurse) 9 indicated the catheter bag needed to be sanitized and a protective covering placed over the bag. During an interview on 7/21/22 at 9:53 A.M., DON (director of nursing) indicated that if a catheter bag is observed in contact with a wheelchair, staff should intervene and move the catheter bag after sanitizing the bag. 4. On 7/19/22 at 7:16 A.M., LPN (licensed practical nurse) 11 was observed preparing medications for Resident 3. LPN 11 dispensed a medication and that pill fell on the medication cart. LPN 11 proceeded to pick up the loose pill and put it in the medication cup and then administer to the resident. During an interview on 7/21/22 at 9:53 A.M., the DON (Director of Nursing) indicated staff should wash hands for 25 seconds, change gloves		*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be monitored using the *Washington Nursing Center F880-20220721 Audit Tool*. Progress will be monitored on various shifts and to include some weekend days/shifts to ensure that the required supervision and education is provided daily for 6 weeks, weekly for 8 weeks, and monthly for 2 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* August 15, 2022	

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	between dirty and clean tasks during care, and wear gloves during insulin administration. She indicated insulin injections should not be exposed when bringing in to a resident's room. On 7/21/22 at 8:50 A.M., a current insulin injection policy, dated 10/2014, was provided and indicated "Insulin should be administered immediately after being prepared ... Cleanse injection site with alcohol sponge" On 7/21/22 at 1:56 P.M., a current handwashing/hand hygiene policy, dated 10/2014, was provided and indicated the handwashing procedure should have a duration of 40-60 seconds, with at least a 20 second soap lather before rinsing. On 7/21/22 at 8:50 A.M., and current Indwelling Catheter Care policy, dated 10/2014, indicated "Care provided for an indwelling catheter will promote good hygiene and reduce the potential for infection." 3.1-18(b)(1) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and sanitary environment was maintained in 3 of 4 resident halls, 2 of 2 nurses stations, 2 of 2 shower rooms, and in an activity room and dining room available to all residents. Water damage was observed on the ceiling, a	F 0921	**F921 (E)** It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in	08/15/2022

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doorway was observed with water damage in a resident's room, floor and wall tiles were broken, doorways were observed with chipping paint, and resident room walls and ceilings were observed with nicks and chipping paint. (short and long South Hall, South Hall nurses station and shower room, Rehab Hall nurses station and shower room)

Findings include:

1. On 7/18/22 at 10:25 A.M., Room 63 was observed. Sheets were observed folded up on the floor against a pair of double doors and were wet. The closet doors were missing a handle on the left side. A used pair of gloves were observed sitting behind a television on a dresser. The private bathroom was observed with a baseboard peeling away from the wall, the sink was observed with spraying water from the base of the faucet and hot water handle when turned on, the hot water handle was loose and coming away from the sink, the sink was slow to drain, and the handles either side of the toilet were loose, with the right one swinging wide enough to hit the sink.

On 7/20/22 at 3:42 P.M., Room 63 was the same except there were no sheets in the floor in front of the double doors. The area in front of the double doors were observed with soft splintering wood that would give when stepped on. At that time, a washbasin was observed on the back of the commode with a bedpan in it with dark yellow and brown substances in it. Both were uncovered.

2. On 7/19/22 at 9:44 A.M., Room 76 was observed with 4 (four) uncovered wash basins stacked on the back of the commode. Several tiles were cracked on the private bathroom floor, and the toilet paper roll holder was missing.

accordance with federal and state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

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	On 7/20/22 at 3:47 A.M., Room 76 was the same. At that time, CNA 17 indicated washbasins were supposed to be covered, and she had not noticed the missing toilet paper holder. 3. On 7/19/22 at 9:42 A.M., Room 74 was observed with a missing closet handle, and several nicks on the walls with paint missing, and a large nick on the door. On 7/20/22 at 3:48 P.M., Room 74 was the same. 4. On 7/19/22 at 9:40 A.M., Room 65 was observed. The private bathroom was observed with 5 (five) open and uncovered incontinent brief bags on the floor, and an uncovered washbasin on the floor with incontinence briefs and underwear sitting in it. On 7/20/22 at 3:52 P.M., Room 65 was the same. 5. On 7/19/22 at 9:40 A.M., Room 64 was observed. The ceiling was peeling by the closet. A brown substance was smeared on the private bathroom toilet seat and on the front of the toilet. The commode was full and almost overflowing with a brownish green colored liquid in it. An uncovered wash basin was observed on the back of the commode, and the bathroom ceiling was peeling. On 7/20/22 at 3:54 P.M., Room 64's ceiling were the same. The wall on the window side of the room was observed nicked and scratched with paint missing. An uncovered wash basin was observed on the back of the commode. 6. On 7/18/22 at 11:36 A.M., Room 69 was observed with an uncovered wash basin on the		*potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?* No residents were identified as having been affected by this alleged deficient practice. A safe, sanitary and odor-free environment will be maintained for all residents. A whole-house audit will be completed by the maintenance director and Administrator to ensure the same and that the alleged deficiencies referenced herein are not present or corrected if noted. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* All staff will be ins-serviced by the Administrator/Designee on infection control practices in resident rooms, cleanliness and turning in maintenance work repairs when repairs are seen to be needed. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Progress toward the successful completion of this POC will be	

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	155145	A. BUILDING 00 B. WING	07/21/2022

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	shared bathroom floor. On 7/20/22 at 3:50 P.M., Room 69 was the same. 7. On 7/19/22 at 9:46 A.M., the South Hall shower room was observed. There were 2 (two) gloves in the tub, and another 2 (two) gloves on the floor by the foot of the tub, along with a rolled up brown sock. A hanger and bottle of deodorant were observed on the floor. An open box of razors were sitting on a bedside table, and one razor was observed outside of the box, uncapped. Hair and other debris was observed on the shower drain. An uncovered emesis basin was observed on the sink, and the structure under the sink did not fit properly, with a sharp edge sticking out of the top where the door was located. The doorway was nicked with paint missing. 8. On 7/20/22 at 3:30 P.M., the South Hall nurses station was observed with water damage on the ceiling. The ceiling was discolored, bubbling, and flaking. The same was observed on the common area ceiling by the nurses station. The walkway into the nurses station from the long hall was observed with duct tape on the floor, covering wires. At the end of the duct tape, exposed wires were observed bunched up on the floor. 9. On 7/21/22 at 9:29 A.M., the nurses station on the Rehab Hall was observed with water damage on the ceiling. The ceiling was discolored, bubbling, and flaking. 10. On 7/21/22 at 8:43 A.M., the Rehab Hall shower room was observed. The toilet bowl was observed to be brown, some sort of holder was observed on the wall above the commode and was broken. 6 (six) tiles were broken behind the commode, tiles were missing in the shower area		monitored using the *Washington Nursing Center F921-20220721 Audit Tool*. Progress will be monitored on various shifts and to include some weekend days/shifts to ensure that the required supervision and education is provided five days weekly for 1 month, weekly for 4 weeks, and semi-monthly for 4 months or until substantial compliance is met. Documentation of all activities associated with this POC will be noted on said audit tool. The Administrator and/or designee will review the audit tool(s) on business days during Standup, in accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Administrator, or designee will be responsible for monitoring this POC to ensure its successful completion. *By what date the systemic changes for each deficiency will be completed?* August 15, 2022	

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	toward the bottom, and a door was broken off of a cabinet and was laying on top of it. The shower room lacked a shower curtain, despite a track and clips where one would be placed. 11. On 7/20/22 at 12:16 P.M., the following rooms on the South Hall were observed with paint chipping from the doorways from the waist down: Room 43 Room 45 Room 46 Room 47 Room 48 Room 49 Room 50 Room 54 Room 55 Room 56 Room 57 Room 58 Room 59 Room 61 Room 62 On 7/21/22 at 9:06 A.M., the same was observed. 12. On 7/20/22 at 12:18 P.M., the activity room was observed to have a large area on the ceiling with peeling paint and the wall was flaking off. In that area, the ceiling was brown in color. In front of the window in the activity room, the wallpaper was peeling. The wallpaper was peeling on 3 of 4 walls in the activity room. On 7/21/22 at 12:00 P.M., the activity room was the same. During an interview on 7/21/22 at 9:29 A.M., the Maintenance Supervisor indicated he was aware of the ceilings over the nurses stations. He indicated he was aware that the resident room doorways needed to be painted, but have not			

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	been done yet. He indicated he was currently the only maintenance staff in the facility, and had been working on "what is important for the residents", and would get to other issues if there was time. He indicated there was not a facility policy for maintenance, but that staff should fill out a work order when they notice a concern, and he would check daily. During an interview on 7/21/22 at 12:00 P.M., the DON (Director of Nursing) indicated washbasins and other things in the bathrooms needed to be covered. 3.1-19(a)(4) 3.1-19(f)			