STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR TRACE HEALTH & LIVING COMMUNITY	**3701 HODGIN RD RICHMOND, IN 47374**

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain two resident's dignity when staff failed to knock on the residents' room doors or announce themselves prior to entrance to the residents' rooms for 2 of 8 random observations. (Residents 53 and 74) Findings include: 1. On 3/03/20 at 3:03 p.m., CNA 4 entered Resident 53's room without knocking. CNA 4 indicated she brought some things in for Resident 53's roommate's shower later. Resident 53 said staff don't usually knock before they come in. The clinical record for Resident #53 was reviewed on 3/9/20 at 10:13 a.m. The resident's [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set (MDS) assessment, dated 1/30/20, indicated Resident 53 was cognitively intact. On 3/10/20 at 2:36 p.m., QMA 1 indicated she will remind staff to knock before entering and she educates them to ask for permission to go into the room. 2. On 3/04/20 at 2:59 p.m., Hospitality Aide 2 entered Resident 74's room without knocking before he entered. CNA 3 was observed entering behind him and didn't knock before entering. Resident 74 indicated he didn't hear either knock before they came in. Resident 74's record was reviewed on 3/06/20 at 12:53 p.m. The record indicated Resident 74 had [DIAGNOSES REDACTED]. A Quarterly MDS assessment, dated 2/6/20, indicated Resident 74 was cognitively intact. A Policy for Quality of Life - Dignity was provided by the Director of Nursing on 3/10/20 at 5:03 p.m. The policy included, but was not limited to: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times .6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms 3.1-3(t)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide fresh fluids within a resident's reach for 1 of 1 resident's reviewed for hydration (Resident 21). Finding include: During an observation on 3/3/2020 at 3:05 p.m., Resident 21 was lying in bed. The resident had a styrofoam cup of water was dated 3/3/2020. It was located on her bedside table on the other side of a recliner that was located beside her bed. The water was out of the resident's reach, full and warm to touch with no ice. During an observation on 3/5/2020 at 1:51 p.m., Resident 21 was lying in bed. The resident's styrofoam cup was dated 3/5/2020. The cup of water was out of her reach on the bedside table. During an observation on 3/6/2020 at 10:45 a.m., Resident 21 was lying in bed. The resident's styrofoam cup was dated 3/5/2020, full, warm to touch and had no ice. During an interview and observation with LPN 7 on 3/6/2020 at 1:30 p.m., Resident 21 was lying in bed. The resident's styrofoam cup was out of the resident's reach and dated 3/5/2020. LPN 7 indicated the resident's water was out of reach and was yesterday's water. She provided the resident with fresh ice water and placed it within the resident's reach. LPN 7 indicated all nursing staff were responsible to ensure residents were provided with fresh water daily and ensure it was in reach of the resident. The clinical record for Resident 21 was reviewed on 3/5/2020 at 2:20 p.m. The resident's [DIAGNOSES REDACTED]. The plan of care, dated 1/3/2020, indicated the resident was at risk for dehydration related to dementia and did not always drink sufficient fluids. The interventions included, but were not limited to, fluids to be in reach. The dehydration risk assessment, dated 3/6/2020, indicated the resident was at risk for dehydration. The hydration policy provided by the Director Of Nursing (DON) on 3/9/2020 at 12:15 p.m., indicated residents with the following conditions are potentially at risk for dehydration: inability to reach fluids. 3.1-3(v)(1)
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) to 1 of 3 residents reviewed for liability and appeal notices. (Resident 14) Findings include: On 3/10/20 at 3:55 p.m., the Administrator provided a SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form for Resident 14. The SNF Beneficiary Protection Notification Review form indicated Resident 14 started Medicare Part A skilled services on 12/16/19, her last covered day of Part A services was 2/21/20 and the facility/ provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Resident 14 did not receive the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) nor the Notice to Medicare Provider Non-coverage (NOMNC) forms and there was no explanation on the Beneficiary Protection Notification Review form why these forms were not provided. On 3/10/20 at 3:55 p.m., the Administrator indicated there was no NOMNC for this resident.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist a dependent resident with brushing her hair and getting dressed for 1 of 1 resident's reviewed for Activities of Daily Living (ADL) assistance (Resident 21). Finding include: During an observation on 3/04/2020 at 11:00 a.m., Resident 21 was in the dining room with several other residents. The resident's hair was uncombed, disheveled. During an observation on 3/05/2020 at 12:37 p.m., Resident 21 was in the dining room eating lunch with several other residents. The resident's hair was disheveled and sticky out all over. During an observation on 3/06/20 at 12:54 p.m., Resident 21 was sitting in front of the nursing station her hair disheveled and uncombed. The review of the clinical record for Resident 21 was on 3/5/2020 at 2:20 p.m. The resident's [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) assessment, dated 1/2/2020, indicated the resident was severely cognitively impaired for daily decision making and had no behaviors of rejection of care. The resident required extensive assistance of one staff member for getting dressed and brushing her hair. The plan of care, dated 1/3/2020, the resident required extensive assist of 1 - 2 with ADL's: dressing/grooming due to general weakness and impaired cognition. During an observation and interview with the Director Of Nursing (DON) on 3/9/2020 at 2:30 p.m., Resident 21 was observed in common areas with her hair uncombed, disheveled. The DON indicated the CNA's were responsible to assist residents with combing their hair before coming out of their room. The ADL policy provided by the Administrator on 3/10/2020 at 9:15 a.m., Residents who are unable to carry out activities of daily living independently will receive the services necessary to

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) maintain good grooming and personal hygiene. The services included, but were not limited to, dressing and grooming. 3.1-38(a)(3)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pressure relieving boots or off loading of heels for dependent residents that were at risk for developing pressure ulcers and developed a pressure for 2 of 2 residents reviewed for pressure ulcers (Resident 18 and Resident 21). Findings include: 1. During an interview with Resident 18's family member on 3/04/20 at 11:55 a.m., the resident had a pressure ulcer on her heel. The facility was not putting pressure relieving boots on her and she developed the pressure ulcer. The facility now was putting pressure relieving boots on her. During an interview with LPN 7 on 3/05/2020 at 12:53 p.m., she indicated the area on the residents heel was resolved today. The black eschar fell off and her heel was pink and shiny now. During an observation on 3/06/2020 at 1:17 p.m., QMA 8 applied skin prep, [MEDICATION NAME] and applied a kerlix dressing on the resident's right heel. The right heel was pink in color. The review of the clinical record for Resident 18, on 3/11/2020 at 3:00 p.m., indicated the resident's [DIAGNOSES REDACTED]. The progress note, dated 2/19/2020 at 9:12 p.m., CNA reported to this writer that resident had a discolored area on her heel. The resident's right heel was assessed and measured 4 centimeter (cm) circumference area brown in color and mushy. Applied skin prep and heel boots while in bed. Family and Medical Doctor (M.D.) notified. The Interdisplinary Team (IDT) wound note, dated 2/20/2020 at 8:08 p.m., indicated the resident noted to had a discolored area to the right heel. Skin was tan/brown and hard. The wound was pink and normal. Area measured 3 cm x 3.9 cm. Resident had [DIAGNOSES REDACTED]. Unable to provide education to reposition/offload heels. Resident spends most her time in bed. Heel boots ordered while in bed for prevention, and [MEDICATION NAME] to heel pad and protect with ABD pad and wrap with kerlix. Nursing to continue to monitor. The wound assessment, dated 2/20/2020, indicated the resident had a 3 cm by 3.9 cm pressure ulcer (no stage) on the right heel. The wound assessment, dated 2/27/2020, indicated the resident had a 3.5 cm by 3.5 cm unstageable- deep tissue pressure ulcer on the right heel. The wound assessment, dated 3/5/2020, indicated the resident's wound had healed. The skin risk assessment, dated 2/24/2020, indicated the resident required assistance to reposition, moves in a way that could cause friction or shearing, does sit up more than two hour periods of time, the resident's skin is exposed to moisture, had a history of [REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 2/25/2020, the resident was severely cognitively impaired for daily decision making. The resident had no behaviors of rejection of care. The resident required extensive assistance of two staff member assistance for bed mobility and transfers. The resident was at risk for developing a pressure ulcers and had an unhealed pressure ulcer that was unstageable - deep tissue injury. The physician's orders [REDACTED]. 2. During an observation on 3/03/2020 at 3:06 p.m., Resident 21 was lying in bed with the side of her heels on the mattress, she had no pressure relieving boots or pillow off loading her heels. The resident had one pressure relieving boot lying in her bed. During an observation on 3/05/2020 at 1:51 p.m., Resident 21 was lying in bed with no pressure relieving boots or pillow to offload her heels. The resident was observed to have one pressure relieving boot lying on a chair. The clinical record for Resident 21 was reviewed on 3/5/2020 at 2:20 p.m. The resident's [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) assessment, dated 1/2/2020, indicated the resident was severely cognitively impaired for daily decision making and had no behaviors of rejection of care. The resident required extensive assistance of two people for bed mobility, transfers, does not ambulate. The resident was at risk for developing pressure ulcers. The plan of care, dated 1/3/2020, indicated the resident was at risk for developing pressure ulcers due to bowel and bladder incontinence, need for extensive assistance with bed mobility and tendency to remain/return to same position. The wound assessment, dated 3/5/2020, indicated the resident had an unstageable pressure ulcer on her left toe that measured 1.3 cm by 1.4 cm. The wound assessment, dated 3/10/2020, the resident had a 0.4 cm by 0.6 cm vascular wound on her left big toe. During an observation on 3/9/2020 at 12:30 p.m., CNA 20 and CNA 21 assisted the resident from her wheelchair to her bed using a gait belt. Provided incontinent care and placed pressure relieving boots on the resident. The resident did not refuse. Both Aides indicated the resident had never refused to have pressure relieving boots applied. Both CNA's had cared for the resident a long time. Interview with the Director Of Nursing (DON) on 3/9/2020 at 2:30 p.m., she indicated the CNA's were responsible to apply pressure relieving boots on resident while in bed, the charge nurse should ensure the pressure relieving boots were in place. During an interview with the DON on 3/11/2020 at 12:25 p.m., she indicated any resident that cannot move themselves in bed should have pressure relieving boots on or a pillow to off load the heels. During an interview with the Medical Director on 3/11/20 at 1:43 p.m., he indicated he assessed the resident's toes and she had some necrotic areas. The Medical Director could not feel pedal pulses on her feet and assessed the areas to be peripheral vascular ulcers. During an interview with the DON on 3/11/2020 at 3:30 p.m., indicated there was no documentation that the resident refused pressure relieving boots. During an observation with the DON on 3/11/2020 at 3:40 p.m., indicated the resident was lying in bed with pressure relieving boots in place. The resident had no areas on her right foot and she had a small black eschar area on her big toe and a small black eschar area on her second toe of her left foot. The skin risk policy provided by the DON on 3/9/2020 at 3:40 p.m., indicated residents that are assessed to be at risk for pressure ulcers interventions would be implemented. 3.1-40
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to investigate the root cause of falls, implement interventions to prevent further falls, and to complete neurological assessments and 15 minute checks after an unwitnessed fall for 1 of 3 residents reviewed for accidents. (Resident 17) Finding include: During an interview with Resident 17 on 3/3/2020 at 2:50 p.m., she indicated she fell at the facility several times. The resident was unsure what was causing her to fall. The resident could not stand long and was weak. During an observation on 3/05/2020 at 12:41 p.m., QMA 8 assisted Resident 17 from her wheelchair to the toilet with a gait belt. The resident was totally dependent of the QMA to transfer and was bent at the waist during the entire transfer. The resident could no longer stand during the transfer and ended up sitting on the toilet with only one buttocks on the toilet. The QMA had to position the resident the rest of the way onto the toilet. The QMA indicated the resident had declined in her ability to walk and transfer in the last month. The review of the CNA assignment sheet, dated 3/6/2020 at 2:45 p.m., indicated the resident required extensive assistance of one staff member's assistance for transfers. The review of the clinical record for Resident 17 on 3/9/2020 at 10:13 a.m., indicated the resident's [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/19, indicated the resident required extensive assistance of one person for transfers and extensive assistance of two people for ambulation. The resident had two falls with no injury. The Significant Change Minimum Data Set (MDS) assessment, dated 2/18/2020, indicated the resident required extensive assistance of two staff for transfers and the resident did not ambulate. The fall assessment, dated 2/18/2020, indicated the resident was at risk for falls. The plan of care, dated 2/19/2020, indicated the resident was at risk for falling and fall related injuries. The resident had weakness and poor balance. There were no updated fall interventions listed since 9/27/2019. The post fall assessment, dated 10/10/2019, indicated the resident had an unwitnessed fall. The resident was lying on her right side next to the bed. The resident indicated the piece connecting the carpet to the linoleum got caught on her shoe and she fell . There were no injuries. The immediate intervention was neurological checks and 15 minute checks. The post fall assessment, dated 11/27/2019, indicated the resident had an unwitnessed fall. The resident was sitting on buttocks outside of the bathroom door. The resident stated she lost her balance and fell backwards onto her bottom as she was walking to the bathroom. There were no injuries. The immediate intervention was 15 minute checks. The post fall assessment, dated 11/29/2019, indicated the resident was lowered to the floor by a staff member onto her buttocks. The resident was almost to the toilet and her knee's gave out, the CNA had to lower her to the floor. There were no injuries. The immediate intervention was 15 minute checks and notifying the physician. During an interview with the Director Of Nursing (DON) on 3/9/2020 at 4:15 p.m., she indicated the facility protocol for falls were the Interdisplinary Team (IDT) would meet and investigate the fall for possible root cause of the fall. The IDT would go to the resident's room and see if there was any environmental factors that caused the fall or maybe the resident's room needed to be rearranged. The IDT then would implement appropriate interventions to prevent further falls. During an interview with the Director Of Nursing (DON) on 3/11/2020 at 12:30 p.m., she indicated there was no Interdisciplinary Team (IDT) investigation for root cause or fall interventions implemented for the resident's falls on

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 10/10/2019, 11/27/2019 or 11/29/2019. During an interview with the DON on 3/11/2020 at 2:55 p.m., there was no documentation that the 15 minute checks or neurological checks were completed for the 10/10/2019 fall. The fall prevention policy provided by the Administrator on 3/10/2020 at 9:15 a.m., the purpose was to provide the facility with the best practices and evidence based approaches to prevent falls and protect residents who are at risk for falling. The IDT team would investigate the root cause of the fall and for any additional information that could be useful in preventing a reoccurrence. The IDT will assist with updating the care plan and nurse aide assignment sheets to ensure accuracy of fall preventions. Strategies for interventions to prevent falls will be individual for each patient. 3.1-45(a)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on interview and record review, the facility failed to maintain records reflecting the food temperatures, refrigerator and freezer temperatures, dishwasher temperatures and sanitizing solution of buckets used for cleaning for the calendar year 2019, through January, 2020. This deficient practice had the potential to affect 96 of 128 resident residing in the facility. Findings include: In an interview with the Dietary Manager on 3/9/20 at 11:08 a.m., he indicated he had identified a problem. I did not realize that the staff here do not input the temperatures into the computer, but kept the handwritten temperature logs. When I came here, I found a whole bunch of temp logs in the file drawers and got rid of them. I had no idea they were not computerized. Where I worked previously, the logs were kept on paper until the end of the month, then I would put them into the computer and throw away all of the paper logs. So, all I have are the logs from February and this month. He clarified the missing logs included food temps, fridge and freezer temps, dishwasher temps and sanitizing solution checks. As a result of this information, the only records for these topics that were reviewed were for the month of February, 2020 and the current month of March, 2020. In a second interview on 3/10/20 at 2:00 p.m., with the Dietary Manager, he added he could not find any other logs for 2019. When I found the paperwork in a file cabinet, I just assumed it had all been logged in the computer and with it being outdated, I just threw it away. I was in the process of cleaning out that file cabinet because the bottom drawer was nearly rusted out. 3.1-21(i)(3)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents had a completed personal inventory sheet related to clothing for 2 of 2 residents reviewed for inventory records. (Resident B) Findings included: The clinical record for Resident B was reviewed on 3/10/20 at 3:20 p.m. The resident's [DIAGNOSES REDACTED]. An inventory sheet, that would have documented the clothing the resident brought with him while in the facility, could not be located. On 3/11/20 at 9:55 a.m., the Director of Nursing indicated they did not have an inventory sheet for Resident B. On 3/11/20 at 10:08 a.m., LPN 7 indicated the first night Resident B came in, he was wearing a hospital gown front and back, slipper socks, and pajama pants. He wore them for a couple of days, then a family member said he would bring in some clothes, but the clothes he brought in were too big, then he brought in additional clothing that fit the resident. The LPN did not know what happened to the resident's clothes when he was discharged , she didn't pack up the room. The staff would fill out an inventory sheet as soon as a resident arrived at the facility. The list would be updated as family brought in items. The inventory sheet was laying there without anything items listed. On 3/11/20 at 12:23 p.m., the Director of Nursing indicated they did not have a policy for inventory forms. They have an admission check list they use, and it is checked off as it is completed. She agreed that his admission check list did not have the inventory form checked off as completed. This Federal Tag relates to Complaint IN 003. 3.1-50(a)(1)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the maintenance of an infection prevention and control program (September through December, 2019) for 4 of 12 months reviewed. This deficient practice had the potential to affect 128 residents that resided in the facility. Findings include: In an interview with Director of Nursing (DON) on 3-9-20 at 1:49 p.m., she indicated the facility's Staff Development Coordinator (SDC) had resigned over the weekend of 3-7-20 to 3-8-20, effective immediately. She explained the SDC was the facility's designated infection control preventionist. The DON and Assistant Director of Nursing (ADON) would be acting in the SDC's role until a replacement was hired. On 3-9-20 at 3:44 p.m., the DON provided an Infection Control Surveillance binder for 2019, and an Infection Control Data Log for January and February, 2020. Upon review of the 2019, binder, it was identified for the months of September, October, November and December, 2019, the infection control surveillance information was missing. When this was brought to the attention of the DON, she indicated she would search for additional information. In an interview with the DON on 3-9-20 at 4:14 p.m., she indicated I cannot locate any of the infection control tracking for September through December, 2019. The previous SDC was here part of the time before I started. I did not start here until early December of 2019. The only explanation that I can offer is that there had been many nurse openings and people doing multiple jobs and it must have fallen through the cracks. Prior to me coming as DON, there was an interim DON in place. The current ADON was not put into that position until sometime in the fall of 2019. The facility's employee records identified the SDC's start date as 11-25-2019. In an interview with the ADON on 3-10-20 at 10:45 a.m., she indicated she started in the ADON position in August or September of 2019. In an interview on 3-10-20 at 10:50 a.m., with the DON, she indicated she had not been aware of the missing information in the Infection Control binder until the previous day, adding the SDC had not made her aware of the missing information. In an interview on 3-10-20 at 10:50 a.m., with the Corporate Nurse, she indicated she had addressed the missing infection control information with the Administrator. This building keeps a calendar for QAPI (Quality Assurance and Performance Improvement) of topics to address and when. Infection control is addressed quarterly, in January, April, July & October. In speaking with the Administrator, she recalled the January, 2020 QAPI discussion included addressing a decrease in the number of UTI's (urinary tract infections). On 3-10-20 at 11:50 a.m., in an interview with the DON, she indicated If a resident has a positive lab test or other symptoms that might lead to being on Isolation Precautions, the nurse on duty, the floor nurse, was expected to make sure the doctor was aware of the situation and get orders for treatment and for whatever type of precautions are required. Plus, the nurse should be letting management know. Actually, the new orders would be reviewed the next morning in morning meeting and will be verified for accuracy and to make sure the appropriate steps have been taken, orders obtained and proper notification has taken place. The management team would make sure the Infection Control staff member is aware of the situation, in case that person hasn't been notified yet. She continued, The infection control logs are retroactive to the previous month. For example, the March infection control log would be looking at the month of February. A review of the Infection Control Log for January 2020, reflecting December 2019, indicated the following information: 19 residents on antibiotics, 11 residents with a respiratory infection, 11 residents with a UTI, 1 resident with clostridioides difficile ([MEDICAL CONDITION]), 2 residents with [MEDICATION NAME]-resistant [MEDICATION NAME] (VRE) and no residents with [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA). A review of the Infection Control Log for February 2020, reflecting January 2020, indicated the following information: 28 residents on antibiotics, 15 residents with a respiratory infection, 5 residents with a UTI, and no residents with [MEDICAL CONDITION], VRE [MEDICAL CONDITION]. A review of the Infection Control Log for March 2020, reflecting February 2020, indicated the following information: 25 residents on antibiotics, 8 residents with a respiratory infection, 6 residents with a UTI, and no residents with [MEDICAL CONDITION] or VRE, and 3 residents [MEDICAL CONDITION]. On 3-11-20 at 4:14 p.m., the DON provided a copy of a policy for Infection Prevention and Control Program. This policy had an policy date of 6-6-19. This policy indicated, (Name of corporation) maintain(s) an infection prevention and control program that involves all disciplines and individuals and is an integral part of the Quality Assurance and Performance Improvement Program. The elements of the infection prevention and control program consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. 3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(b)(1)(B)
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.**

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate documentation was maintained for the antibiotic stewardship (September through December, 2019) for 1 of 4 quarters reviewed. This deficient practice had the potential to affect all residents in the facility. Findings include: In an interview with Director of Nursing (DON) on 3-9-20 at 1:49 p.m., she indicated the facility's Staff Development Coordinator (SDC) had resigned over the weekend of 3-7-20 to 3-8-20, effective immediately. She explained the SDC was the facility's designated infection control preventionist. The DON and Assistant Director of Nursing (ADON) would be acting in the SDC's role until a replacement was hired. On 3-9-20 at 3:44 p.m., the DON provided an Infection Control Surveillance binder for 2019, and an Infection Control Data Log for January and February, 2020. Upon review of the 2019, binder, it was identified for the months of September, October, November and December, 2019, information was missing. When this was brought to the attention of the DON, she indicated she would search for additional information. In an interview with the DON on 3-9-20 at 4:14 p.m., she indicated I cannot locate any of the infection control tracking for September through December, 2019. .it must have fallen through the cracks . In an interview on 3-10-20 at 10:50 a.m., with the DON, she indicated she had not been aware of the missing information in the Infection Control binder until the previous day, adding the SDC had not made her aware of the missing information. In an interview on 3-10-20 at 10:50 a.m., with the Corporate Nurse, she indicated she had addressed the missing infection control information with the Administrator. This building keeps a calendar for QAPI (Quality Assurance and Performance Improvement) of topics to address and when. Infection control is addressed quarterly, in January, April, July & October. In speaking with the Administrator, she recalled the January, 2020 QAPI discussion included addressing a decrease in the number of UTI's (urinary tract infections). On 3-10-20 at 11:50 a.m., in an interview with the DON, she explained, If a resident has a positive lab test or other symptoms that might lead to being on Isolation Precautions, the nurse on duty, the floor nurse, is expected to make sure the doctor is aware of the situation & get orders for treatment and for whatever type of precautions are required. Plus, the nurse should be letting management know. Actually, the new orders would be reviewed the next morning in morning meeting and will be verified for accuracy and to make sure the appropriate steps have been taken, orders obtained and proper notification has taken place. The management team would make sure the Infection Control staff member is aware of the situation, in case that person hasn't been notified yet. She continued, The infection control logs are retroactive to the previous month. For example, the March infection control log would be looking at the month of February. A review of the Infection Control Log for January 2020, reflecting December 2019, identified the following information: 19 residents on antibiotics, 11 residents with a respiratory infection, 11 residents with a UTI, 1 resident with clostridioides difficile ([MEDICAL CONDITION]), 2 residents with [MEDICATION NAME]-resistant [MEDICATION NAME] (VRE) and no residents with [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA). On 3/11/20 at 5:54 p.m., the Assistant Director of Nursing provided resident census information which documented the average monthly resident census for November, 2019, was 98.43, for December, 2019 was 96.77 and for January, 2020 was 96.61. On 3-11-20 at 4:14 p.m., the DON provided a copy of a policy entitled, Infection Prevention and Control Program. This policy had an policy date of 6-6-19. This policy indicated, (Name of corporation) maintain(s) an infection prevention and control program that involves all disciplines and individuals and is an integral part of the Quality Assurance and Performance Improvement Program. The elements of the infection prevention and control program consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. 3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(b)(1)(B)