

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Williamsport Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Short St Williamsport, IN 47993	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49068</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity for 1 of 1 resident reviewed for dignity (Resident 4).</p> <p>Findings include:</p> <p>During a dining observation on 5/8/24 at 11:50 a.m., the Speech Language Pathologist (SLP) was observed to be standing at Resident 4's left side, assisting him with eating and drinking. She was not observed to sit down while assisting him.</p> <p>Resident 4's record was reviewed on 4/15/24 at 11:21 a.m. His diagnoses included, but were not limited to, paraplegia (loss of muscle function in the lower body), lack of coordination (poor muscle control), contracture of muscles (permanent shortening of a muscle causing deformity), abnormal posture (involuntary abnormal position of the body), and mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions).</p> <p>A comprehensive care plan, last reviewed 5/13/24, indicated resident had a problem with activities of daily living (ADL) that started 1/19/23 and needed assistance with ADL's, including eating, with an intervention approach to assist resident with eating as needed.</p> <p>During an interview on 5/15/24 at 11:50 a.m., the Director of Nursing (DON) indicated that on 5/8/24, during lunch, Resident 4 was receiving his quarterly screening to determine if there was a need for therapy services. When he was being assisted with eating it was not a swallow study and if anyone was assisting him with eating, she hoped that they would be sitting in a chair like they would with normal assisting. She indicated that the SLP answers should not be any different.</p> <p>During an interview on 5/15/24 at 1:15 p.m., the SLP indicated when she completed quarterly evaluations, she would occasionally assist residents with eating and drinking and she would be sitting down next to them while working with them. It was an evaluation just to lay eyes on them to see how they are doing and determine if there were any indicators that would warrant them to be picked up for therapy.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/24 at 1:51 p.m., the DON provided a document, updated 3/15/17, titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Respect and dignity. You have the right to be treated with respect and dignity, including . the right to reside and receive services in the facility with reasonable accommodation of your needs and preferences</p> <p>3.1-3(v)(1)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317</p> <p>Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 1 of 3 residents reviewed for care plan meetings (Resident 7), and the facility failed to ensure an oxygen care plan was implemented for 1 of 3 residents reviewed for care plans (Resident 15).</p> <p>Findings include:</p> <p>1. During an interview, on 5/10/24 at 10:22 a.m., Resident 7 indicated he did not remember being invited to or attending a care plan meeting. He did not recall when the last one was.</p> <p>Resident 7's record was reviewed on 5/14/24 at 9:45 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/22/24, indicated the resident had moderate cognitive impairment.</p> <p>Census information indicated the resident was admitted to the facility on [DATE].</p> <p>A Social Service Director (SSD) note, dated 8/29/23, indicated a care plan meeting was conducted on this day for Resident 7.</p> <p>A SSD note, dated 2/22/24, indicated a care plan meeting was conducted on this day for Resident 7.</p> <p>Resident 7's record lacked documentation of a quarterly care plan meeting being conducted for the last year from May 2023 to May 2024. The resident had two care plan meetings for the entire year.</p> <p>During an interview, on 5/14/24 at 10:33 a.m., the SSD indicated she could not find where Resident 7 had quarterly care plan meetings for the last year. She indicated they should be conducted quarterly, and she would normally send invites to the resident representatives via mail or by phone.</p> <p>During an interview, on 5/14/24 at 11:45 a.m., the Director of Nursing (DON) indicated care plan meetings should be conducted quarterly.</p> <p>48226</p> <p>2. A. On 5/09/24 at 10:52 a.m., during an observation and interview, Resident 15 was sitting in a wheel chair in his room. The portable oxygen tank meter flow gauge was set on 2 liters (L) and being administered to the resident by a nasal canula (NC). The resident indicated it should have been on 3 L.</p> <p>On 05/13/24 at 11:30 a.m., during routine observation, the resident was sitting in the dining room. The portable oxygen tank meter flow gauge was set on 2L and being administered by a NC.</p> <p>On 5/14/24 at 10:19 a.m., during routine observation, the resident was sitting in his wheelchair in his room. The portable oxygen meter flow gauge was set on 2L and being administered through a NC.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/24 at 10:22 a.m., during an interview with LPN 9, the LPN indicated she was not sure what the oxygen should be set at.</p> <p>On 05/14/24 at 10:27 a.m., during an interview with the Director of Nurses (DON). The DON verified the oxygen for Resident 15 is ordered to be set on 3L per NC and administered continually.</p> <p>On 5/14/24 at 10:35 a.m., the medical record for Resident 15 was reviewed. Diagnoses included but were not limited to. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24.</p> <p>Physician orders included but were not limited to: Change oxygen tubing and humidity. Clean concentrator and filter. Once A Day on Sun dated 2/23/2024, oxygen at 3 liters per nasal cannula every shift dated 5/07/2024.</p> <p>An admission care plan dated 2/26/24 lacked documentation of a care plan for oxygen use.</p> <p>On 5/13/24 at 10:00 a., During an interview with Registered Nurse (RN) 23, she indicated the resident did not have a care plan for oxygen use or impaired gas exchange.</p> <p>An admission Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident was on oxygen during the initial look back period.</p> <p>On 5/14/2024 at 1:26 p.m., the Director of Nursing (DON) provided a document titled, IDT Comprehensive Care Plan Policy, dated 8/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy .It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process .Purpose .Improve relationships between resident, families and or representative, and facility caregivers through understanding of resident's social history, culture and preferences to enhance the resident's life .Procedure .Resident, resident's representative, or others as designated by the resident will be invited to care plan review .Care plan problems, goals and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment</p> <p>3.1-35(d)(2)(B)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49068</p> <p>Based on observation and interview, the facility failed to ensure hot water temperatures were maintained within safe range for 5 of 7 residents reviewed for accidents (Resident 49, 36, 5, 29, and 208).</p> <p>Findings include:</p> <p>During random observation on 5/9/24 at 9:30 a.m., the public bathroom sink water was too hot to hold hands under for more than a few seconds without burning the skin.</p> <p>During random observation on 5/9/24 at 11:01 a.m., Residents 49's and 36's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running at one and two minutes read 130.1 degrees Fahrenheit (F).</p> <p>During an interview on 5/9/24 at 11:19 a.m., Resident 5 indicated the water was too hot when she washed her hands. Residents 5's and 29's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running one minute read 132.3 degrees F, and after running two minutes read 134.2 degrees F.</p> <p>During random observation on 5/9/24 at 11:31 a.m., Resident 208's sink water was too hot to hold hands under for more than a few seconds without burning the skin. The water temperature after running one minute read 128 degrees F, and after two minutes read 130 degrees F.</p> <p>During an interview on 5/9/24 at 11:55 a.m., the Administrator (ADM) indicated they recently had the water heater replaced that provided hot water to the Resident rooms and indicated they would need to adjust the hot water temperatures right away. She also indicated that their Maintenance Supervisor was new and had just started on 5/8/24.</p> <p>During an interview on 5/9/24 at 11:59 a.m., the Maintenance Supervisor indicated he was not able to locate temperature logs yet and indicated he had checked the water temperatures that morning, noticed they were running high but did not document them. He indicated there were two water heaters in the building, one for kitchen and laundry, one for resident rooms and the temperatures should read below 120 degrees F. During the interview, the ADM provided login information to access TELS (an online platform used to track maintenance tasks) to the Maintenance Supervisor.</p> <p>On 5/9/24 at 12:09 p.m., the faucet water temperatures were checked with the Maintenance Supervisor. He indicated he was not sure how to calibrate the thermometer and the water temperatures were to be between 100-120 degrees F. He read Residents 49's and 36's water temperature, in less than one minute, reached 134.4 degrees F. Resident 208's water temperature reached 129 degrees at one minute.</p> <p>On 5/14/24 at 11:52 a.m., the Maintenance Supervisor indicated he was still unable to locate temperature logs from before 5/8/24 but learned there were three hot water heaters in the building, one for each resident wing, after having a plumber come out the evening of 5/9/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/14/24 at 1:18 p.m., the Maintenance Supervisor provided water temperature logs for the last 30 days. No temperature logs were provided for between 4/23/24-5/9/24.</p> <p>During an interview on 5/14/24 at 1:50 p.m., the ADM indicated they did not have a policy related to monitoring water temperatures or temperature guidelines and that the TELS program notifies maintenance when temperatures should be checked weekly.</p> <p>During an interview on 5/15/24 at 10:27 a.m., the ADM indicated the former Maintenance Supervisors last day was 4/26/24 and that nobody had been checking the water temperatures after he left until the new Maintenance Supervisor started she was not sure how long the temperatures had been running high.</p> <p>3.1-45 (a)(1)</p> <p>3.1-45 (a)(2)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on observation, interview, and record review, the facility failed to ensure catheter care and placement of catheter equipment for 1 of 1 residents reviewed for catheter care. (Resident 15)</p> <p>Findings include:</p> <p>On 5/8/24 at 11:07 a.m., during main dining room meal observation, Resident 15 sat in his wheelchair. The catheter bag was completely in contact with floor touching wheel of wheelchair dignity bag (a cloth bag covering the urinary drainage bag) was not completely covering bag and urine was visible.</p> <p>On 5/08/24 at 11:21 a.m., during routine observation, observed catheter bag had continued to be in contact with the floor coming out of the dignity bag resident continues to pull on tubing causing bag to go up and down. touching the floor, his shoes, and wheel of wheelchair.</p> <p>On 5/08/24 at 11:28 a.m., during routine observation, observed Resident 15 pick up catheter bag and placed it in his lap. The resident continued to touch the drainage bag tubing with hands while in the drainage bag continued to be in his lap.</p> <p>On 5/08/24 at 11:34 a.m. during routine observation, Licensed Practical Nurse (LPN) 9 picked up the drainage bag from Resident 15's lap and placed drain bag into the dignity bag and left dining room with resident to fix the placement of the bag and tubing.</p> <p>On 5/13/24 at 11:43 a.m., observed Resident 15 sitting in dining room waiting on meal. The urinary drainage bag was within the dignity bag under the wheelchair. The dignity bag was touching floor.</p> <p>On 5/13/24 1:00 p.m., interview with the Director of Nurses (DON). She indicated the foley catheter drainage bag and tubing must not be touching the floor and the drainage dignity bag should be off the floor.</p> <p>On 5/14/24 at 10:00 a.m., during an observation and interview with Resident 15 noted he no longer had a urinary drainage bag. The resident indicated he had a urinary leg drainage bag, but he liked the other one better. He indicated he did not like the feeling of the straps from the leg bag around his leg.</p> <p>On 5/14/24 at 11:00 a.m., the medical record for Resident 15 was reviewed. Diagnosis included but were not limited to: Essential (primary) hypertension (high blood pressure) dated 2/23/24. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician orders included but were not limited to: 02/26/2024 Store collection bag inside a protective dignity pouch dated 2/26/24, Suprapubic Catheter dated 4/24/2024. Catheter orders: Change Super Pubic Foley catheter and urinary drainage bag as needed for dislodgement, leakage or occlusion dated 2/23/24, Cath orders: Foley catheter care, Catheter securement device in place, Every Shift dated 2/23/24.</p> <p>A care plan, dated 2/26/2024, indicated the Resident requires an indwelling urinary related to bladder/prostate mass. Interventions included but were not limited to: Do not allow tubing or any part of the drainage system to touch the floor dated 2/26/24.</p> <p>An admission Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident had a foley catheter during the initial look back period.</p> <p>On 5/13/24 at 2:45 p.m., the DON provided a document titled, Suprapubic Catheter Care, dated, 12/2012 and indicated it was the policy currently being used by the facility. The policy indicated, .Established suprapubic catheter .6. Check drainage bag and tubing placement</p> <p>On 5/13/24 at 2:45 p.m., the DON provided a document titled, Catheter Care (Urinary), dated, 05/2023, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure steps .14. Replace catheter in securement device</p> <p>3.1-41(a)(1)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided to 2 of 2 residents reviewed for respiratory services (Residents 15 and 8).</p> <p>Findings include:</p> <p>A. On 5/09/24 at 10:52 a.m., during an observation and interview, Resident 15 was sitting in a wheel chair in his room. The portable oxygen tank meter flow gauge was set on 2 L (Liters) and being administered to the resident by a nasal canula (NC). The resident indicated it should have been on 3 L. The resident indicated he was not getting any air. CNA 7 remove portable oxygen tank from the resident and failed to place resident on an oxygen concentrator (a device that converts ambient room air to a higher concentration of level of oxygen) that was in his room. Certified Nurse Aide (CNA) 7 spoke to Licensed Practical Nurse (LPN) 9. The CNA failed to inform the nurse the residents oxygen concentrator was not on.</p> <p>On 5/09/24 at 10:56 a.m., during an interview with CNA 7, she indicated she would normally not remove a resident from portable oxygen without placing the resident on an oxygen concentrator. She continued to proceed to fill station to refill portable oxygen tank.</p> <p>On 5/09/24 at 10:58 a.m., during an interview with LPN 9 she indicated CNA 7 did not inform her she had removed the portable oxygen tank from Resident 15. She indicated she observed the CNA with the portable tank, and she knew the resident would not be receiving oxygen until she turned the concentrator on. She indicated she was going to place Resident 15 on the concentrator, but she was busy with medication pass. She acknowledged a resident should be changed to a concentrator when the portable tank was removed.</p> <p>On 5/13/24 at 11:30 a.m., during a routine observation, the resident was sitting in the dining room. The portable oxygen tank meter flow gauge was set on 2L and being administered by a NC.</p> <p>On 5/14/24 at 10:19 a.m., during routine observation, the resident was sitting in his wheelchair in his room. The portable oxygen meter flow gauge was set on 2L and being administered through a NC.</p> <p>On 5/14/24 at 10:22 a.m., during an interview with LPN 9, the LPN indicated she was not sure what the oxygen should be set at.</p> <p>On 05/14/24 at 10:27 a.m., during an interview with the Director of Nurses (DON), the DON verified the oxygen for Resident 15 was ordered to be set on 3L per NC and administered continually.</p> <p>On 5/14/24 at 10:35 a.m., the medical record for Resident 15 was reviewed. Diagnoses included but were not limited to. Hypoxemia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate, and bluish skin) dated 2/28/24, Type 2 diabetes mellitus with hyperglycemia (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/24/24, Obstructive sleep apnea (a common condition in which your breathing stops and restarts many times while you sleep) dated 2/28/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician orders included but were not limited to: Change oxygen tubing and humidity. Clean concentrator and filter. Once A Day on Sunday dated 2/23/2024, and oxygen at 3 liters per nasal cannula every shift dated 5/07/2024.</p> <p>Admission care plan, dated 2/26/24, lacked documentation of a care plan for oxygen use.</p> <p>On 5/13/24 at 10:00 a.m., during an interview with Registered Nurse (RN) 23, she indicated the resident did not have a care plan for oxygen use or impaired gas exchange.</p> <p>An admission Minimum Data Set Assessment (MDS) dated [DATE] indicated the resident was on oxygen during the initial look back period.</p> <p>B. On 5/10/24 at 10:40 a.m., during an observation and interview with Resident 8, observed the resident lying in bed with head of bed elevated. Resident had removed nebulizer mask and laid it on the bed. LPN 6 removed the nebulizer treatment mask from the residents bed and placed it in a bag without cleaning the medication chamber. LPN 6 failed to assess the resident after the administration of the breathing treatment. The resident indicated the nurse did not assess her lungs before or after nebulizer treatment and indicated sometimes the nurses did assess and sometimes they did not.</p> <p>On 5/10/24 at 10:55 a.m., during an interview with LPN 6, she indicated she provided a nebulizer treatment to Resident 8 and indicated she did not assess the resident after the treatment. She did not wear personal protective equipment (PPE) to administer the treatment and she did not stay in the room during the treatment.</p> <p>On 5/13/24 at 11:46 a.m., during an interview with LPN 16 she indicated when nebulizer treatment completed she wiped out the nebulizer medication chamber with a paper towel and then placed it in a bag after it had dried. She indicated she assessed the resident before and after nebulizer treatment.</p> <p>On 5/13/24 at 11:57 a.m., during routine observation and interview with Resident 8, observed the resident lying down in bed. The nebulizer mask and medication chamber was laying on top of a dry paper towel. The nebulizer equipment was not bagged. The resident indicated the nurse did not assess her before or after nebulizer treatment today.</p> <p>On 5/13/24 at 1:00 p.m., the medical record for Resident 8 was reviewed. Diagnoses included but were not limited to: Chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems). Dated 10/02/2018, pulmonary hypertension (a condition that affects the blood vessels in the lungs), Type 2 diabetes mellitus with unspecified complications (a disease that occurs when your blood glucose, also called blood sugar, is too high) dated 2/19/2024, Generalized anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat), Acute and chronic respiratory failure (a serious condition that makes it difficult to breathe on your own. Respiratory failure develops when the lungs can't get enough oxygen into the blood) dated 5/18/2023, and chronic pain syndrome dated 6/04/2020.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician orders included but were not limited to: Albuterol sulfate solution for nebulization; 2.5 mg /3 mL (milliliters)(0.083 %); amount: 1 unit dose inhalation as needed at bedtime for shortness of breath or respiratory distress daily 2/01/2024, Ipratropium-albuterol solution for nebulization; 0.5 mg (milligrams)-3 mg (2.5 mg base)/3 mL; amount: 0.5 mg - 3 mg; inhalation, three Times A Day dated 2/01/2024, Change nebulizer tubing/set, Once A Day on Sunday dated 2/22/2022, Change oxygen tubing and humidity and clean concentrator and filter once a day on Sunday dated 4/09/2020. Oxygen at 5 liters per nasal cannula every shift dated 6/01/2023.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/27/24, indicated the resident received oxygen and respiratory treatments during the look back period.</p> <p>A care plan, dated 10/4/18, indicated the resident has impaired gas exchange and received continual oxygen and nebulizer treatments as ordered.</p> <p>On 5/10/24 at 1:27 p.m., the Director of Nursing provided an undated document, titled, Oxygen Concentrator, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose .To provide oxygen for therapeutic use by utilizing a concentrator that converts ambient air to a higher concentration of level of oxygen. It is commonly used to provide oxygen therapy .Procedure .1. Verify and understand the physicians order .9. Adjust the flow meter control to the knob to the flow setting prescribed by the physician</p> <p>On 5/10/24 at 1:27 p.m., the Director of Nursing (DON) provided a document, titled, Nebulizer (small volume Nebulizer-SVN Medicated Aerosol Therapy), dated 9/2023, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure steps .12. Stay with the resident during the entire medication administration .14 b. Rinse with saline or wipe with alcohol c. Air dry on paper towel d. Once dry, place in plastic bag</p> <p>3.1-47(a)(4)</p> <p>3.1-47(a)(5)</p> <p>3.1-47(a)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Williamsport Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Short St Williamsport, IN 47993	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>48226</p> <p>Based on observations, interview, and record review, the facility failed to provide mental health services to 1 of 4 residents reviewed (Resident 48).</p> <p>Findings include:</p> <p>On 5/09/24 at 2:30 p.m., during an observation and interview with Resident 48, the resident was very confused, crying indicated she was not supposed to be married to her husband and she wanted to leave the facility. The staff indicated she was an elopement risk and had been trying to leave the facility. She often went to the front but did not attempt to leave the exit next to her room. The resident became more agitated while interviewing and distressed about wanting to leave. Ended the interview due to evident distress of the resident.</p> <p>On 5/14/24 at 1:45 a.m., the medical record for Resident 48 was reviewed. Diagnoses included but were not limited to: Essential (primary) hypertension (high blood pressure) dated 9/19/2023, dementia, severe, with other behavioral disturbance (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) dated 9/19/2023, Depression dated 9/19/2023, Hyperlipidemia (high cholesterol) dated 9/19/2023, Psychotic disorder with delusions due to known physiological condition (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) dated 9/19/2023.</p> <p>Physician Orders included but were not limited to: Donepezil at Bedtime 9/19/2023, Sertraline tablet; 100 mg (milligrams); amount: 100 mg; oral Twice A Day 4/23/2024, Wander-guard- check every shift for placement and proper functioning. Check skin under wander guard every shift.</p> <p>A care plan, dated 2/13/2024, indicated behavioral symptoms. Resident experiences the following behavior expressions: tearfulness, paranoia, short temper, history of delusions, yelling at others, exit seeking. Resident has a diagnosis of depression with a treatment of psychoactive medication.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, indicated the resident had not shown any behavior symptoms during the look back period.</p> <p>Documentation within the medical record indicated several entries of behaviors including agitation and exit seeking.</p> <p>On 5/14/24 at 1:16 p.m., during an interview with the Social Services Director, regarding Resident 48, she indicated the resident did not try to exit any of the side doors she only tries to go out the front door. She indicated the facility was in the process of getting her seen by Psychiatric Services. She indicated the primary physician was apprehensive about working with psychological medications and prefers psychiatric services to oversee the medications. She indicated the family has been reluctant to allow psychiatric services to see her. She acknowledged the resident needed to be seen but she did not have any documentation regarding discussion with the family about services.</p> <p>The medical record lacked documentation of consultation with family.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/2024 at 9:00 a.m., the Director of Nursing (DON) provided a document, titled, Behavioral Health, dated 10/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy . It is the policy of this facility to ensure that each resident receive the necessary behavioral healthcare and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being . Procedure .2. Residents will be assessed for Behavioral Health needs using Social Services Assessment, which is completed upon admission, annually and with significant change. Residents will be referred to Behavioral Health providers when needed for situations such as, mental health disorders, psychotropic medication management, behavior intervention development .and or adjustment or mood issues</p> <p>3.1-37</p> <p>3.1-43</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>34525</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5%, related to not administering medications in a safe and sanitary manner and failed to follow manufacturer's guidelines for 2 of 9 residents observed for medication administration (Residents 31 and 159), 2 errors were observed during 31 opportunities resulting in an error rate of 6.45%.</p> <p>Findings include:</p> <p>1. On 5/13/24 at 12:50 p.m., Licensed Practical Nurse (LPN) 16 was observed administering medications to Resident 31. While dispensing the resident's Creon (a medication to assist with pancreatic enzyme [protein that help speed up metabolism, or the chemical reactions in the body]) from the medication bottle, the LPN touched the capsule with her ungloved finger, and continued to administer the medication to the resident.</p> <p>On 5/14/24 at 1:13 p.m., Resident 31's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, other chronic pancreatitis (a condition where the pancreas becomes permanently damaged from inflammation).</p> <p>A physician's order, dated 8/16/22, indicated Creon (lipase-protease-amylase-pancreatic enzymes) capsule, delayed release (DR) 12,000-38,000-60,000 units, 1 capsule by mouth three times a day. Special instruction: To be given with food.</p> <p>During an interview, on 5/14/24 at 1:09 p.m., the Director of Nursing (DON) indicated medications should never be administered if touched by the nurse with a bare hand.</p> <p>On 5/14/24 at 1:26 p.m., the DON provided a document, with a revision date of 7/2023, titled, Medication Administration (Medication Pass Procedure), and indicated it was the skills competency for the nurses currently being used by the facility. The skill competency indicated, .Procedure Steps: .5. Medications are opened without contaminating</p> <p>On 5/14/24 at 1:57 p.m., the DON provided a document, dated January 2022, titled, General Dose Preparation and Medication Administration. and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .3 .3.4. Facility staff should not touch the medication when opening a bottle or unit dose package</p> <p>2. On 5/14/24 at 11:00 a.m., Licensed Practical Nurse (LPN) 9 was observed performing a blood sugar reading on Resident 159. At the same time, the LPN indicated the resident blood sugar reading was 245 and per the physician's order, 3 units of insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) were to be administered.</p> <p>On 5/14/24 at 11:10 a.m., 3 units of insulin lispro (a rapid acting insulin) were verified and administered in the right upper arm to the resident by LPN 9.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/24 at 11:13 a.m., the resident was taken to the dining room for his lunch meal and provided a glass of water. A continuous meal service observation indicated the resident did not receive his lunch meal until 11:52 a.m.</p> <p>On 5/14/24 at 1:18 p.m., Resident 159's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes (a disease that occurs when the blood glucose is too high) with hyperosmolarity (occurs in people with type 2 diabetes who experience very high blood glucose levels).</p> <p>A physician's order, dated 5/3/24, indicated insulin lispro solution; 100 units/milliliter (ml), administer subcutaneous (SQ-under all layers of the skin), four times daily, per sliding scale.</p> <p>If Blood Sugar is less than 70, call physician.</p> <p>If Blood Sugar is 161 to 200, give 1 Unit.</p> <p>If Blood Sugar is 201 to 240, give 2 Units.</p> <p>If Blood Sugar is 241 to 280, give 3 Units.</p> <p>If Blood Sugar is 281 to 320, give 4 Units.</p> <p>If Blood Sugar is 321 to 360, give 5 Units.</p> <p>If Blood Sugar is greater than 360, call physician.</p> <p>During an interview, on 5/14/24 at 1:09 p.m., the Director of Nursing (DON) indicated residents who receive fast-acting insulin should get their meal within 15 minutes of receipt of the insulin.</p> <p>On 5/14/24 at 1:26 p.m., the DON provided a document, with a revision date of 9/2023, titled, Highlights of Prescribing Information, and indicated it was the manufacture's guidelines for the insulin lispro solution. The guidelines indicated, .Dosage and Administration .Subcutaneous Injection: Administer Insulin Lispro by subcutaneous injection .within 15 minutes before a meal or immediately after a meal</p> <p>3.1-48(c)(1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317</p> <p>Based on observations, interview, and record review, the facility failed to ensure proper food handling for 1 of 2 dining observations and the facility failed to ensure proper hand sanitization was performed during meal service for of 1 of 2 dining observations. This had the potential to affect 50 out of 50 residents who ate meals from the kitchen.</p> <p>Findings include:</p> <p>1a. During a dining observation, on 5/8/24 at 11:36 a.m., Certified Nurse's Aide (CNA) 12 was preparing drinks for the residents. She scooped the ice into 2 glasses and returned the ice scoop into the ice bucket. At 11:37 a.m., the Housekeeping Supervisor prepared a glass of fruit punch for a resident and placed the ice scoop back into the ice bucket that contained ice. At 11:56 a.m., the ice scoop remained in the ice bucket. At 11:57 a.m., another staff member approached the ice bucket and placed the ice scoop into an empty behind the ice bucket.</p> <p>1b. During an observation of hall trays being served on 5/8/24 at 12:17 a.m., CNA 3 grabbed two empty plastic glasses off the cart and scooped ice into them. She obtained the ice from a plastic container that contained pitchers of water, milk, juice, and tea. The container of the pitchers was used to keep the drinks cold. The CNA served the two glasses to a resident with their lunch tray.</p> <p>During an interview, on 5/13/24 at 11:11 a.m., the Dietary Manager indicated the ice scoop was to be placed in the clear plastic container on the cart. The ice scoop should not be placed in the ice bucket when not in use. She indicated the staff should not use the ice from the container that had the pitchers in it. The ice in the containers was not for consumption and is only used to keep the drinks cold. She indicated staff had been educated before and the facility was working on a solution.</p> <p>On 5/13/24 at 2:05 p.m., the Administrator provided a document, dated 2/02 with a revised date 5/23, titled, Food Storage, and indicated it was the policy currently used by the facility. The policy indicated, .Scoops are not to be stored in the food. Scoops can be stored within the container using designated scoop storage space of they should be kept covered in a protected area near the containers</p> <p>48226</p> <p>2. On 5/08/24 at 11:37 a.m., during initial observation of the restorative dining room noon meal service. Observed Certified Nurse Aide (CNA 3) assisting residents with repositioning and with feeding residents. Observed CNA 3 assisting resident 47 by repositioning her and her wheelchair and setting up meal.</p> <p>CNA 3 assisted Resident 21. She applied a clothing protector to the chest, repositioned the residents wheel chair and prepared meal tray.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CNA 3 assisted resident 21 to eat and reached over with the same hand and continued to assist resident 47 by feeding the residents. She then placed a clothing protector over the residents chest and assisted the resident to eat.</p> <p>CNA 3 failed to sanitize her hands between residents. She continued to assist both residents to eat without sanitizing her hands between assisting each one and after repositioning each resident.</p> <p>On 5/08/24 at 11:46 a.m., during interview with CNA 4. She indicated she would sanitize her hands between residents while assisting them with their meal and when repositioning.</p> <p>On 5/08/24 at 12:10 p.m., observed CNA 5 deliver a meal tray to resident 18. The CNA failed to sanitize her hands prior to passing meal tray.</p> <p>On 5/13/2024 at 2:45 p.m., the Director of Nursing (DON) provided a document, titled, Hand Hygiene Policy, dated 12/2021, and indicated it was the policy currently being used by the facility. The policy indicated, . Definitions .Alcohol-based hand rub (ABHR) (hand rubbing)- alcohol-containing preparation based designed for application for the hands to reduce number of viable microorganisms .5. Moments of hand hygiene .After touching a resident .Healthcare personnel should use an alcohol based hand rub or wash with soap and water for the following clinical indications .Immediately before touching a resident .before having direct contact with a resident and or equipment .After each resident contact and after contact with a residents belongings, environmental surfaces, touching items on the floor, and resident care equipment .[NAME] touching self or clothing during meal service</p> <p>3.1-21(i)(1)</p> <p>3.1-21(i)(3)</p>		