| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155775 | A. Building<br>B. Wing | 06/10/2024 |

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| Cumberland Pointe Health Campus | 1051 Cumberland Ave<br>West Lafayette, IN 47906 |

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| F 0642<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a qualified health professional conducts resident assessments.<br><br>48525<br><br>Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) level 2 was accurately documented on the comprehensive/annual MDS (Minimum Data Set) assessment submitted for 1 of 3 residents reviewed for PASRR level 2. (Resident 34)<br><br>Finding includes:<br><br>The clinical record for Resident 34 was reviewed on 6/5/24 at 10:00 a.m. The diagnoses included, but were not limited to, cerebral palsy, major depressive disorder, bipolar disorder, anxiety disorder, and insomnia.<br><br>A PASARR level 2 was completed on 9/12/23.<br><br>An annual MDS assessment, dated 12/25/23, indicated a PASARR level 2 had not been completed.<br><br>During an interview, on 6/7/24 at 11:12 a.m., the MDS Clinical Support nurse indicated the MDS assessment should have been marked to indicate the level 2 had been completed<br><br>During an interview, on 6/7/24 at 11:30 a.m., the MDS Clinical Support nurse indicated the facility followed the RAI manual as a policy.<br><br>3.1-31(f) |

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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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>48525<br><br>Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) after a resident was started on an antipsychotic medication for 1 of 3 residents reviewed for PASARR. (Resident 18)<br><br>Finding includes:<br><br>The clinical record for Resident 18 was reviewed on 6/6/24 at 10:08 a.m. The diagnoses included, but were not limited to bipolar disorder, insomnia, and depression.<br><br>A physician's order, with a start date of 11/4/22 and an end date of 11/21/22, indicated to give Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime.<br><br>A current physician's order, with a start date of 11/21/22, indicated to give the resident Seroquel 50 milligrams (mg) at bedtime.<br><br>A notice of PASARR level 2 outcome, dated 9/9/22, indicated the resident was approved for long term approval without specialized services. The resident's mental health medications did not include Seroquel.<br><br>There had not been another PASARR assessment completed after the resident was placed on Seroquel.<br><br>During an interview, on 6/7/24 at 11:14 a.m., the Assessment Clinical Support nurse indicated if a resident was placed on an antipsychotic medication, they would need a PASARR level 2 completed again.<br><br>A standard operating procedure, titled Indiana PASRR, received from the Clinical Support nurse on 6/10/24 at 4:00 p.m., indicated .Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure individuals are appropriately placed in nursing facilities for long-term care .Change in Status . PASRR Level 1 Complete for change in status .Required: H&P MAR<br><br>3.1-16(d)(1)(A)<br><br>3.1-16(d)(1)(B) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>38872<br><br>Based on observation, interview and record review, the facility failed to provide a bowel stimulant according to the bowel protocol, failed to ensure residents were wearing compression hose as ordered by the physician, failed to hold a medication per the physician's hold orders, and failed to ensure a preventive cushion was in place for 4 of 4 residents reviewed for quality of care. (Residents 43, 44, 15 and 25)<br><br>Findings include:<br><br>1. The record for Resident 43 was reviewed on 6/4/24 at 3:44 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood) and constipation.<br><br>a. The bowel record was reviewed and did not include documentation of a bowel movement between 2/11/24 to 2/14/24 (4 days).<br><br>The Medication Administration Record, for February 2024, did not have documentation to show the resident received the PRN (as needed) bowel stimulants to promote bowel movements.<br><br>The bowel protocol was not initiated.<br><br>A physician's order, initiated on 2/7/24, indicated if there was no bowel movement within 72 hours give 2 tablespoons of Natural Laxative and assign to bowel protocol flow sheet. If no results within 24 hours of Natural Laxative give 30 milliliters (ml) of Milk of Magnesia (MOM). The special instructions indicated to give every day for constipation. If no results, within approximately 12 hours from the administration of MOM, give Dulcolax suppository rectally. The instructions indicated to give daily if no results from MOM. If results of suppository are not satisfactory within 2 hours give a Fleets enema rectally.<br><br>A physician's order, initiated on 2/7/24, indicated to give senna (a laxative) tablet 8.6 mg daily as needed for constipation.<br><br>During an interview, on 6/7/24 at 10:32 a.m., the Corporate Support Nurse 2 indicated the bowel protocol was not started and four (4) days was outside the parameters for the bowel protocol.<br><br>b. During an observation, on 6/5/24 at 10:20 a.m., Resident 43 was observed up in the dining area watching television, she was wearing nonskid shoes and regular socks. She was not wearing compression hose/socks.<br><br>During an observation, on 6/6/24 at 9:28 a.m., Resident 43 was up in activities without compression hose on her legs.<br><br>During an observation, on 6/7/24 at 9:44 a.m., Resident 43 was observed up in a wheelchair in her room, the resident did not have compression stockings/hose on at the time.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A physician's order, initiated on 2/22/24, indicated to apply TED hose (compression hose) to the bilateral lower extremities every morning.<br><br>A care plan, initiated on 2/8/24, indicated .Ted hose/Splints: ted hose as ordered<br><br>During an interview, on 6/5/24 at 11:02 a.m., LPN 4 indicated the resident was to have compression stockings/hose on. The resident should have had them put on when she got up in the morning.<br><br>During an interview, on 6/6/24 at 9:30 a.m., RN 5 indicated they were not putting compression hose/stocking on Resident 43 per the daughters request due to a wound on the resident's leg.<br><br>During a telephone interview, on 6/7/24 at 10:49 a.m., the responsible party/daughter indicated she did not tell the facility not to use the compression hose on the resident.<br><br>There was no documentation in the resident's notes to indicate the daughter did not want compression hose used.<br><br>There was no order found in the chart to hold the compression hose.<br><br>2. During an observation, on 6/6/24 at 9:27 a.m., Resident 44 was in an activity. He was not wearing his TED hose.<br><br>The record for Resident 44 was reviewed on 6/3/24 at 1:19 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertensive heart, chronic kidney disease, and heart failure.<br><br>A physician's order, initiated on 3/26/24, indicated .Apply TED hose to bilateral lower extremities every am. Remove at HS (bedtime)<br><br>A care plan, initiated on 3/21/24, indicated [NAME] Hose/Splints: Ensure [NAME] hose is worn daily to prevent swelling<br><br>During an interview, on 6/6/24 at 9:31 a.m., RN 5 indicated she did not know why the resident was not wearing his TED hose and she would have it corrected.<br><br>48525<br><br>3. The clinical record for Resident 15 was reviewed on 6/6/24 at 2:48 p.m. The diagnoses included, but were not limited to, chronic combined systolic (congestive) and diastolic (congestive) heart failure), hypertensive heart disease with heart failure and atherosclerotic (plaque buildup) heart disease.<br><br>A physician's order, with a start date of 4/3/24, indicated the resident received metoprolol (a medication which lowers blood pressure) 25 milligrams twice per day. Hold the medication for a systolic (top number) blood pressure (BP) under 110 or a heart rate (HR) under 65 beats per minute.<br><br>The Medication Administration Record (MAR) indicated the following:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/14/24, the HR was 62. The medication was administered.<br><br>On 4/21/24, the systolic BP was 103. The medication was administered.<br><br>On 4/27/24, the systolic BP was 101 and the HR was 62. The medication was administered.<br><br>On 5/2/24, the systolic BP was 100. The medication was administered.<br><br>On 5/4/24, the systolic BP was 107. The medication was administered.<br><br>On 5/5/24, the systolic BP was 106. The medication was administered.<br><br>On 5/9/24, the systolic BP was 107. The medication was administered<br><br>On 5/18/24, the systolic BP was 102. The medication was administered.<br><br>On 5/19/24, the systolic BP was 102. The medication was administered.<br><br>On 5/26/24, the systolic BP was 104. The medication was administered.<br><br>On 5/30/24, the systolic BP was 100. The medication was administered.<br><br>During an interview, on 6/7/24 at 3:14 p.m., the Clinical Support Nurse indicated she did not see any notes to indicate the metoprolol was held.<br><br>During an interview, on 6/10/24 at 11:14 a.m., the Clinical Support Nurse indicated they did not have a policy about following physicians orders.<br><br>4. During an observation, on 6/5/24 at 11:11 a.m., Resident 25 was sitting in her wheelchair in the activities room. A pressure reducing cushion was not located in her wheelchair.<br><br>During an observation, on 6/5/24 at 3:02 p.m., Resident 25 was sitting in her wheelchair in the activities room. A pressure reducing cushion was not located in her wheelchair.<br><br>During an observation, on 6/6/24 at 10:40 a.m., Resident 25 was in the activities room sitting in her wheelchair. A pressure reducing cushion was not located in her wheelchair.<br><br>The clinical record for Resident 25 was reviewed on 6/5/24 at 10:36 a.m. The diagnoses included, but were not limited to, unstageable pressure ulcer of the sacral region, encounter for surgical aftercare following debridement on the skin and subcutaneous tissue to the coccyx, and type 2 diabetes mellitus with other skin ulcers.<br><br>A current care plan, with a start date of 8/5/2021, indicated the resident was to have a Roho cushion (pressure reducing cushion) applied to her wheelchair.<br><br>A physician's order, with a start date of 9/20/23, indicated the resident was to have a pressure reducing cushion to her wheelchair.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview, on 6/6/24 at 10:42 a.m., CRCA 15 indicated she could not find the resident's pressure reducing cushion in the resident's room and she was not sure where it was.<br><br>During an interview and observation, on 6/6/24 at 10:45 a.m., CRCA 15 went to observe the resident in the activities room for the cushion and indicated the resident was not sitting on a pressure reducing cushion.<br><br>During an interview and observation, on 6/6/24 at 10:50 a.m., CRCA 15 searched the resident's room again and indicated she could not find the pressure reducing cushion.<br><br>During an interview, on 6/6/24 at 10:55 a.m., the Administrator indicated the cushion could have been soiled so they would check the laundry.<br><br>During an interview, on 6/6/24 at 11:15 a.m., the Administrator indicated if a pressure relieving cushion was soiled or needed cleaned, they would replace the cushion right away until the soiled one was clean.<br><br>During an interview, on 6/10/24 at 11:14 a.m., the Corporate Support Nurse 10 indicated she did not have a policy for following physician orders.<br><br>During an interview, on 6/10/24 at 3:00 p.m., Clinical Support Nurse 10 indicated the facility did not have a policy for ensuring a resident was to wear their pressure reducing cushion.<br><br>A facility policy, titled Bowel Protocol Guidelines, dated as last reviewed on 12/31/23 and received from Corporate Support Nurse 2 on 6/7/24 at 10:02 a.m., indicated .The Ineffective Bowel Pattern Event should be initiate for any resident does not have a BM (bowel movement) with 72 hours .orders may be written as follows .If no bowel movement within 72 hours, 2 tablespoons .of 'Natural Laxative'<br><br>3.1-37(a) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>36454<br><br>Based on interview and record review, the facility failed to administer pain medication as ordered by the physician and failed to notify the physician when the medication was not administered for 1 of 1 resident reviewed for pain. (Resident 9)<br><br>Finding includes:<br><br>During an interview, on 6/4/24 at 11:23 a.m., the resident indicated she had pain due to not getting her medications on time.<br><br>The clinical record for Resident 9 was reviewed on 6/4/24 at 3:38 p.m. The diagnoses included, but were not limited to, chronic pain, chronic respiratory failure, and type 2 diabetes mellitus.<br><br>A care plan, dated 4/18/24 and last updated on 5/17/24, indicated the resident was at risk for pain related to the diagnosis of chronic pain and decreased mobility. The interventions included, but were not limited to, administering medications as ordered.<br><br>A physician's order, dated 2/14/24, indicated to give hydrocodone-acetaminophen (an opioid pain medication) every 6 hours for pain.<br><br>A Medication Administration Record (MAR), dated 5/1/24 through 5/31/24, indicated the resident did not receive the 6:00 a.m. dose and 6:00 p.m. dose of hydrocodone-acetaminophen on 5/5/24 due to the medication was not available and the staff were waiting on the pharmacy.<br><br>During an interview, on 6/10/24 at 12:55 p.m., the Clinical Support Nurse indicated the facility had hydrocodone-acetaminophen 10-325 in the Emergency Drug Kit (EDK) and the staff could have obtained the medication from there and did not. The electronic health record did not include notification to the physician of the pain medication not being administered as ordered.<br><br>A current policy, titled Medication Ordering and Receiving from Pharmacy, dated as revised on 1/17 and received from the Clinical Support Nurse on 6/10/24 at 2:19 p.m., indicated .Emergency pharmacy services are available on a 24-hour basis. Emergency needs for medications are met by using the facility's approved emergency medication supply or by special order from PCA Pharmacy. PCA Pharmacy supplies emergency medications in compliance with applicable state regulations .There is a physician on call 24/7 .Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency drug supply, from the provider pharmacy or a back-up pharmacy .To access medication from the emergency medication supply, secondary to a new order or when medication for which there is a current prescription is not readily available, the appropriate facility personnel should not take a medication from the e-box or ADS without checking allergies on the medical record and possible drug-drug interactions .The appropriate facility personnel confers with the prescriber to determine whether the order is true emergency .order cannot be delayed until the scheduled pharmacy delivery .If the medication is a controlled substance, the prescriber either faxes a complete prescription to the facility and pharmacy or communicates the verbal order to both the appropriate facility personnel and directly to the pharmacist along with details about the situation to verify it meets the criteria of an 'emergency situation'<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3.1-37(a) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>38872<br><br>Based on observation, interview and record review, the facility failed to provide a full meal in a timely manner, as noted on the dietary menu slip, to a resident on a gluten free diet for 1 of 1 resident reviewed for an alternate diet. (Resident 43)<br><br>Finding includes:<br><br>During a dining observation, on 6/3/24 beginning at 12:13 p.m., Resident 43 was observed at the dining table with her meal consisting of chicken, brussels sprouts, and a dessert. The menu, for Resident 43, indicated she was to have a gluten free diet of caprese chicken with gluten free pasta, roasted brussels sprouts, gluten free garlic bread, and lemon mousse.<br><br>During an interview, on 6/3/24 at 12:23 p.m., [NAME] 12 indicated the resident did not receive her gluten free items because it was not prepared. She indicated the meal should have been served all at once and not in parts. She would call the kitchen to have the remainder of the meal prepared.<br><br>During an observation, on 6/3/24 at 12:37 p.m., Resident 43 did not have her gluten free garlic bread or gluten free pasta.<br><br>During an observation, on 6/3/24 at 12:44 p.m., Resident 43 had not received her gluten free items. The resident had one half of a brussels sprout left on her plate. At that time, [NAME] 12 indicated she had not called the kitchen and she could call them now.<br><br>During an interview, on 6/4/24 at 3:44 p.m., [NAME] 7 indicated he had prepared the previous days gluten free items and did not know why it was not served to her.<br><br>During an interview, on 6/6/24 at 9:37 a.m., the Dietary Manager indicated the missing items for Resident 43's lunch were delivered to her at around 1:00 p.m., the entire meal should have been delivered at the same time, and they were to check the meal ticket to ensure the meal was per the diet order.<br><br>A facility policy, titled Altered Diet Verification Process, dated as approved 3/2024 and received from the Corporate Support Nurse 2 on 6/7/24 at 10:02 a.m., indicated .During meal service the meals will be plated according to diet requirements listed on the tray card<br><br>3.1-20(a) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>38872<br><br>Based on observation, interview and record review, the facility failed to provide adaptive dining equipment for 1 of 3 residents reviewed for dining. (Resident 43)<br><br>Finding includes:<br><br>During a dining observation, on 6/3/24 at 12:13 p.m., Resident 43 was observed to have chicken, brussels sprouts and a dessert. Her meal was served on a regular plate.<br><br>During a dining observation, on 6/7/24 at 12:08 p.m., the resident was served grilled cheese, applesauce, and tomato soup on regular dishes. CNA 1 indicated the resident should have had a divided plate.<br><br>The record for Resident 43 was reviewed on 6/4/24 at 3:44 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood) and constipation.<br><br>A care plan, initiated on 2/8/24, indicated a divided plate at meals.<br><br>A facility document, titled Profile Care Guide, included an intervention which was initiated, on 3/1/24, which indicated .Resident should have divided Plates with all meals<br><br>A physician's order, initiated on 5/14/24, indicated a divided plate at meals.<br><br>The dietary menu indicated Resident 43 was to have a divided plate.<br><br>During an interview, on 6/4/24 at 3:44 p.m., [NAME] 7 indicated he was not aware the resident had a divided plate for meals.<br><br>During an interview, on 6/6/24 at 9:37 a.m., the Dietary Manager indicated Resident 43 should have a divided plate, it was on her menu ticket. Staff were to ensure the meal was served per diet order to include silverware and plates, etc. (other assistive dining equipment).<br><br>A facility policy, titled Assistive Device Guideline, undated and received from the Corporate Support Nurse 10 on 6/10/24 at 5:21 p.m., indicated .Assistive eating devices, such as plate guards and built up utensils, are provided for individuals who need them to encourage feeding independence .A physician's order will be obtained for all assistive devices and Dining Services department will be notified of the new order .Dining services and direct care staff will be responsible for insuring the individuals received the appropriate assistive devices for each meal as ordered<br><br>3.1-21(h) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38872<br><br>Based on observation, interview and record review, the facility failed to ensure staff were wearing hair and facial covers while in the kitchen for 3 of 3 randomly observed staff members. (Staff Member 52, [NAME] 6 and Kitchen Employee 13)<br><br>Finding includes:<br><br>During a random observation, on 6/6/24 at 9:35 a.m., Staff Member 52 and [NAME] 6 were observed in the kitchen. Staff Member 52 was in the kitchen past the line by the door, and did not have a hairnet over her hair. [NAME] 6 who was standing between the grill and the prep table did not have a facial covering over his mustache.<br><br>During a random observation, on 6/7/24 at 8:50 a.m., Kitchen Employee 13 was observed at the prep table to the left of the door wearing a facial hair covering under his chin. At that time, he indicated he forgot to put it back on. He was noted to have hair on his chin, jaw line and under his nose.<br><br>During an interview, on 6/6/24 at 9:38 a.m., Staff Member 52 indicated [NAME] 6 did have facial hair which should have been covered.<br><br>During an interview, on 6/10/24 at 11:09 a.m., Kitchen Employee 13 indicated [NAME] was to be past the barrier on the kitchen floor without a head and/or facial hair covering. The border was noted to be approximately 2.5 feet into the kitchen and approximately 3 feet wide and found on the floor right inside the door to the kitchen.<br><br>A facility policy, titled Hair Restraint, dated as last approved January 2024 and received from the Regional Coorporate Nurse on 6/6/24 at 1:50 p.m., indicated .employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair<br><br>3.1-21(i)(3) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155775 | A. Building<br>B. Wing | 06/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cumberland Pointe Health Campus | 1051 Cumberland Ave<br>West Lafayette, IN 47906 |

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 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>46961<br><br>Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) was professionally trained in nursing, medical technology, microbiology, epidemiology, or other related field and was also able to dedicate at least part-time to the roll for 1 of 1 Infection Preventionist reviewed.<br><br>Findings include:<br><br>During an interview, on 6/10/24 at 3:00 p.m., the Executive Director indicated she was the Infection Preventionist. She had taken CEU (continuing education unit) classes for the Infection Preventionist. The Assistant Director of Nursing (ADON) was the acting Infection Preventionist. The ADON had not passed the testing and was not certified.<br><br>The Executive Director did not have a nursing degree and could not dedicate part-time to the role of the Infection Preventionist while overseeing the day-to-day operations of the facility.<br><br>The State Operations Manual (SOM) indicated .The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections .The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field .The facility should ensure the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the resident population, such as interpreting clinical and laboratory data .the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment .Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP. A facility should consider resident census as well as resident characteristics, types of units such as respiratory care units, memory care, skilled nursing and the complexity of the healthcare services it offers as well as outbreaks and seasonality of infections such as influenza in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA<br><br>3.1-18(b)(1) |