STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155150	A. BUILDING 00 B. WING	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 16, 17, 18, and 21, 2024 Facility number: 000071 Provider number: 155150 AIM number: 100273140 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 2 Medicaid: 14 Other: 11 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 22, 2024	F 0000		
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review the facility failed to ensure safe and comfortable temperatures between 71 and 81 degrees were maintained in resident areas for 4 of 27 residents reviewed (Resident 4, Resident 11, Resident 14 and Resident 128). Findings include:	F 0584	It is the intent of the facility to ensure temperatures are safe comfortable between 71 and 81 degrees in the resident areas. **What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? How will other**	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie Barnes	Administrator	11/04/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	During an observationon, on 10/16/24 at 9:08 AM, the ambietn temperature of the building felt cold. During an interview, on 10/16/24 at 9:10 AM, the Administrator indicated she understood the building was cold and a Heating Ventilation and Air Conditioning (HVAC) technician was scheduled to come to the facility the following day to activate the boiler heating system. During an interview on 10/16/24 at 11:40 AM, Resident 4 indicated they were very cold. She was able to answer questions appropriately. 1) During an observation, on 10/16/24 at 11:42 AM, Resident 4 was observed transferring from a wheelchair to a recliner. Resident 4 sat in the wheelchair and covered up with a blanket. Resident 4 had been rubbing their hands together. At 11:48 AM, a thermometer was placed in Resident 4's room. At 1:07 PM the thermometer, placed at 11:48 AM, read 61 degrees. Resident 4's Quarterly Minimum Data Set (MDS) dated 7/5/24, indicated Resident 4's Brief Interview for Mental Status (BIMS) was 12 (mild cognitive impairment). The MDS indicated Resident 4 required supervision or touching assistance for chair to chair transfers. 2) During an observation, on 10/16/24 at 10:55 AM, Resident 11 was sitting in a recliner pulling a blanket over his shoulders. During an interview, on 10/16/24 at 10:58 AM, Resident 11 indicated it was too cold in his room. Resident 11's record was reviewed on 10/16/24 at 1:49 PM. Diagnoses included acute kidney failure		**residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** The DON/Designee assessed residents 4, 11, 14, 128 and , no negative outcome related to the alleged deficient practice on October 17, 2024. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged cited deficiency, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Administrator/Designee in-serviced the Maintenance Director on maintaining temperatures in resident rooms and facility at a safe and comfortable level on October 17, 2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined	

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	with medullary necrosis, unspecified dementia, pressure ulcer of the sacral region, unstageable. Resident 11's current quarterly Minimum Data Set (MDS) dated 9/16/24 indicated his Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). 3) During an observation, on 10/16/24 at 10:11 AM, Resident 14 was observed lying in bed under several blankets. During an interview, on 10/16/24 at 10:13 AM, Resident 14 indicated she felt like she was freezing, and the room had been very cold for several days. She indicated she did not know what the problem was, and staff was unable to make the room any warmer. Resident 14's record was reviewed on 10/18/24 at 12:45 PM. Diagnoses included hemiplegia, unspecified, affecting right dominant side, type 2 diabetes mellitus, and long- term current use of insulin. Resident 14's current quarterly, MDS dated 10/8/24, indicated her BIMS score was 15 (cognitively intact). 4) During an observation, on 10/16/24 at 1:31 PM, Resident 128 was observed lying in bed covered in blankets wearing gloves. During an interview, on 10/16/24 at 1:31 PM, Resident 128 indicated her room had been terribly cold for days. She indicated when she was in her room, she had to be bundled in bed to try to stay warm. She indicated she had asked staff if they should adjust the heat, and they indicated they were waiting to have the heat turned on.		as indicated. **How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?** The Maintenance Director/Designee will audit 10 random resident room temperatures weekly x 4 weeks, then 5 random resident rooms weekly x 4 weeks, then 3 random resident rooms monthly x 4 months. **Date corrective action will be completed by November 1, 2024**	

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Resident 128's record was reviewed on 10/18/24 at 11:24 AM. Diagnoses included cerebral infarction, emphysema and hydronephrosis with urethral stricture.

A current Minimum Data Set (MDS) was not available for review due to Resident 128's recent admission to the facility. A Document titled Brief Interview for Mental Status (BIMS) dated 10/17/24, provided by the Director of Nursing on 10/18/24 at 12:48 PM indicated Resident 128 had a BIMS score of 15 (cognitively intact).

In an interview on 10/16/24 at 1:34 PM, the Administrator indicated the temperature in the building should be 71- 81 degrees. She indicated Maintenance 3 had called the HVAC company on Monday, 10/7/24 and they were booked solid until 10/17/24 and could not come out any sooner. She indicated her corporate office called the HVAC company and they were coming out that day to activate the boiler. She indicated she activated her shelter in place plan today and was providing residents with extra blankets until the building reached the desired temperature range after activation.

During an interview on 10/17/24 at 8:52 AM, Maintenance 3 indicated he turned off the chiller (air conditioning cooling system) and turned on the rooftop heating units that serviced the building hallways on 10/7/24. He indicated the facility boiler was used to provide heat to the individual resident rooms. He indicated he placed a call to a heating and air conditioning company and requested a service technician come to the building to activate the boiler heating system on Friday, 10/11/24. He indicated a service tech from the company was scheduled to come to the

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	facility on 10/17/24. He indicated his corporate supervisor called the company on 10/16/24 and they sent someone out that same day. He indicated it was difficult to determine when to activate the boiler system because the temperatures vary this time of year. He indicated the temperature should be around 70 to 74 degrees, but it would tend to get a little colder at night. He indicated he was aware that he had readings under 70 degrees over the last few weeks, but he hesitated to notify the heating and air company until daytime temperatures were cooler. He indicated there were probably protocols in the emergency preparedness book to provide guidance on what to do if the rooms became too cold. A document titled Building Temperature Log Daily Check provided by the Administrator on 10/16/24 at 3:00 PM indicated the following temperatures were logged: 9/30/24: Front Lobby first shift, 10:00 AM: 68 degrees. 9/30/24: Front Lobby second shift (no time specified) 68 degrees. 10/1/24: Hillcrest Unit (Hall where residents reside), first shift, 10:15 AM, 68 degrees. 10/1/24: Hillcrest Unit (Hall where residents reside), second shift, no time specified, 68 degrees. 10/2/24: Columbia Court (Hall where residents reside), first shift, 9:45 AM, 70 degrees. 10/2/24: Columbia Court (Hall where residents reside), second shift, no time specified, 71 degrees. 10/3/24: Dining Room, first shift, 11:00 AM, 69 degrees. 10/3/24: Dining Room, second shift, no time specified, 69 degrees. 10/4/24: Kitchen, first shift, 9:15 AM, 62 degrees.			

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	10/4/24: Kitchen, second shift, no time specified, 64 degrees. 10/7/24: Dining Room, first shift, no time specified, 70 degrees. 10/7/24: Dining Room, second shift, no time specified, 70 degrees. 10/8/24: Kitchen, first shift, no time specified, 63 degrees. 10/8/24: Kitchen, first shift, no time specified, 65 degrees. 10/9/24: Columbia Court (Hall where residents reside), first shift, no time specified, 70 degrees. 10/9/24: Columbia Court (Hall where residents reside), second shift, no time specified, 69 degrees. 10/10/24: Hillcrest Unit (Hall where residents reside), first shift, no time specified, 70 degrees. 10/10/24: Hillcrest Unit (Hall where residents reside), second shift, no time specified, 68 degrees. 10/11/24: Front Lobby: first shift, no time specified, 70 degrees. 10/11/24: Front Lobby: second shift, no time specified, 69 degrees. 10/14/24: Front Lobby: 69 degrees 10/14/24: Dining room: 70 degrees 10/14/24: Hillcrest 69 degrees 10/15/24: Columbia Court 9 AM 70 degrees 10/15/24: Kitchen 65 dgrees There were no temperatures available on the temperature logs for the following days: There were no temperatures taken in individual rooms between 9/30/24 and 10/16/24. During an interview on 10/17/24 at 10/18 AM, temperature logs were reviewed with Maintenance 3. He indicated he would not turn boilers on when daytime temperatures were still warm outside. He indicated he used outside temperatures to determine when to turn the boilers on. He			

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	indicated the building was old and made of brick, so it was not capable of holding temperatures. He indicated he did not notify anyone of temperatures below 71 degrees because he did not need to. Maintenance 3 indicated the only temperature monitoring completed was in the common areas of the building and no monitoring had been completed in residnet rooms. A current policy, undated, titled Building Temperature Log provided by the Administrator on 10/16/24 at 3:00 PM indicated building temperatures should be checked during each shift and recorded on the building temperature log. The policy indicated any deviations from the state regulations must be reported to the facility Administrator, the facility Environmental Supervisor and the Vice President of Property Management. The policy indicated when building temperatures go outside of 71-81 degrees Fahrenheit, evacuations of the affected areas must be followed. A current policy, undated, excerpt from the emergency preparedness manual, provided by Maintenance 3 on 10/17/24 at 10:23 AM indicated ambient air temperatures should be documented in various locations throughout the building to determine when and if evacuation should be necessary, such as dining areas, lounges and a sampling of resident rooms. The policy indicated if temperatures are not maintained between 71 and 81 degrees, the Vice President of Property Management should be notified, and the Maintenance Director should arrange for technical service from an HVAC provider. 3.1-19 (h)(i)(j)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to ensure personal hygiene of fingernails was met for 1 of 6 residents reviewed (Resident 22). Findings include: On 1017/24 at 2:40 PM, Resident 22's fingernails were observed to be long and uneven. A dark brown substance was observed under Resident 22's fingernails. In an interview on 10/17/24 at 2:53 PM, Resident 22 indicated they had a rash on their perianal area. Resident 22 indicated it was difficult for them to cleanse the area themself. Resident 22 indicated the staff had repeatedly failed to cleanse their perianal region adequately. Resident 22 indicated the staff had never offered to assist with them with trimming their fingernails. On 10/18/24 at 12:02 PM, Resident 22 was observed in the hallway ambulating with their walker. Resident 22's fingernails were long and uneven. There was a dark brown substance under Resident 22's fingernails. Resident 22's record was reviewed on 10/18/24 at 12:50 PM. Diagnoses included diabetes, heart failure, lung disease with dependence on oxygen and body mass index of 45-49 (morbid obesity). Resident 22's Quarterly Minimum Data Set (MDS), dated 9/19/24, indicated Resident 22's Brief Interview for Mental Status (BIMS) was 15 (no cognitive deficit). The MDS indicated Resident 22	F 0677	It is the intent of the facility to ensure personal hygiene of fingernails is provided. **What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** The DON/Designee completed nail care for residents #22's on October 18, 2024. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** The DON/Designee completed an audit on all residents' nails to ensure personal hygiene of fingernails were met on or before 10/23/24. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** DON/Designee educated all	11/01/2024

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	required partial to moderate assistance with toileting hygiene. The MDS indicated Resident 22 required partial to moderate assistance with personal hygiene (washing and drying hands, shaving, combing hair). The MDS indicated Resident 22 was occasionally incontinent with bowel movements. The MDS indicated Resident 22 was frequently incontinent of urine. Resident 22's Kardex, (care plan summary for direct care staff) current as of 10/18/24, indicated staff was to refer to the most current "Choices for Resident Care" document to determine Resident 22's care preferences for their personal hygiene. The Kardex indicated cleansing of the perianal region was to be provided after every incontinent episode. In an interview, on 10/18/24 at 12:22 PM, the Director of Nursing (DON) indicated resident choices were included in each resident's care plan. The DON indicated Resident 22 had a history of refusing care. Resident 22's Care Plan, dated 7/31/24, indicated Resident 22 required assistance with activities of daily living (ADLs). The target goal was for Resident 22 to have their ADL needs met by 11/26/24. Interventions included referring to the most current "Choices for Resident Care" document for resident preferences, following the resident's preferences as detailed on the resident's Kardex, and assisting the resident as needed to maintain cleanliness and dryness. Resident 22's Care Plan did not indicate the resident had refused ADL care. Resident 22's point of care task sheets, dated 9/1/24 through 10/20/24, did not indicate the resident had refused ADL care.		nursing staff on providing personal hygiene of fingernails on or before 11/1/24. **How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?** DON/Designee will complete an Audit for hygiene of fingernails for 10 random Residents weekly x 4 weeks, 5 random Residents weekly x 4 weeks, 3 random Residents monthly x 4 months. **Date corrective action will be completed on 11/1/24**	

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	In an interview, on 10/21/24 at 10:36 AM, the DON indicated nail care should be performed during routine ADL care. The DON indicated residents diagnosed with diabetes were to only have their nails trimmed by licensed nurses. The DON indicated the facility did not have a schedule for when nails were to be trimmed. The DON indicated the facility did not have a list available of which residents were to have nail care provided by the nurses. The DON indicated the facility did not document when nail care had been provided. A current facility policy, dated 3/21/23, provided by the DON on 10/21/24 at 10:36 AM, indicated the area under the fingernails was to be cleaned during morning care. The policy indicated fingernails were to be maintained at a safe and smooth length. A current facility policy, dated 3/27/23, provided by the DON on 10/21/24 at 10:36 AM, indicated only a licensed nurse was to trim fingernails of diabetic residents. The policy indicated nail care should be documented in the appropriate location. 3.1-38(a)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review the facility failed to ensure safe storage of treatment supplies for 1 of 27 residents reviewed (Resident 11). Findings include: During an observation, on 10/16/24 at 10:57 AM, a	F 0761	It is the intent of the facility to ensure safe storge of treatment supplies. **What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice?**	11/01/2024

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	bottle of wound cleanser, a tube of medi-honey (medical grade honey used for skin ulcer treatment), nystatin powder (medicated powder for treatment of fungal infections of the skin, Calmoseptine cream (a medicated skin protectant cream) and an open bag of cough drops. During an interview, on 10/16/24 at 10:58 AM, Resident 11 indicated these items were normally kept in the room to make it easier for the staff, so they didn't have to go to the desk to get them. During an observation, on 10/16/24 at 11:12 AM, treatment supplies were observed on top of a table in the bathroom about 2 feet from the toilet including nystatin powder, medi-honey and Preparation H cream. During an interview, on 10/16/24 at 11:14 AM, Qualified Medicine Aide (QMA) 2 indicated should not be stored in the bathroom. QMA 2 indicated she removed the items from the bedside table and placed them in the bathroom because she saw them in the resident's room and knew they should not be there. She indicated the items should be in the treatment cart, but she did not have the keys to lock them up. Resident 11's record was reviewed on 10/16/24 at 1:49 PM. Diagnoses included acute kidney failure with medullary necrosis, unspecified dementia, pressure ulcer of the sacral region, unstageable. Resident 11's current quarterly Minimum Data Set (MDS), dated 9/16/24, indicated his Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). Physician orders, dated 10/11/24 at 9:45 AM, indicated Nystatin powder should be applied to		Residents identified were not affected by the deficient practice of safe storage of treatment supplies. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** Audit of all rooms completed ensuring all treatment supplies are removed from resident rooms on or before 10/23/24. All residents are at risk for this deficient practice, but no other issues were found. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? How will the corrective action be monitored to ensure the deficient practice will not reoccur?** DON/Designee educated all Nurses on proper storage of treatment supplies on or before 11/1/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **What quality assurance program will be put into place?**	

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	Resident 11's groin every eight hours as needed for excoriation. Physician orders, dated 10/8/24 at 6:00 AM, indicated medical grade honey should be applied to Resident 11's ulcer on his buttocks every shift. Physician orders, dated 7/22/24 at 2:00 PM, indicated Preparation H External Cream, 5-14.4% should be applied to Resident 11's rectum every four hours as needed for itching or burning. Physician orders, dated 7/19/24 at 12:15 PM, indicated triad cream should be applied to Resident 11's buttocks daily and as needed after incontinent episodes. In an interview, on 10/16/24 at 2:06 PM, the Administrator indicated treatment supplies should be kept locked in the treatment cart for sanitary and security reasons. A current policy, undated, provided by the Regional Nurse Consultant on 10/16/24 at 2:14 PM, indicated medications should be stored safely and securely, only accessible to nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. The policy indicated medications for skin irritations and wound applications should be kept in a treatment cart or in a separate labelled drawer of the medication cart. 3.1-25(m)		DON/Designee will complete audit of resident's rooms to ensure no treatment supplies are left in rooms 5 x a week x 4 weeks, 3 x a week x 4 weeks, 1 x a week x 4 months. **Date corrective action will be completed on11/1/24**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record	F 0812	It is the intent of this facility to ensure safe and sanitary food	11/01/2024

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	review, the facility failed to ensure safe and sanitary food storage practices for facility prepared leftovers. Food prepared in the facility kitchen was consumed by 27 of 27 residents who lived in the facility. Findings include: On 10/16/24 at 9:05 AM, a tour of the kitchen was guided by the Cook 7. Five plastic containers were observed on the counter next to the sink. The dates on the containers ranged from 10/9/24 through 10/12/24. During an interview, on10/16/24 at 9:07 AM, Cook 7 indicated the containers held leftovers that were going to be thrown away. Cook 7 indicated they were unaware of how long leftovers should be kept, but thought leftovers should be thrown away after about 1 week. On 10/18/24 at 11:35 AM, a tour of the kitchen was guided by the Certified Dietary Manager in training (CDM 8). A pan covered with clear plastic wrap containing approximately 3 servings of meatloaf was observed in a walk-in cooler. The pan of meatloaf was dated 10/13/24. A half full, 1-gallon sized plastic container, labeled as meat sauce, was observed in a walk-in cooler. The meat sauce label did not include a date. A pan covered with clear plastic wrap containing approximately 1 serving of meatloaf was observed in a walk-in cooler. The pan of meatloaf did not include a date. During an interview, on 10/18/24 at 11:35 AM, CDM 8 indicated leftovers should be thrown away after 5 days. CDM 8 indicated there should have been dates on the meat sauce and the meatloaf.		storge practices for facility prepared leftovers. **What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice?** The DON/Designee assessed all residents on DATE, no negative outcome related to the alleged deficient practice. The Dietary Manager/Designee disposed of the leftovers on October 18, 2024. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** The Dietary Manager/Designee completed an audit of the food storage areas and disposed of foods not dated and any foods outdated on November 1, 2024. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? How will the corrective action be monitored to ensure the deficient practice will not reoccur?** The Administrator/Designee	

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	A current facility policy, dated 1/1/17, indicated all food should be labeled with the date the item was opened and the date the item expired. The policy indicated all food prepared at the facility would be discarded after 72 hours. 3.1-21(i)(1) and (3)		in-serviced the Dietary staff on food storage and expiration dates on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **What quality assurance program will be put into place?** The Dietary Manager/Designee will audit the food storge area for dating food and proper food storage 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then 3 times a month x 4 months. **Date corrective action will be completed on 11/1/24**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review the facility failed to ensure hand hygiene was correctly performed and blood glucose monitors were properly cleaned during care for 4 of 8 residents reviewed (Resident 11, Resident 13, Resident 14, and Resident 128). Findings include: 1) During a medication pass observation,	F 0880	It is the intent of this facility to ensure hand hygiene is performed correctly and blood glucose monitors are cleaned properly. **Corrective action for residents affected:** Residents 11, 13, 14 and 128 were assessed and no negative outcomes related to this deficient practice by the DON/Designee on October 23, 2024.	11/01/2024

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	beginning 10/18/24 at 8:44 AM, Licensed Practical Nurse (LPN) 6 prepared medications for Resident 128, handed her the cup of medications and water and received the items back from the resident when she was finished. LPN 6 then washed her hands, scrubbing them for 9 seconds. Resident 128's record was reviewed on 10/18/24 at 11:24 AM. Diagnoses included cerebral infarction, emphysema and hydronephrosis with urethral stricture. A current Minimum Data Set (MDS) was not available for review due to Resident 128's recent admission to the facility. A Document titled Brief Interview for Mental Status (BIMS) dated 10/17/24, provided by the Director of Nursing on 10/18/24 at 12:48 PM indicated Resident 128 had a BIMS score of 15 (cognitively intact). 2) During a medication pass observation, beginning 10/18/24 at 8:44 AM, LPN 6 prepared medications for Resident 13, floated the medications in applesauce and delivered them to Resident 13. Resident 13 handed LPN 6 the cup after she consumed the medicine. LPN 6 washed her hands, scrubbing for 13 seconds. Resident 13's record was reviewed on 10/18/24 at 12:16 PM. Diagnoses included hereditary and idiopathic neuropathy, type 2 diabetes, and dementia. Resident 13's current quarterly Minimum Data Set (MDS) dated 8/23/24 indicated her Brief Interview for Mental Status (BIMS) score was 6 (cognitively impaired). 3) During a medication pass observation, beginning 10/18/24 at 8:44 AM, LPN 6 removed a		**How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The DON/Designee will in-service all Nursing staff on proper hand Hygiene during care and Nurses/QMA's on proper cleaning of blood glucose monitors after use on or before 11/1/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the facility will monitor system:** The DON/Designee will monitor 10 random nursing staff members weekly x 4 weeks, for hand hygiene during care, then 5 random nursing staff members weekly x 4 weeks, then 3 random nursing staff members weekly x 6 months. The DON/Designee will monitor 6 Nurses/QMA's weekly x 4 weeks, for proper glucometer cleaning, then 4 Nurses/QMA's weekly x 4 weeks, then 2 Nurses/QMA's	

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	glucometer from the top drawer of the medicine cart and performed a blood glucose check by obtaining a pin prick blood sample for Resident 14. LPN 6 did not perform hand hygiene or a glove change after obtaining the blood glucose results. LPN 6 obtained a cloth disinfectant wipe from the cart and wiped the machine for about 3 seconds, placed the machine in a plastic container and put the container in the medicine cart. LPN 6 prepared a cup of pills for Resident 14 with no additional hand hygiene performed. LPN 6 washed her hands, scrubbing for 11 seconds after administering the medications to Resident 14. Resident 14's record was reviewed on 10/18/24 at 12:45 PM. Diagnoses included hemiplegia, unspecified, affecting right dominant side, type 2 diabetes mellitus, and long- term current use of insulin. Resident 14's current quarterly, MDS dated 10/8/24, indicated her BIMS score was 15 (cognitively intact). During an observation, on 10/18/24 at 11:26 AM, LPN 6 had a blood glucose meter in her hand as she stepped out of a resident's room, placed it in a plastic container, and placed the container in the medicine cart. During an interview, on 10/18/24 at 11:28 AM, LPN 6 indicated blood glucose meters should be cleaned after each use. She indicated she did not clean the meter that was in her hand because she would normally collect all of her blood glucose meters and disinfect them after lunch when she had more time. She indicated the meters should be wiped with a disinfectant towelette and should stay wet for a minute. She indicated she did not do this during the morning observation or during		weekly x 6 months. If the facility is within 95% compliance with the above monitoring, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **Date corrective action will be completed on 11/1/24**	

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	the current observation due to concerns with time constraints. She indicated the staff had used egg timers in the past and wrapped the device in a towelette, but she was unclear on current company policies. LPN 6 also indicated hands should be washed with thorough scrubbing addressing all hand surfaces for at least 20 seconds and hand hygiene should occur after each resident contact or contact with contaminated items. She indicated she might not have scrubbed her hands for a long enough period due to nervousness. During an interview, on 10/18/24 11:48 AM, the DON indicated she was not sure how a glucometer should be cleaned and would provide a policy. A current policy titled Policy and Procedure Cleaning/Disinfecting/Maintaining Glucose Meters, undated, provided by the DON on 10/18/24 at 10:57 AM indicated staff should wipe the entire surface of a blood glucose meter 3 times horizontally and 3 times vertically using one disinfecting towelette to clean blood and body fluids and dispose of the towelette. Staff should then wipe the entire surface of the meter 3 times horizontally and 3 times vertically and the meter should be maintained wet for a duration recommended by the towelette manufacturer. During an interview, on 10/18/24 at 11:49 AM, the DON indicated the staff should go by the blood glucose meter cleaning competency form instead of the policy presented. A document titled Blood Glucose Meter Cleaning Competency, undated, provided by the DON on 10/18/24 at 11:49 AM indicated using a disinfecting wipe, staff should wipe the meter on			

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	the front, back and sides and let the meter dry by manufacturer's instructions. A document titled Microdot Minute Wipe, dated 12/23/15, provided by the DON on 11/18/24 at 11:58 AM, indicated the treated surface must remain visibly wet for one minute to achieve complete disinfection of pathogens. During an interview, on 10/18/24 at 12:24 PM, the DON indicated blood glucose meters should be cleaned upon completion of the procedure. She indicated when the blood glucose meter was immediately put away, wetness over all surfaces of the meter for one minute could not be determined. 4) During a wound care observation, on 10/18/24 at 9:28 AM, Certified Nurse Aide (CNA) 4, the Director of Nursing (DON), and Nurse Practitioner (NP) 5 donned gowns and gloves before entering Resident 11's room. The DON, NP, and CNA 4 used a mechanical sling lift to transfer Resident 11 to bed for his dressing change. After the transfer the DON removed her gloves and gown, washed her hands for 11 seconds and left the room. CNA 4 removed her gloves and gown, washed her hands for 14 seconds and left the room. NP 5 removed her gloves, rinsed her hands in the sink for 2 seconds and applied new gloves. The DON returned to the room, applied a gown and gloves and assisted Resident 11 to turn on his side. NP 5 released the closure on Resident 11's brief, sprayed wound cleanser on a gauze sponge and cleansed the wound. NP 5 went into the restroom, removed her gloves and rinsed her hands for about 2 seconds, dried them and applied clean gloves. NP 5 obtained measurements of the wound and palpated the surrounding tissue during her assessment. No hand hygiene was			

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	performed. She opened a box of medical grade honey, poured a marble sized amount of product onto her hand and applied it to the wound. After the treatment application, she closed Resident 11's incontinent brief and assisted the DON in repositioning the resident into a sitting position. Using the gloved hand she had used to apply the medi-honey, NP 5 handed Resident 11 a glass of apple juice to drink. NP 5 then went to the bathroom, removed her gloves and washed her hands for 9 seconds. The DON removed her gloves and washed her hands for 14 seconds. Resident 11's record was reviewed on 10/16/24 at 1:49 PM. Diagnoses included acute kidney failure with medullary necrosis, unspecified dementia, pressure ulcer of the sacral region, unstageable. Resident 11's current quarterly Minimum Data Set (MDS) dated 9/16/24 indicated his Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). In an interview, on 10/18/24 at 12:30 PM, the DON indicated handwashing should include at least 20 seconds of scrubbing to all surfaces of the hands. She indicated during wound care hand hygiene and clean glove application should be performed before wound treatment removal, before cleansing, after assessments requiring touching the wound, and after treatment was applied. She indicated she observed NP 5 handing Resident 11 a glass of apple juice while wearing dirty gloves. She indicated NP 5 should have removed her dirty gloves and performed hand hygiene prior to touching Resident 11's glass. A current policy titled Hand Hygiene Guidelines, undated, provided by the DON on 10/18/24 at 12:28 PM, indicated staff should wet hands with			

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	warm water, apply a generous amount of soap to hands and rub hands vigorously for at least 20 seconds during handwashing. A current policy titled Guidelines/Policy/Procedure Non-Sterile Dressings, dated 5/23/23, provided by the DON on 10/18/24 at 12:28 PM, indicated hand hygiene should occur after removing the previous treatment, after cleaning the area, and after applying the new treatment. 3.1-18(l)			