STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 28, 29, 30, 31, and November 1, 2024 Facility number: 000224 Provider number: 155331 AIM number: 100267700 Census Bed Type: SNF/NF: 79 SNF: 10 Total: 89 Census Payor Type: Medicare: 20 Medicaid: 51 Other: 18 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/8/24.	F 0000	I respectfully request consideration for paper compliance. I have forwarded the signed 2567 via fax to 1-317-233-7322. I will also forward all documents, inservices, etc. upon date certain to the same number listed above. Please reference the attached 2567 as "Credible Allegation of Compliance" for our annual survey conducted on October 28, 29, 30, 31 and November 1, 2024. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you! Amber Janeczko, Executive Director	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed and in place for a resident with a history of MDROs	F 0656	**F 656** 1. Resident #71 had a care plan developed by the nurse managers	12/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Janeczko	Executive Director	11/21/2024

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	(multi-drug resistant organisms) for 1 of 18 resident care plans reviewed. (Resident 71) Finding includes: The record for Resident 71 was reviewed on 10/29/24 at 11:10 a.m. Diagnoses included, but were not limited to, congestive heart failure, fracture of the lower end of tibia with routine healing, and hypertension. The Admission Minimum Data Set assessment, dated 9/3/24, indicated the resident was cognitively intact and was dependent on staff for toileting and transfer assistance. A Physician's Order, dated 9/4/24, indicated the resident should be on EBP (Enhanced Barrier Precautions) due to ESBL (extended spectrum beta-lactamase, a bacterial enzyme resistant to many antibiotics) and VRE (Vancomycin Resistant Enterococci, a bacteria resistant to some powerful antibiotics) every shift. There was not a care plan in place related to EBP or the MDROs. During an interview on 10/29/24 at 11:40 a.m., the Infection Prevention Nurse indicated there should be a care plan in place related to the EBP and MDROs. There had been a care plan previously when the resident was on antibiotics, but it had been discontinued. 3.1-35(a)		to address MDRO/EBP. 2. The DON and designees audited all care plans developed for the resident population by date of compliance to ensure triggered areas for care planning of medical conditions were addressed with a resident specific plan of care. 3. Education was completed/received by the DON/Designee on addressing Care Planning Guidelines by the date of compliance. IDT members involved in the care planning process will receive this education at least annually, upon hire, and as needed. No IDT member involved in the care planning process will work past date of compliance without this education being completed. 4. The DON or designees will audit for compliance twice weekly for 6 months utilizing a “Care Plan Audit Tool”. The DON or designee will analyze trending data monthly and present the findings during the monthly QAPI meeting with action plans developed and/or revised to address any negative trends. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, record review, and interview, the facility failed to ensure care plans were implemented and/or updated for 2 of 21 resident care plans reviewed. (Residents 21 and 14) Findings include: 1. On 10/28/24 at 10:46 a.m., Resident 21 was observed lying in bed. She had a Geri sleeve (protective covering) to her left arm that was pushed down to her wrist area. Multiple small circular purple discolorations were observed to her left outer forearm. On 10/30/24 at 10:42 a.m., Resident 21 was observed sitting in her chair in her room. No Geri sleeves were in place. Multiple small circular purple discolorations were observed to her left outer forearm. On 10/30/24 at 2:48 p.m., Resident 21 was observed sitting in her chair in the Main Dining Room playing bingo. No Geri sleeves were in place. Multiple small circular purple discolorations were observed to her left outer forearm. The record for Resident 21 was reviewed on 10/31/24 at 9:04 a.m. Diagnoses included, but were not limited to, spontaneous ecchymosis, Alzheimer's disease, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/25/24, indicated the resident was cognitively impaired and received antiplatelet medication.	F 0657	**F657** 1. Resident #14 and #21 had care plans developed by the nurse managers to address skin discoloration. 2. The DON and designees audited all care plans developed for the resident population by date of compliance to ensure triggered areas for care planning of medical conditions were addressed with a resident specific plan of care. Any issues identified have been corrected. 3. Education was completed by the DON and designees addressing Care Planning Guidelines by date of compliance. This education will be completed at least annually, upon hire, and as needed. No IDT member involved in the care planning process will work past the date of compliance without this education being completed. 4. The DON or designees will audit for compliance twice weekly for 6 months utilizing a “Care Plan Audit Tool”. The DON or designee will analyze trending data monthly and present the findings during the monthly QAPI meeting with action plans developed and/or revised to	12/03/2024

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	A Care Plan, updated 9/4/24, indicated the resident was at risk for abnormal bruising and bleeding due to anticoagulant therapy. There was lack of any documentation related to the diagnosis of spontaneous ecchymosis or the skin discolorations. A Care Plan, updated 11/29/23, indicated the resident was at risk for breaks in skin integrity. There was lack of any documentation related to the diagnosis of spontaneous ecchymosis or the skin discolorations. The Physician Order Summary, dated 10/2024, indicated the resident was to receive Aspirin (an antiplatelet medication) 81 mg (milligrams) daily. The Medication Administration Record (MAR), dated 10/2024, indicated the resident had received the Aspirin medication as ordered. There was monitoring every shift for signs and symptoms of bleeding (black tarry stools, bleeding gums, bruising, or nose bleed) related to anticoagulant use. A negative sign (-) had been documented every shift, to indicate there were no signs and symptoms present. During an interview on 10/31/24 at 11:52 a.m., the Director of Nursing (DON) indicated she had updated the resident's care plan to include the spontaneous echymosis diagnosis. 2. During an interview on 10/28/24 at 10:59 a.m., Resident 14 indicated she had a cancerous skin lesion on her left upper arm that she had for a long time. She had seen a skin doctor regarding the area, had it removed, and it came back later on. It did not hurt, but it itched. The staff were putting a cream on it twice daily.		address any negative trends. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	

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	During an observation of Resident 14 on 10/31/24 at 10:01 a.m., her left upper arm had a round area, approximately 1.5 inches in diameter with flaky skin noted around the edges. It was reddish-pink in the center. Resident 14's record was reviewed on 10/30/24 at 9:01 a.m. Diagnoses included, but were not limited to, acute kidney failure, respiratory failure, and heart failure. The Quarterly Minimum Data Set assessment, dated 10/8/24, indicated the resident was cognitively intact for daily decision making. She had no skin issues. The October 2024 Physician Order Summary indicated the resident received triamcinolone acetonide external cream 0.1% (steroid cream) application twice daily to the right lower leg and left upper arm lesion. A Weekly Skin Integrity Data Collection, dated 10/17/24 at 3:16 a.m., indicated the resident had a left upper arm lesion. The triamcinolone acetonide cream was applied twice daily. There were no other skin abnormalities. A Weekly Skin Integrity Data Collection, dated 10/24/24 at 12:51 a.m., indicated the resident had redness to the right lower extremity. There were no other skin abnormalities. A Care Plan, dated 5/29/24, indicated the resident had a risk for break in skin integrity related to weakness, decreased mobility, incontinence, and chronic kidney disease. Interventions included, but were not limited to, apply moisturizers as needed, avoid prolonged skin to skin contact, CNA to inspect skin during activities of daily			

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	living (ADL) care for reddened or open areas and report to nurse if present, and nurse to perform weekly head to toe assessment and report abnormal findings to the physician as needed. There were no Care Plans related to the left upper arm skin lesion and treatment. During an interview on 10/31/24 at 10:54 a.m., the Director of Nursing indicated the resident's care plan should have been updated to reflect the skin lesion The resident had the lesion since before she arrived to the facility. 3.1-35(c)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations and a skin lesion for 2 of 3 residents reviewed for non-pressure related skin conditions. (Residents 21 and 14) Findings include: 1. On 10/28/24 at 10:46 a.m., Resident 21 was observed lying in bed. She had a Geri sleeve (protective covering) to her left arm that was pushed down to her wrist area. Multiple small circular purple discolorations were observed to her left outer forearm. On 10/30/24 at 10:42 a.m., Resident 21 was observed sitting in her chair in her room. No Geri sleeves were in place. Multiple small circular purple discolorations were observed to her left	F 0684	F684 1. Resident #14 and #21 had no negative outcomes and the physician was notified with no new orders received, care plan was initiated immediately. 2. An in-house audit was completed by the wound nurse and/or designee for residents with skin integrity issues to ensure no other concerns were identified by the date of compliance. 3. Nursing staff will be educated by the wound nurse and/or designee on assessing and notifying the wound nurse of any identified areas or change in skin within 24 hours. Nursing staff who	12/03/2024

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	outer forearm. On 10/30/24 at 2:48 p.m., Resident 21 was observed sitting in her chair in the Main Dining Room playing bingo. No Geri sleeves were in place. Multiple small circular purple discolorations were observed to her left outer forearm. The record for Resident 21 was reviewed on 10/31/24 at 9:04 a.m. Diagnoses included, but were not limited to, spontaneous echymosis, Alzheimer's disease, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/25/24, indicated the resident was cognitively impaired and received antiplatelet medication. A Care Plan, updated 9/4/24, indicated the resident was at risk for abnormal bruising and bleeding due to anticoagulant therapy. There was no documentation related to the diagnosis of spontaneous echymosis or the skin discolorations. A Care Plan, updated 11/29/23, indicated the resident was at risk for breaks in skin integrity. There was no documentation related to the diagnosis of spontaneous echymosis or the skin discolorations. The Physician Order Summary, dated 10/2024, indicated the resident was to receive Aspirin (an antiplatelet medication) 81 mg (milligrams) daily. The Medication Administration Record (MAR), dated 10/2024, indicated the resident had received the Aspirin medication as ordered. There was monitoring every shift for signs and symptoms of		have not been educated will not work until this has been completed and all new hires will receive this education in orientation as well as at least annually and as needed. 4. The wound nurse and/or designee will audit for compliance weekly for six months utilizing a "Skin Integrity Audit Tool" for all skin integrity issues ongoing for any changes and document appropriately. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	

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	bleeding (black tarry stools, bleeding gums, bruising, or nose bleed) related to anticoagulant use. A negative sign (-) had been documented every shift, to indicate there were no signs and symptoms present. The Weekly Skin Integrity Data Collection assessments, dated 10/1/24, 10/8/24, 10/15/24, 10/22/24, and 10/29/24, lacked any documentation related to spontaneous echymosis or the left forearm skin discolorations. During an interview on 10/31/24 at 11:52 a.m., the Director of Nursing (DON) indicated she had updated the resident's Care Plan to include the spontaneous echymosis diagnosis. 2. During an interview on 10/28/24 at 10:59 a.m., Resident 14 indicated she had a skin lesion on her left upper arm that she had for a long time. She had seen a skin doctor regarding the area, had the area removed, and it came back later on. It did not hurt, but it itched. The staff were putting a cream on it twice daily. During an observation of Resident 14 on 10/31/24 at 10:01 a.m., her left upper arm had a round area, approximately 1.5 inches in diameter with flaky skin noted around the edges. It was reddish-pink in the center. Resident 14's record was reviewed on 10/30/24 at 9:01 a.m. Diagnoses included, but were not limited to, acute kidney failure, respiratory failure, and heart failure. The Quarterly Minimum Data Set assessment, dated 10/8/24, indicated the resident was cognitively intact for daily decision making. She had no skin issues.			

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	The October 2024 Physician Order Summary indicated the resident received a triamcinolone acetonide external cream 0.1% (steroid cream) application twice daily to the right lower leg and left upper arm lesion. A Weekly Skin Integrity Data Collection, dated 10/10/24 at 8:58 a.m., indicated the resident had no skin abnormalities. A Weekly Skin Integrity Data Collection, dated 10/17/24 at 3:16 a.m., indicated the resident had a left upper arm lesion. The triamcinolone acetonide cream was applied twice daily. There were no other skin abnormalities. A Weekly Skin Integrity Data Collection, dated 10/24/24 at 12:51 a.m., indicated the resident redness to the right lower extremities. There were no other skin abnormalities. A Care Plan, dated 5/29/24, indicated the resident had a risk for break in skin integrity related to weakness, decreased mobility, incontinence, and chronic kidney disease. Interventions included, but were not limited to, apply moisturizers as needed, avoid prolonged skin to skin contact, CNA to inspect skin during activities of daily living (ADL) care for reddened or open areas and report to nurse if present, and nurse to perform weekly head to toe assessment and report abnormal findings to the physician as needed. There were no care plans related to the skin lesion. During an interview on 10/31/24 at 10:54 a.m., the Director of Nursing (DON) indicated the left upper arm skin lesion should have been documented on			

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	the weekly skin checks as it was an abnormal skin condition that she had since she came to the facility. The DON was not sure why the nurses did not document the area on each weekly skin assessment. A policy titled "Skin Integrity & Pressure Ulcer/Injury Prevention and Management," indicated "...A skin assessment/inspection should be performed weekly by a licensed nurse. a. Skin observations also occur throughout points of care provided by CNAs during ADL care. Any changes or open areas are reported to the Nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review, and interview, the facility failed to ensure palm protectors and/or splints were in place as ordered for residents with contractures (a shortening of muscles, tendons, skin and nearby soft tissues that causes joints to shorten and become very stiff) for 2 of 2 residents reviewed for range of motion. (Residents 56 and 40) Findings include: 1. On 10/28/24 at 11:05 a.m. and 10/30/24 at 9:42 a.m., Resident 56 was observed in her room. Her right hand was contracted and there was no palm protector in place to her right or left hand. On 10/29/24 at 10:41 a.m., 10/29/24 at 2:54 a.m. and	F 0688	F688 1. Resident #40 and #56 had no negative outcomes, a physician order was obtained, and the care plan was updated. 2. An in-house audit will be completed by the date of compliance by nursing management of residents with adaptive devices and care plans and kardex will be audited and updated as required. Any issues will be addressed by the date of compliance.	12/03/2024

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	10/30/24 at 8:43 a.m., the resident was observed in her room. Her left hand was under the covers during these observations and not visible. Her right hand was contracted and there was no palm protector in place. Resident 56's record was reviewed on 10/29/24 at 10:52 a.m. Diagnoses included, but were not limited to, hemiparesis (one sided weakness) and hemiplegia (one sided paralysis) affecting right side, diabetes mellitus, and acute and chronic respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 9/24/24, indicated the resident had significant cognitive impairment and was dependent on staff for bed mobility, toileting, and transfers. A Physician's Order, dated 9/4/24, indicated to apply palm protectors to the right and left hands every shift for protection at all times as tolerated, may remove them for hygiene and skin checks. The October 2024 Treatment Administration Record indicated on 10/28/24 the palm protector was not on the resident's left hand, it was signed out for the right hand. There were no progress notes that indicated the resident was not able to tolerate the palm protectors. During an interview on 10/30/24 at 9:44 a.m., CNA 1 indicated the aides were supposed to apply the palm protectors. She indicated the resident's palm protectors were at the laundry, but she would find another pair. 2. On 10/29/24 at 9:33 a.m., Resident 40 was observed in her room. There were no palm protectors in place to either hand. She indicated		3. Education will be provided to nursing staff, therapy, MDS, and nursing managers by the DON and/or designee related to application and monitoring of adaptive devices by the date of compliance. Any required staff who have not completed/received this education will not work until this has been completed. This education will be provided in orientation, at least annually and as needed. 4. Nurse managers will complete audits using an “Adaptive Device Audit Tool” weekly for compliance, 5 residents weekly x 3 months than 3 residents weekly x 3 months to ensure compliance to include the device has an order in place and that it is care planned and on the kardex. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	

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	she was unable to use her left hand. On 10/29/24 at 1:57 p.m., Resident 40 was observed in her room. There were no palm protectors in place to either hand. Her left hand was in a closed fist. Resident 40's record was reviewed on 10/29/24 at 2:37 p.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and epilepsy. The Quarterly Minimum Data Set (MDS) assessment, dated 9/6/24, indicated the resident was moderately cognitively impaired, required staff assistance for all activities of daily living (ADLs), and had impaired range of motion to the upper extremity on one side. A current Care Plan, updated 4/11/23, indicated the resident had a left hand contracture. An intervention, dated 7/12/22, indicated palm protectors to bilateral hands as tolerated. The Physician's Order Summary, dated 10/2024, indicated orders for palm protectors to the left and right hands as tolerated every shift, may remove for bathing and skin assessments. The Medication Administration Record and Treatment Administration Record, dated 10/2024, indicated the palm protectors were in place as ordered. The only documented refusal was 10/29/24 evening shift. The Progress Notes, dated 10/1/24 through 10/29/24, lacked any documentation the resident was not tolerating wearing the palm protectors. During an interview on 10/30/24 at 9:45 a.m., the			

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(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
	Administrator was made aware that the resident's palm protectors had not been in place. During an interview on 10/31/24 at 2:25 p.m., the Director of Nursing indicated the palm protector orders indicated to wear as tolerated. She had interviewed the QMA who worked on 10/28/24 and 10/29/24 and she had observed the palm protectors in place when she had completed morning medication administration. She was unsure what time the palm protectors had been removed. 3.1-42(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure an indwelling suprapubic (urinary) catheter tubing and collection bag was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 1) Finding includes: Resident 1 was observed on 10/28/24 at 2:39 p.m., 3:19 p.m., 3:54 p.m., and 4:11 p.m. She was asleep in her bed. The catheter tubing and collection bag were lying on the floor. The collection bag was uncovered and could be viewed from the doorway. Resident 1's record was reviewed on 10/29/24 at 10:49 a.m. Diagnoses included, but were not limited to, intellectual disabilities and epilepsy. The Quarterly Minimum Data Set assessment, dated 9/17/24, indicated the resident was severely	F 0690	F690 1. Resident #1 had no negative outcomes related to the catheter bag being improperly placed. 2. An in-house audit was completed by the DON and designee of all residents with catheters to ensure that no further concerns were identified by the date of compliance. 3. Education was provided by the DON and designees addressing Urinary Catheter Management and presented to the nursing staff and CNA's by the date of compliance. Any required staff who has not completed this education will not work until this has been completed. This education will be	12/03/2024

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	155331	A. BUILDING 00 B. WING	11/01/2024

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	cognitively impaired for daily decision making. She was dependent on staff for daily care including, but not limited to, toileting, showering, personal hygiene, and transfers. She had an indwelling catheter. The October 2024 Physician Order Summary indicated the resident had a suprapubic catheter and the catheter bag was to be placed below the level of the bladder. A Care Plan, dated 9/12/24, indicated the resident had a suprapubic catheter and was dependent on staff for the care and management of all catheter needs. Interventions included, but were not limited to, catheter care every shift, and position catheter bag and tubing below the level of the bladder. During an interview on 10/29/24 at 9:45 a.m., the Director of Nursing indicated she had no further information to provide. A policy titled, "Indwelling Urinary Catheter (Foley) Management," indicated "...General Urinary Catheter Maintenance Guidelines...2. Maintain unobstructed urine flow...b. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor." 3.1-41(a)(2)		provided in orientation, at least annually, and as needed. 4. The DON and/or designee will audit for compliance weekly for 6 months utilizing a “Catheter Management Audit Tool” for all residents with catheters. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control measures were in place and implemented related to a glucometer (blood sugar monitor) used for multiple residents and not cleaned and	F 0880	**F880** 1. Resident #71 had no negative outcomes identified, proper signage and equipment were	12/03/2024

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	sanitized after each resident use. (RN 1) This had the potential to affect two residents on the 200 hall who received glucometer testing. The facility also failed to ensure a resident with a Multi-Drug Resistant Organism was placed on Enhanced Barrier Precautions (EBP) as ordered. (Resident 71) Findings include: 1. During an observation on 10/30/24 at 11:30 a.m., RN 1 was observed checking Resident 14's blood sugar with a glucometer. The RN did not sanitize the glucometer afterward. She exited the resident's room and indicated another resident was also due to have his blood sugar tested. She gathered the resident's insulin, lancets, alcohol prep pads, and the same glucometer and entered Resident 61's room. She donned gloves and prepared to check the resident's blood sugar. The RN was stopped and asked to step into the hallway. She indicated the glucometer should have been sanitized and she had forgotten to do so. She then reentered Resident 61's room and cleaned the glucometer with an alcohol prep pad and proceeded to test his blood sugar. During an interview with the RN after the observation, she indicated the glucometers were supposed to be cleaned with Sani Wipe germicidal disposable wipes between each resident. The current policy, "Glucometer-Assure Prism Quality Control Checks and Cleaning Procedures," indicated, "The meter should be cleaned and disinfected after use on each patient... disinfecting procedure is needed to prevent the transmission of blood born pathogens..."		placed on the room door and the care plan was updated to reflect the MRDO/EBP. Resident #14 did not have any negative outcomes identified related to the improper cleaning of the glucometer. 2. An in-house audit was completed by the Infection Preventionist and/or designee for residents with Enhanced Barrier Precautions to ensure no other concerns were identified by the date of compliance. An in-house audit was completed by the DON and/or designee for all residents who utilize the glucometer to ensure that no other concerns were identified by the date of compliance. Any issues identified were corrected immediately. 3. Education was completed by the DON and designee and provided to the Infection Preventionist and Interdisciplinary Team addressing Enhanced Barrier Precautions. This education included all systems initiated when EBP are being utilized, to include signage, PPE availability, and care planning. Education was immediately provided to RN #1. Education was also provided to all licensed nursing staff addressing glucometer cleaning protocol. This education will be completed annually, upon hire and as needed for licensed nurses. No licensed	

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	2. On 10/28/24 at 1:50 p.m. and 10/29/24 at 11:22 a.m., Resident 71 was observed seated in her room. There was no signage on the door that indicated she was on EBP and there was no Personal Protective Equipment (PPE) present in or near the room. Resident 71's record was reviewed on 10/29/24 at 11:10 a.m. Diagnoses included, but were not limited to, congestive heart failure, fracture of the lower end of tibia with routine healing, and hypertension. The Admission Minimum Data Set assessment, dated 9/3/24, indicated the resident was cognitively intact and was dependent on staff for toileting and transfer assistance. A Physician's Order, dated 9/4/24, indicated the resident should be on EBP due to ESBL (extended spectrum beta-lactamase, a bacterial enzyme resistant to many antibiotics) and VRE (Vancomycin resistant enterococci, a bacteria resistant to some powerful antibiotics) every shift. During an interview on 10/29/24 at 11:25 a.m., LPN 1 indicated she did not know if the resident was supposed to be on EBP but would check with the IP (Infection Prevention) Nurse. During an interview on 10/29/24 at 11:30 a.m., the IP Nurse indicated she was aware of the EBP order and thought there was EBP in place for the resident. She later indicated the EBP had been placed on the incorrect room. The current policy, "Infection Prevention and Control Program (IPCP) and Plan," indicated, "...4. The program includes early detection,		nurses will work past date of compliance without this education being completed. 4. The Infection Preventionist and/or designee will audit for compliance weekly for six months utilizing an “Enhanced Barrier Precaution Audit Tool” for all residents for any changes and document appropriately. The DON/Designee will audit 3 residents weekly x 3 months then 2 residents weekly x 3 months on EBP to ensure compliance. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits. The DON and/or designee will audit for compliance weekly for 6 months utilizing a “Glucometer Cleaning Audit Tool” for all residents who use a glucometer. Audits will be presented to the QAPI committee monthly x 6 months and then the committee will determine the need for further audits.	

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	management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate TBP/PPE..." 3.1-18(b)(2)			