STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 17, 18, 19, 20, 21, and 22, 2023 Facility number: 000514 Provider number: 155503 AIM number: 100266800 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 9 Medicaid: 32 Other: 15 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 27, 2023.	F 0000	Re: Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On sept 22, 2023 an annual survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of oct 16, 2023. Please feel free to call me with any further questions at 1 (812) 446-2636. Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Manoj Berry	Executive Director	10/11/2023

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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was free from accidents for 1 of 2 residents reviewed for accidents (Resident 14). Finding includes: During an interview, on 09/18/23 at 9:50 a.m., Resident 14 indicated she was in the shower room sitting on the toilet when staff had left the shower room to obtain supplies needed for her shower. The resident indicated she attempted to transfer herself from the toilet to her wheelchair and she fell and hit her head on the floor in the shower room. She had to go to the hospital for treatment. Resident 14's record was reviewed on 9/19/23 at 10:23 a.m. The profile indicated the resident's diagnoses included, but were not limited to traumatic subarachnoid hemorrhage without loss of consciousness (the sudden onset of a severe headache, often accompanied with nausea, vomiting, and a loss of consciousness caused by traumatic brain injury or ruptured brain aneurysm [a bulge in a week area of blood vessel in or around your brain]), type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). A quarterly Minimum Data Set (MDS) assessment, dated 6/17/23, indicated the resident	F 0689	div=""> F 689 Free of accident hazards/Supervision/Devices. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Resident 14’s chart was reviewed and updated to include fall prevention interventions on both the care plan and resident profile. 2)How the facility identified other residents: All residents could be affected by the alleged deficient practice. Audit was completed on all falls which occurred in the last thirty days to ensure fall prevention interventions were documented on both the care plan and the resident	10/16/2023

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	had moderate cognitive impairment and required the assistance of 1 for transfers, toilet use, dressing, and personal hygiene. A care plan, dated 2/6/22 and revised on 9/1/23, indicated the resident was at risk for falls related to weakness, gait, and balance deficits. Resident had poor safety awareness and is impulsive. Interventions included, but were not limited to, re-educate staff on proper transfer, sign placed in bathroom to remind resident to call for assistance from staff, resident educated per staff on calling for help with call light, and stay with resident when assisted to bathroom. Review of progress note, dated 8/31/23 at 10:53 p.m., indicated Resident 14 had an unwitnessed fall at approximately 10:20 p.m. The resident was in the shower room and attempted to transfer self to a wheelchair and the brakes were not locked. Resident had a large knot on the back of skull. 911 was called for a transfer to the emergency room. Review of progress note, dated 9/1/23 at 3:38 a.m., indicated the resident had been admitted to the Intensive Care Unit (ICU) at the hospital. Review of Interdisciplinary Team (IDT) note, dated 9/1/23 at 5:06 a.m., indicated a root cause analysis of the fall was the resident tried to stand up and transfer self. Staff had left the shower room to go get items for care. Post fall intervention was for staff to stay with residents when assisted in the bathroom. Review of hospital discharge summary, dated 9/5/23, indicated the resident had a traumatic subarachnoid hemorrhage (bleeding in the subarachnoid space), and traumatic cerebral intraparenchymal hemorrhage (bleeding into the		profile. 3)Measures put into place/ System changes: The Licensed staff Inservice was completed with emphasis on fall prevention interventions documented on both the care plan and the resident profile. DON or Designee will review 3 residents who have experienced a fall 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months to ensure fall prevention interventions are documented on both the care plan and resident profile. 4)How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 10/16/2023.	

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	brain). The resident was admitted to the hospital on 8/31/23 and discharged on 9/5/23, back to the facility. During an interview, on 9/20/23 at 9:59 a.m., Certified Nurse's Assistant (CNA) indicated Resident 14 did not use her call light, she just got up on her own. She was an assist of 1 prior to her fall at the end of August but now she required a Hoyer lift (mechanical lift) for transfers. During an interview, on 9/20/23 at 10:04 a.m., Licensed Practical Nurse (LPN) 10 indicated Resident 14 used her call light about 50 percent of the time. When she did use her call light, she would often become impatient waiting on staff and would attempt to transfer herself without staff assistance. During an interview, on 9/20/23 at 11:40 a.m., Director of Nursing (DON) indicated the resident probably should not have been left alone in the shower room. The DON was aware that the resident would need to be reminded by staff to use her call light for assistance. She was not aware of a facility policy regarding leaving residents alone while in the shower room. During an interview, on 9/20/23 at 12:36 p.m., CNA 11 indicated she would always stay with a resident in the shower room because she would never know what could happen if she left a resident alone. She indicated you could not hear in the shower room if you left, and the door was closed. During an interview, on 9/21/23 at 10:00 a.m., the Administrator indicated he had talked with the staff member that had left the resident alone in the shower room and indicated she should not have			

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	left her alone. On 9/20/23 at 11:46 a.m., the DON provided a document, dated 5/19/21, titled, "Fall Management," and indicated it was the policy currently being used by the facility. The policy indicated," ...Communicate residents risk status and interventions to care givers," ...Fall prevention is achieved and interdisciplinary approach of managing risk factors and implementing appropriate interventions to reduce risk for falls" ...Develop a plan of care which can include general and specific interventions to reduce falls ...." 3.1-45(a)(2)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the			

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	attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to ensure pharmacy recommendations were completed for 1 of 5 residents reviewed for unnecessary medications (Resident 34). Finding includes: On 9/20/23 at 8:54 a.m., Resident 34's record was reviewed, with diagnoses included, but not limited to, congenital malformation of heart (abnormality in the heart that develops before birth), cardiomyopathy (chronic disease of the heart muscle), and heart failure (chronic, progressive condition in which the heart muscle is unable to pump blood as well as it should). A pharmacy consultation report, dated 11/14/22, recommended Resident 34 to have blood lab work	F 0756	F 756 Drug Regimen Review The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents	10/16/2023

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	of a basic metabolic panel (BMP) (blood test to assess several important aspects and the general physical health of the blood) and blood lab work of a vitamin D level (blood test to assess the level of vitamin D in the blood to ensure the muscles, nerves, and immune system are working normally). The pharmacy consultation report was blank without a physician's response. On 9/20/23 at 10:00 a.m., the Director of Nursing (DON) indicated the pharmacy recommendation for labs was not completed in a timely manner and she was unable to locate a pharmacy recommendation where the physician had addressed the recommendation for the lab blood work. On 9/20/23 at 12:30 p.m., DON provided and identified a document as a current facility policy, titled, "Pharmacy Recommendations," dated 8/14/2019. The policy indicated, "...Policy: Pharmacy recommendations from the Registered Pharmacist will be implemented or the reason for non-implementation will be documented...3. All pharmacy recommendations requiring a physician's action will be brought to the attention of the appropriate physician in a timely manner (three to five business days)...4. If a physician is not in agreement with and declines the recommendation, this will be documented in the medical record...." 3.1-25(i)		identified: Resident 34 chart was reviewed, and MD was notified about missed pharmacy recommendations and lab work. New Lab work was ordered and carried out for resident 34. 2)How the facility identified other residents: All residents could be affected by the alleged deficient practice. DON or Designee completed audit on the pharmacy drug regimen review in the last thirty days to ensure all recommendations by registered pharmacist were communicated to the MD and all orders have been carried out. 3)Measures put into place/ System changes: Inservice was completed with all licensed staff with emphasis on completion of pharmacy recommendations. DON or Designee will review 10 pharmacy recommendations monthly x 6 months to ensure these have been completed. 4)How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 10/16/2023.	

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure fast-acting insulin medication was administered within a timely manner of meal service for 2 of 2 residents reviewed for significant medication error resulting in a medication error rate of 6.25 percent (Resident's 7 and 23). Findings include: During the survey, medication administration was observed. There were 2 errors observed during the 32 opportunities for errors observed resulting in a 6.25% error rate. 1. On 9/20/23 at 11:10 a.m., Licensed Practical Nurse (LPN) 10 was observed obtaining a blood glucose (the main sugar found in your blood) reading for Resident 7. The resident's blood glucose reading measured 245. On 9/20/23 at 11:18 a.m., LPN 10 was observed to administer a total of 15 units of Novolog (a rapid-acting insulin that helps lower mealtime blood sugar spikes in adults and children with diabetes) into Resident 7's abdomen. On 9/20/23 at 11:40 a.m., the resident was observed sitting in the activity lounge area participating in a trivia activity. On 9/20/23 at 11:53 a.m., staff was observed	F 0759	F 759 Free of medication Errors. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Resident 7 and Resident 23 orders were reviewed to ensure administration of insulin is ordered to be administered within the recommended time parameters. 2)How the facility identified other residents: Any resident who receives a sliding scale insulin can be affected by the alleged deficient practice. A facility wide audit was completed for all current residents who receive sliding scale insulin to ensure medication administration timings are	10/16/2023

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	transporting the resident into the main dining room for her lunch meal. On 9/20/23 at 12:13 p.m., Resident 7's lunch meal tray was observed being served to her. Resident 7's record was reviewed on 9/20/23 at 3:03 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a condition where the body doesn't make enough insulin [a hormone that lowers the level of glucose in the blood] or doesn't use insulin well) with diabetic neuropathy (nerve damage that is caused by diabetes) and long-term use of insulin. A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 9/30/23, indicated the resident received insulin. A care plan, dated 7/6/21 and updated on 7/18/23, indicated the resident was at risk for complications related to diagnosis of diabetes mellitus. A physician's order, dated 12/27/22, indicated Novolog Flexpen (an injection device with a needle that delivers insulin into the subcutaneous (SQ) tissue [the tissue between your skin and muscle] 100 unit/milliliter (ml), administer 8 units SQ before meals. A physician's order, dated 8/19/23, indicated Novolog Flexpen 100 unit/ml, administer insulin amount per sliding scale (varies the dose of insulin based on blood glucose level) SQ, before meals and at bedtime. The sliding scale indicated the amount of insulin to be administered for a		accurate. No discrepancies were noted. 3)Measures put into place/ System changes: In service provided to licensed staff with emphasis on timing of administration of sliding scale insulin and meal consumption. DON/Designee will observe licensed nurse administering sliding scale insulin 3 times weekly x4 weeks ,2 times weekly x 4 weeks and then 1 time weekly for 4 months to ensure insulin is administered within appropriate time limit as defined by manufacture guidelines. 4)How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 10/16/2023	

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	blood glucose reading of 245 was 7 units. On 9/20/23 at 1:30 p.m., the Director of Nursing (DON) provided a document with a revision dated of 2/2023, titled, "Novolog insulin aspart injection 100 units/ml," and indicated it was the manufacturer's guidelines for the Novolog insulin policy that the facility followed. The policy indicated, "...Dosage and Administration...Subcutaneous injection...Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks, or upper arm...." 2. On 9/20/23 at 11:22 a.m., Licensed Practical Nurse (LPN) 10 was observed obtaining a blood glucose (the main sugar found in your blood) reading for Resident 23. The resident's blood glucose reading measured 375. On 9/20/23 at 11:34 a.m., LPN 10 indicated she had administered 10 units of Humalog (a rapid-acting insulin that helps lower mealtime blood sugar spikes in adults and children with diabetes) insulin to the resident, in her abdomen. Upon completion of the insulin administration, staff was observed transporting the resident to the main dining room for her lunch meal. On 9/20/23 at 12:13 p.m., Resident 23's lunch meal tray was observed being served to her. Resident 23's record was reviewed on 9/20/23 at 3:06 p.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus (a condition where the body doesn't make enough insulin [a hormone that lowers the level of glucose in the blood] or doesn't use insulin well) due to underlying condition with other diabetic kidney complication			

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	(a common kidney complication of diabetes) and hyperglycemia (high blood glucose levels) unspecified. An annual Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 8/16/23, indicated the resident received insulin. A care plan, dated 1/25/19, and revised on 9/6/23, indicated the resident was at risk for hypoglycemia (low blood glucose levels) and hyperglycemia due to her diagnosis of diabetes mellitus. A physician's order, dated 6/7/23, indicated Humalog Kwikpen (a small, lightweight pen that's prefilled with mealtime insulin) 100 units/milliliter (ml), administer insulin amount per sliding scale (varies the dose of insulin based on blood glucose level) subcutaneous (SQ), before meals. On 9/20/23 at 1:30 p.m., the Director of Nursing (DON) provided an untitled document, with a revision date of 3/2013, and indicated it was the manufacturer's guidelines for the Humalog insulin policy that the facility followed. The policy indicated, "...Dosage and Administration...Subcutaneous injection. Administer within 15 minutes before or immediately after a meal...." During an interview, on 9/20/23 at 12:36 p.m., the Assistant Director of Nursing (ADON) indicated the residents should have received their trays within 15 minutes following the administration of their Humalog and Novolog. During an interview, on 9/20/23 at 2:25 p.m., the			

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	Regional Clinical Support indicated the facility policy did not address the timing between the administration of the insulin and serving the resident's meal. The facility would follow the manufacturer's guidelines. 3.1-48(c)(1) 3.1-48(c)(2)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview and record review, the facility failed to ensure the appropriate temperature and palatability of food served for 2 of 24 residents reviewed for dietary services (Residents 23, and 52), 1 of 1 resident council meeting reviewed for dietary concerns, and 1 of 1 test tray reviewed for temperature and palatability. Findings include: During an interview, on 9/18/23 at 9:32 a.m., Resident 23 indicated, she ate breakfast and supper in her room and ate lunch in the main dining room, and the food, at times, was cold. During an interview, on 9/18/23 9:36 a.m., Resident	F 0804	F804 Nutritive Value /Appear, Palatable /Prefer temp. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	10/16/2023

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	155503	A. BUILDING 00 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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	52 indicated, she ate meals in her room and the food was often cold, when her meal came to her room. A group resident council meeting from 7/12/23, indicated the residents had a concern for the dietary department that the meat was too tough. The kitchen had provided education to the dietary staff regarding tough meat that was served to the residents. On 9/20/23 at 12:57 p.m., test tray food temperatures were measured by the Dietary Director. The roast beef temperature measured at 126 degrees Fahrenheit, and the cooked carrots temperature measured at 131 degrees Fahrenheit. The Dietary Director indicated the roast beef and carrots temperatures should be at least 135 degrees Fahrenheit, and the meat was too tough to cut. On 9/20/23 at 1:30 p.m., the Director of Nursing (DON) provided and identified a document as a current facility policy, titled, "Food Temperatures," dated 8/14/19. The policy indicated, "...Procedure: ...F. Food sent to the units for distribution (such as meals...) will be transported and delivered to maintain temperatures...at or above 135 degrees Fahrenheit for hot foods...." 3.1-21(a)(2)		1)· Immediate action taken for those residents identified: Residents 23 and 52 were notified of improvements made by the facility to ensure food was at appropriate temperatures when served. Both residents agree with the plan. 2) How the facility identified other residents: All residents have potential to be affected by the alleged deficient practice and none noted. 3) Measures put into place/System changes: Dietary service staff were educated on proper temperatures and palatability of food by the administrator. Dietary manager/Designee will monitor food temperature, and palatability, for 1 test tray 3 days week x 4 weeks, 1 day a week x 4 weeks and then one time a month x 4 months to ensure compliance. 4) How the corrective actions will be monitored: The monitoring for compliance will be a joint effort between the Executive Director/DNS, Medical records, and Social Services. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6months or until 100% compliances achieved	

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			for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of Compliance :10/16/2023	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff sanitized their hands appropriately, the deep fryer and stove were cleaned, and a cup was not stored in the flour canister, for 2 of 2 kitchen observations and the facility failed to ensure hand hygiene was completed and safe handling of food during 2 of 2	F 0812	F812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of	10/16/2023

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	meal observations. Findings include: 1. On 9/17/23 at 10:26 a.m., the Dietary Director (DD) washed her hands for less than 10 seconds, then began the initial tour of the kitchen with the following concerns observed: The deep fryer was observed with a large amount of food debris floating in the oil with food debris on top and down the sides of the deep fryer. The stove/oven had food debris and oil buildup on the top, down the sides, and in the grease trap of the appliance. The inside of the oven was soiled with food debris and grease running down the inside of the oven door. A Styrofoam cup was observed in the flour canister. On 9/17/23 at 10:34 a.m., the DD indicated when washing her hands, she should have scrubbed her hands with soap for 20 seconds before rinsing them in the water. The deep fryer oil was changed weekly and needed to be changed with fresh oil. The sides and top of the deep fryer and the stove/oven were soiled and should be cleaned daily. The Styrofoam cup should not have been stored in the flour canister. During a second kitchen observation, on 9/20/23 at 11:01 a.m., the deep fryer was observed with a large amount of food debris floating in the oil with food debris on the top and down the sides of the deep fryer and the stove/oven appliance units. On 9/21/23 at 10:07 a.m., the Administrator indicated he went into the kitchen and showed the		compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No residents were identified as being affected by the alleged deficient practice. 2)How the facility identified other residents: All residents can be affected by this alleged deficient practice. None were identified. 3)Measures put into place/ System changes: In-service was completed with dietary staff emphasizing proper hand hygiene and kitchen cleanliness. DON/Designee will visually audit 3 dietary staff members 3 times weekly for 4 weeks, then 3 staff members 2 times weekly for 4 weeks, then 3 staff member 1 times weekly for 4 months for proper Handwashing and Hand Hygiene. Administrator, DON or Designee will inspect kitchen 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 months to ensure kitchen is clean and sanitized. Any concerns will be addressed immediately. 4)How	

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	dietary staff how to move the deep fryer and stove to clean between and around the appliances. 2. During a dining observation, on 9/17/23 at 12:13 p.m., Certified Nurse's Assistant (CNA) 3 served a resident her tray of food. CNA 3 took the resident's brownie out of the plastic wrap with bare hands and placed the brownie on the plastic wrap in front of the resident's plate. On 9/17/23 at 12:20 p.m., CNA 3 served a resident her tray of food. CNA 3 took the resident's brownie out of the plastic wrap with bare hands and placed the brownie on the plastic wrap in front of the resident's plate. During an interview, on 9/1923 at 1:40 p.m., CNA 7 indicated staff should not touch the resident's food with their bare hands. During an interview, on 9/20/23 at 2:30 p.m., Regional Nurse Consultant indicated staff should not touch resident's food with bare hands. 3. During observation of hall tray administration, on 9/17/23 at 12:42 p.m., Certified Nursing Assistant (CNA) 3 was observed washing her hands at the handwash station behind the nurse's station. During the procedure, she reached her hand under the automatic paper towel dispenser, several times, but no paper towel was dispensed. The CNA was observed to turn off the faucet with her bare hands. On 9/17/23 at 12:45 p.m., paper towels were observed dispensed from the towel dispenser4. During a dining observation, on 9/20/23 at 12:20 p.m., in the closed unit dining area, Qualified Medication Aide (QMA) 12 was observed washing her hands in the kitchen sink area. QMA 12 washed her hands, then using the handle, hand cranked the paper towel dispenser with her bare		the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance:10/16/2023	

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	hand she then dried her hands. QMA 12 served several trays to residents and returned to wash her hands again. QMA 12 washed her hands and then using the handle, hand cranked the paper towel dispenser with her bare hand, she dried her hands then continued to serve meal trays to the residents. On 9/20/23 at 12:35 p.m., during an interview with QMA 12, she indicated she should have gone to another area to obtain paper towel. The paper towel was not dispensed prior to washing hands because they were instructed, they did not need to turn on the water with a paper towel. She acknowledged she should have dispensed paper towel first to avoid soiling hands after washing. During an interview, on 9/21/23 at 10:27 a.m., Infection Preventionist (IP) Registered Nurse (RN) 16 indicated, staff should use correct handwashing prior to and during meal service. If staff were using the towel holder which must be dispensed by hand, they must dispense paper towel by the handle before washing the hands, to prevent contamination of clean hands. On 9/18/23 at 9:10 a.m., the Dietary Director provided a document titled, "FOOD SAFETY AND SANITATION," dated 8/14/2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: Follow all local, state and federal standards and regulations in order to assure a safe and sanitary Food Service Department ...Procedure ...B. Employees ...4. All staff shall wash their hands just before they start to work in the kitchen. And when they have used their hands in an unsanitary way such as smoking, sneezing, using the restroom, handling poisonous compounds, dirty dishes, or handling patients/residents ...."			

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	On 9/21/23 at 8:48 a.m., the Administrator provided a document, titled, "Hand Washing Hand Hygiene," dated 7/19/21, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Skilled validation: When cleaning hands with soap and water. Wet hands first with water ...Apply soap product ...Rub hands together vigorously for at least 15-20 seconds covering all surfaces of the hands and fingers ... Rinse hands with water and use disposable towels to dry ...Use towel to turn off faucet ...." On 9/18/23 at 9:27 a.m., the Dietary Director provided a document, titled, "Electric Floor Fryers," dated 12/2022, and indicated it was the user manual currently being used by the facility. The User Manual indicated, " ...6.2 Cleaning: The device should be cleaned regularly. Clean the fry pot at least once each week by filling it to just below the upper oil level mark with water ...." On 9/20/23 at 3:19 p.m., the DON provided a document titled, "Food Service Distribution," dated December 2010, and indicated it was the policy currently being used by the facility. The policy indicated, "...6. Bare hand contact with food is prohibited ... Gloves must be worn when handling food directly ...." 3.1-21(i)(1) 3.1-21(i)(3)			