| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155003 | A. BUILDING 00<br>B. WING | 08/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| MASON HEALTH CARE CENTER | 900 PROVIDENT DRIVE<br>WARSAW, IN 46580 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: August 26, 27, 28, 29 & 30 of 2024<br><br>Facility number: 000003<br>Provider number: 155003<br>AIM number: 100290600<br><br>Census Bed Type:<br>SNF/NF: 72:<br>Total: 72<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 48<br>Other: 17<br>Total: 72<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quallity Review completed on 9/9/2024 | F 0000 | We at the facility are hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br><br>Based on record review and interview, the facility failed to ensure a care plan regarding activities was revised and updated for 1 of 21 residents reviewed for care plans (Resident 6).<br><br>Finding includes:<br><br>The record for Resident 6 was reviewed on 8/29/2024 at 9:45 A.M. . Diagnoses, included but | F 0657 | Resident #6 experienced no adverse reactions related to this deficient practice. Resident #6's individualized care plans were reviewed, revised, and implemented as appropriate. All residents residing in the facility that have individualized care plans related to activities have the | 09/26/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jaime Sevier | RN, RDQA | 09/15/2024 |

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| | were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, gastrostomy status, liver disease, diabetes mellitus with neuropathy, bipolar disorder, contracture, depression, anxiety and chronic kidney disease.<br><br>An annual Minimum Data Set (MDS) assessment,, dated 3/27/24, indicated it was very important for Resident 6 to listen to music, be around pets, do favorite activities, go outside, and participate in religious activities. Resident 6 indicated it is not very important to do things with groups, keep up with news, and have magazines to read.<br><br>An activity care plan, dated 7/13/2023, indicated Resident 6 benefited from individualized programming, enjoyed music like the Beatles, and enjoyed visits from her Jehovah Witness church. Interventions included, but were not limited to: provide resident with activity supplies such as magazines, crosswords and writing instruments, talk to resident about her face cream, and having her hair and nails done.<br><br>An activity assessment updated on 6/27/2024, indicated Resident 6 was to receive one to one visits to help with socialization, attended sensory club and accepted pet visits.<br><br>Activities note indicated Resident 6 received friendly visits 23 times from the dates of 8/1/2024 through 8/25/2024 and a manicure on 8/20/2024.<br><br>During an interview, on 8/29/2024 at 2:01 P.M., the Administrative Director indicated the Activities Director was responsible for updating the activity care plan when she completed the activity quarterly assessments. | | potential to be affected by this deficient practice. Care plans for resident residing in the facility were reviewed and revised as indicated. The facility policy and procedure for Care Plan Revisions Upon Status Change was reviewed with no changes indicated. Facility staff were re-inserviced on the facility policy related to Care Plan Revisions. The Activity Director and/or designee will randomly complete the Care Plan Revision audit (Attachment A). The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the Activity Director and/or designee will randomly complete the Care Plan Revision audit to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The Activity Director report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. | |

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| | On 8/29/2024, at 11:17 A.M. the Corporate Nurse provided a policy titled, "Care Plan Revisions Upon Status Change," dated 11/1/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...care plan will be reviewed, and revised as necessary, when a resident experiences a status change..."<br><br>3.1-35(d)(2)(B) | | | |
| F 0676 SS=D Bldg. 00 | 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br>Activities Daily Living (ADLs)/Mntn Abilities<br><br>Based on interview, observation, and record review, the facility failed to provide appropriate communication devices for a Spanish speaking resident for 1 of 1 resident reviewed for communication. (Resident 29)<br><br>Finding includes:<br><br>During an interview with Resident 29's son, on 8/26/2024 at 3:21 P.M., he indicated Resident 29 could not speak English, and Spanish was her normal launguage for communication.<br><br>A record review for Resident 29 was completed, on 8/28/2024 at 10:01 A.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, dysphagia, and major depressive disorder.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 7/19/2024, indicated Resident 29 had moderate cognitive deficit and could make herself understood, and understood others.<br><br>A Care Plan, dated 4/26/2024, and revised on 6/27/2024, indicated Resident 29 had a cognitive | F 0676 | Resident #29 experienced no adverse reactions related to this deficient practice. Resident #29 has been provided with appropriate communication devices for Spanish speaking residents. All residents residing in the facility who require communication devices have the potential to be affected by this deficient practice. Resident requiring communication devices were identified. Communication devices are in place for indicated residents. The facility policy and procedure for Communication with Persons with Limited English Proficiency was reviewed with no changes indicated. Facility staff were re-inserviced on the facility policy related to Communication with Persons with Limited English Proficiency. The SSD and/or designee will randomly complete the Communication audit (Attachment B). The random audit will occur weekly for four weeks, | 09/26/2024 |

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| | deficit related to a diagnosis of altered mental status, and her primary language was Spanish, which may required a translator at times. Interventions included:<br>- Call my family to translate.<br>- I benefit from tasks that are broken down into simple one step instructions.<br>- I have difficulty understanding full complex sentences and benefit from using simple one- or two-word instructions and questions.<br>- Use LTC communicator to translate for me.<br>-When talking to me allow me enough time to process the information.<br><br>A Care Plan, dated 8/27/2024, indicated Resident 29's primary language was Spanish and she reqired a translator at times. The goal was for Resident 29 to effectively communicate her needs and understand others. The interventions included:<br>- Call my family to interpret as necessary.<br>- Utilize interpreter services via LTC Solutions as indicated.<br><br>During an observation, on 8/29/2024 at 11:15 A.M. through 11:45 A.M., Resident 29 was observed to be yelling out in Spanish.<br><br>On 8/29/2024 at 12:52 P.M. through 1:04 P.M., Resident 29 was yelling out. A staff member gave her cookie, and took her to her office.<br><br>On 8/29/2024 at 1:27 P.M., Resident 29 was observed yelling out with staff pushing her in the wheelchair up and down hallway.<br><br>On 8/29/2024 at 1:29 P.M., RN 14 indicated he offered Resident 29 pain medication and an anxiety pill earlier, but she refused. He indicated he knows what she is saying using Google | | every other week for four weeks, then monthly thereafter. Monitoring will continue until compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the SSD and/or designee will randomly complete the Communication audit to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The SSD report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. | |

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| | translator, some of the staff can spoke Spanish, and she had dementia and yelled all the time.<br><br>At 1:50 P.M., the staff continued to push Resident 29 in her wheelchair as she was yelling out repeatedly in Spanish.<br><br>On 8/30/2024 at 11:08 A.M., Resident 29 was in bed repeating "Aya ya ya ya!" Housekeeper 16 responded, "I don't speak Spanish honey." During an interview, Housekeeper 16 indicated she tried to do her best with communication with Resident 29. She indicated she knew a little bit of Spanish, but not much. She indicated Resident 29 did not have a communication board in her room.<br><br>During an interview, on 8/30/24 at 11:28 A.M., QMA 13 indicated if one of the Spanish speaking girls was available, she would have them speak to the resident, and she was supposed to use the online translation application for Spanish translation. She indicated she did not know about a communication board for Resident 29 as she has never paid attention to the process needed for translation.<br><br>During an interview, on 8/30/2024 at 11:45 A.M., the Executive Director indicated a Spanish communication board in-service was completed on 7/16/2024 due to findings during a mock survey. The communication board for Resident 29 was to be placed at the nursing station. She provided the in-service attendance, the agenda and a poster of Spanish communication. There was no housekeeping staff in attendance.<br><br>During an interview, on 8/30/2024 at 11:47 A.M., Housekeeper 15 did not know about the communication board. | | | |

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| | During an interview, on 8/30/2024 at 11:48 A.M., RN 14 indicated the Spanish communication board was not available at the nursing station.<br><br>During an interview, on 8/30/2024 at 11:51 A.M., RN 17 indicated she could not find a Spanish communication board at the nurse's station, but found it in another Spanish speaking resident's room.<br><br>A policy was provided, on 8/30/2024 at 1:24 P.M. by the Director off Nursing. the policy titled, "Communicating with Persons with Limited English Proficiency", indicated, "...It is the policy of this facility to take reasonable steps to ensure that persons with Limited English Proficiency [LEP] have meaningful access and equal opportunity to participate in our services, activities, programs, and other benefits. The purpose of this policy is to ensure meaningful communication with LEP residents and their authorized representatives involving their medical conditions and treatments...1. Facility staff will identify the language and communication needs of the LEP person during the pre-screening and admission process...4. Notification of the availability of language assistance services will also be provided through one or more of the following: outreach documents, telephone voice mail menus, and/or the facility's website...5. Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services...9. All staff will be provided notice of this policy, and staff that may have direct contact with LEP individuals will be trained in ineffective communication techniques, including the effective use of an interpreter...." | | | |

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| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>Based on observation, record review and interview, the facility failed to ensure respiratory equipment was changed per Physician orders for 1 of 1 resident reviewed for oxygen use. (Resident 14)<br><br>Finding includes:<br><br>During an observation, on 8/26/2024 at 2:38 P.M., Resident 14's oxygen tubing was dated 8/18/2024. The humidification bottle, dated 8/18/2024, was empty.<br><br>During an observation, on 8/28/2024 at 10:25 A.M., Resident 14's water bottle was dated 8/18/2024, and remained empty. The 02 tubing was dated 8/18/2024.<br><br>During an observation, on 8/29/2024 at 8:40 A.M., Resident 14's oxygen humidification water bottle, dated 8/18/2024, was empty and the 02 tubing was dated 8/18/2024.<br><br>The record for Resident 14 was reviewed on 8/28/2024 at 9:38 A.M. Diagnoses included, but were not limited to: paraplegia, malnutrition, depression, asthma.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 6/6/2024, indicated the resident used oxygen.<br><br>Current Physician Orders, dated 10/18/2023, indicated Resident 14 received oxygen at 2 liters per minute via nasal cannula for chronic obstructive pulmonary disease (COPD). A Physician's Order, dated 5/28/2024, indicated to | F 0695 | Resident #14 experienced no adverse reactions related to this deficient practice. Resident #14's humidification bottle and tubing has been changed. All residents residing in the facility who require oxygen have the potential to be affected by this deficient practice. Resident residing in the facility who require oxygen have had their humidification and tubing changed per physician's order. The facility policy and procedure for Oxygen Concentrator was reviewed with no changes indicated. Facility staff were re-inserviced on the facility policy related to Oxygen Concentrator. The DON and/or designee will randomly complete the Oxygen Concentrator audit (Attachment C). The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Oxygen Concentrator audit to ascertain continued compliance at least biannually. Any concerns noted will receive immediate | 09/26/2024 |

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| | change the oxygen tubing and supplies weekly, every night shift on Sunday.<br><br>A Care Plan, dated 9/21/2023, indicated the resident had COPD. Interventions included, but were not limited to: will receive oxygen as ordered and oxygen tubing will be changed weekly as indicated.<br><br>A Treatment Administration Record (TAR), dated 8/1/2024, indicated the O2 tubing and the water bottle had not been changed since 8/18/2024.<br><br>During an interview, on 8/30/2024 at 1:23 P.M., LPN 3 indicated the tubing had not been changed and the water humidification water bottle should not be empty.<br><br>On 8/29/2024 at 10:49 A.M., the Corporate Nurse provided the policy titled, "Oxygen Concentrator", dated 2023, and indicated the policy was the one currently used by the facility. The policy indicated"...e. Fill the humidifier container to the correct level with distilled water and attach to concentrator; or use a disposable humidifier... 5... c. i. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. ii. Change humidifier bottle when empty, weekly, or as recommended by the manufacturer...."<br><br>3.1-47(6) | | follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation, record review and interview, the facility failed to ensure medication storage carts were locked when not in use; failed to store medications appropriately; failed to | F 0761 | No residents were negatively affected by this practice. All residents who reside in the facility that receive individualized drugs | 09/26/2024 |

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| | ensure expired medications were removed from medication carts; and failed to ensure the freezer section of a medication refrigerator was free from ice build up for 4 of 4 medication storage areas observed. (400 hall Medication Cart, 300 hall Medication Cart, 100 hall Medication Cart, and 100 hall Medication room)<br><br>Findings include:<br><br>1. At 2:50 P.M., QMA 8 walked away from the 400 hall medication cart and went down the hall. The medication cart was unlocked.<br><br>During an observation, on 8/26/2024 at 2:56 P.M., LPN 11 walked by the 400 hall medication cart twice.<br><br>During an interview, on 8/26/2024 at 3:00 P.M, QMA 8 indicated the medication cart should not have been left unlocked.<br><br>2. During a medication storage observation on the 300 hall medication cart, on 8/27/2024 at 2:30 P.M., with RN 9 the following was observed:<br>- A bottle of shampoo was in with the liquid medications in the bottom drawer.<br>- A container of skin cream with an expiration date of 3/22/2023.<br><br>During an interview, on 8/27/22024 at 2:46 P.M., LPN 3 indicated the items should not have been stored in the medication cart.<br><br>3. During a medication storage observation on the 100 hall medication cart, on 8/28/2024 at 1:36 P.M. with QMA 10, the following was observed:<br>- An opened and undated bottle of Miralax.<br><br>During an interview, on 8/28/2024 at 1:38 P.M., | | and/or biologicals that are stored by authorized personnel of the facility have the potential to be affected by this practice. Items identified in the 2567 have been corrected. The facility policy and procedure for Medication Storage was reviewed with no changes indicated. The facility nursing staff was re-inserviced on the facility policy and procedure for Medication Storage. The DON and/or designee will randomly audit medication and treatment carts weekly for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the Medication Storage review form (Attachment D). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Medication Storage review to ascertain continued compliance at least biannually The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |

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| | QMA 10 indicated the Miralax should have been dated when opened.<br><br>4. During a medication storage observation on the 100 hall medication room, at 8/28/2024 at 1:46 P.M. with LPN 3, the following was observed:<br>- the medication fridge had a large build up of ice in the freezer section.<br><br>During an interview, on 8/28/2024 at 1:47 P.M., LPN 3 indicated the freezer should not have a build up of ice.<br><br>The refrigerator temperature log sheet dated August 2024 indicated the temperature was below the appropriate temperatures of 35- 46 degrees on the following dates: 8/19--32, 8/23--32, 8/25--34, 8/26--34, and 8/28 --34.<br><br>On 8/29/2024 at 9:00 A.M., the Director of Nursing provided the policy titled, "Medication Storage", dated 11/1/2023, and indicated the policy was the one currently used by the facility. The policy indicated" ...1. General Guidelines: a. All drugs and biological's will be stored in locked compartments( i.e., medication carts, cabinets, drawers, refrigerators, medications rooms) under proper temperature controls... c. During a medication pass, medication carts must be under the direct observation of the person administering medications or locked in the medication storage area/cart... b. Temperatures area maintained within 36-46 degrees F... c. In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such finding to Maintenance for emergency repair... 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn illegible, or | | | |

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| | missing labels...."<br><br>On 8/29/2024 at 9:00 A.M., the Director of Nursing provided the policy titled, "Drug Disposition", with a revision date of 7/2024, and indicated the policy was the one currently used by the facility. The policy indicated" ...5. Discontinued, outdated, or deteriorated medication shall not be maintained or used by the facility. Medications shall be disposed of in compliance with federal, state and local laws...."<br><br>3.1-25(m)<br>3.1-25(o) | | | |
| F 0812 SS=E Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>Based on observation, interview and record review, the facility failed to store, prepare and serve food in a sanitary manner in 1 of 1 kitchens observed and 2 of 2 nutrition pantries observed. This deficient practice had the potential to affect 72 of 72 who consumed food from the kitchen and nutrition pantries.<br><br>Findings include:<br><br>1. During an initial tour of the kitchen, on 8/26/2024 at 11:59 A.M., with the Dietary Manager, the following was observed:<br>- black specs of a substance on a shelf in the walk-in cooler.<br>- an opened, undated bag of tater tots not sealed in the freezer.<br>- an opened bag of diced pepperoni with a used by date of 7/4/2024 in the freezer.<br><br>During an interview, on 8/26/2024 at 12:10 P.M., the Dietary manager indicated the shelf should | F 0812 | No residents were negatively affected by this practice. All residents residing in the facility that receive food prepared by dietary services or handled by staff have the potential to be affected by these deficient practices. Items identified in the 2567 have been corrected. The facility policy and procedure for Serving a Meal, Date Marking for Food Safety, and Food Safety Requirements was reviewed with no changes indicated. Staff were re-inserviced regarding the facility policy and procedure for Serving a Meal, Date Marking for Food Safety, and Food Safety Requirements. The Dietary Manager and/or designee will randomly complete the Sanitation/Food Safety audit weekly for four weeks, then every | 09/26/2024 |

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| | 155003 | A. BUILDING 00<br>B. WING | 08/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| MASON HEALTH CARE CENTER | 900 PROVIDENT DRIVE<br>WARSAW, IN 46580 |

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| | have been cleaned, the tater tots should have been dated and sealed and the pepperoni should have been removed.<br><br>2. During a meal observation, on 8/26/2024 from 12:40 P.M., to 12:46 P.M., the following was observed:<br>-at 12:43 P.M. CNA 5 passed a lunch tray with her finger extending over the rim of the plate.<br>-at 12:46 P.M. CNA 4 passed a lunch tray with her finger extending over the rim of the plate.<br><br>3. During a meal observation, on 8/27/2024 from 12:18 P.M. to 12:25 P.M., the following was observed:<br>-at 12:18 P.M., CNA 4 assisted a resident with her meal. CNA 4 opened a bag containing a dinner roll, reached in and removed the dinner roll from the bag and placed it on the resident's plate with her bare hand.<br><br>During an interview, on 8/27/2024 at 12:25 P.M., CNA 4 indicated she should have worn a glove to remove the roll from the bag.<br><br>4. During a follow up visit of the main kitchen, on 8/27/2024 at 9:38 A.M., the following was observed:<br>- an opened and undated bag of cookies pieces not sealed appropriately in the dry storage area.<br>- an opened, undated bag of confectioners sugar, opened packet of lemonade drink mix and an opened gravy packet.<br>- 2 containers of Basil spice and black pepper with the expiration date of 5/2024, on a shelf in the kitchen.<br><br>During an interview, on 8/27/2024 at 9:40 A.M., the Dietary manager indicated the cookies should have been sealed. | | other week for four weeks, then monthly thereafter. The audit will be documented on the Sanitation/Food Safety review form (Attachment E). The DON and/or designee will randomly complete the Meal Service Observation form weekly for four weeks, then every other week for four weeks, then monthly thereafter. (Attachment F) Monitoring will continue until compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the Dietary Manager and/or designee as well as the DON and/or designee will randomly complete the identified audit tools to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The Dietary Manger and DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. | |

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| | During an interview, on 8/27/2024 at 9:55 A.M., the Dietary manager indicated the opened items should have been sealed and the expired items should have been thrown out.<br><br>5. On 8/30/2024 at 9:06 A.M., an observation of the 300/400 hall pantry was completed with QMA 13. The following was observed: the microwave had a dried crusty substance on the glass dish and there was dried food debrison the top of the inside.<br><br>During an interview, on 8/30/2024 at 9:08 A.M., QMA 13 indicated the microwave should not be that way and needed to be cleaned.<br><br>6. During an observation, on 8/30/2024 at 9:10 A.M., of the 100/200 hall pantry with CNA 7, the following was observed: there was dried food debris on the top of the inside of the microwave.<br><br>During an interview, on 8/30/2024 at 9:12 A.M., CNA 7 indicated the microwave should have been cleaned.<br><br>On 8/29/2024 at 11:09 A.M., the Corporate Nurse provided the policy titled, "Serving a Meal", dated 11/29/2023, and indicated the policy was the one currently used by the facility. The policy indicated" ...6...Avoid handling actual unwrapped food items with bare hands...."<br><br>On 8/29/2024 at 11:10 A.M., the Corporate Nurse provided the policy titled, " Date Marking for Food Safety", dated 4/9/2024, and indicated the policy was the one currently used by the facility. The policy indicated" ...2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded... | | | |

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| | 4. The marking system shall consist of color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded... 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly...."<br><br>On 8/29/2024 at 11:10 A.M., the Corporate Nurse provided the policy titled, "Food Safety Requirements", dated 11/1/2023, and indicated the policy was the one currently used by the facility. The policy indicated" ...1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with the delivery of the food to the resident... b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms...d. Distribution and service of food to the resident, including transportation, set up, and assistance... f. Employee hygienic practices... iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded... e. Use of gloves when touching and assisting with ready-to-eat foods... b. Stall shall not touch food with bare hands, exhibiting appropriate use of gloves... h. Gloves will be worn when directly touching ready-to-eat foods...."<br><br>3.1-21(i)(3) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, record review and interview, the facility failed to ensure staff used | F 0880 | Resident #14 experienced no adverse reactions related to this | 09/26/2024 |

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| | appropriate PPE (Personal Protective Equipment) when emptying a Foley catheter drainage bag for 1 of 1 resident reviewed for catheters. (Resident 14)<br><br>Finding includes:<br><br>During an observation, on 8/26/2024 at 2:31 P.M., Resident 14's Foley urine catheter drainage tubing had a large amount of sediment.<br><br>The record for Resident 14 was reviewed on 8/28/2024 at 9:38 A.M. Diagnoses included, but were not limited to paraplegia, malnutrition, depression, and neuromuscular dysfunction of bladder.<br><br>Current Physician Orders, dated 4/17/2024, indicated Resident 14 was on enhanced barrier precautions related to an: extended -spectrum beta-lactamase (ESBL (an enzyme found in some bacteria that can cause serious urinary tract infections) in the urine.<br><br>A current Care Plan, dated 8/14/2024, indicated the resident had an indwelling catheter related to a neurogenic bladder. Interventions included the following: Staff will care for my catheter and personal hygiene needs, proper positioning of the drainage bag to reduce my risk of infection. Treatments as ordered per Physician.<br><br>During an observation, on 8/28/2024 at 1:31 P.M., QMA 12 was observed to empty Resident 14's catheter urine drainage bag. The QMA did not have a face shield and or gown on while emptying the urinary drainage bag. When questioned if she should have worn a gown and face shield, she indicated she did not think so, but would find out. | | deficient practice. QMA #12 received re-education regarding Enhanced Barrier Precautions. All residents residing in the facility that require EBP related to indwelling medical devices have the potential to be affected by this deficient practice. The facility policy and procedure for Enhanced Barrier Precautions was reviewed with no changes indicated. Nursing staff were re-inserviced regarding the facility policy and procedure Enhanced Barrier Precautions. The DON/designee will randomly complete the Enhanced Barrier Precautions audit form (Attachment G) weekly for four weeks, then every other week for four weeks, then monthly thereafter. Monitoring will continue until compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Enhanced Barrier Precautions audit form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. | |

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| | On 8/29/2024 at 9:00 A.M., the Director of Nursing provided the policy titled, "Enhanced Barrier Precautions", dated 3/26/2024, and indicated the policy was the currently used by the facility. The policy indicated" ...Enhanced barrier precautions (EBP) refer to an infection control intervention designated to reduce transmission of multi-resistant organisms that employs targeted gown and gloves use during high contact resident care activities... b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i... indwelling medical devices (e.g., central lines urinary catheters...b. PPE for enhanced barrier precautions is only necessary when performing high -contact care activities...4. High-contact resident care activities include:...g. Device care or use: central lines, urinary catheters...."<br><br>3.1-18(b)(1) | | | |