STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155596	A. BUILDING 00 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKELAND REHAB AND HEALTHCARE CENTER	500 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 23, 24, 25, 26 and May 30, 2023 Facility number: 000474 Provider number: 155596 AIM number: 100290510 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 7 Medicaid: 40 Other: 19 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 1, 2023	F 0000	**This facility request paper compliance of all citations** *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.*	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sarah M Trewett | RN, DON | 06/14/2023

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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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record review, the facility failed to provide privacy during personal care in 1 of 2 residents reviewed (Resident 13). Findings include: During an observation on 5/23/23 at 11:23 AM,	F 0550	**F550 Resident Rights/Exercise of Rights** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/09/2023

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	Qualified Medication Aide (QMA) 5 and QMA 6 transferred Resident 13 back to bed after a shower. Registered Nurse (RN) 6 and RN 7 were in the room preparing to apply a dressing to Resident 13. Resident 13 was lying on a pad used with a mechanical lift and a blanket. The front of her body was uncovered and exposed. After applying lotion to Resident 13's upper body, QMA 6 indicated she should have covered Resident 13's exposed body parts. QMA 6 took two dry washcloths and placed them over each of Resident 13's breasts. Resident 13's peri area and lower body remained exposed. In an interview on 5/26/23 at 2:05 PM, Resident 13 indicated she preferred to be covered as much as possible during personal care. In an interview on 5/23/23 at 3:04 PM, the Director of Nursing (DON) indicated Resident 13 should have been draped and covered to limit exposure during personal care. Resident 13's record was reviewed on 5/23/23 at 1:03 PM. Diagnoses included multiple sclerosis, pressure area of the sacral region, stage 4, neuralgia, and neuritis, unspecified. A review of Resident 13's current quarterly Minimum Data Set (MDS) dated 4/25/23 indicated Resident 13 had a Basic Interview for Mental Status score of 11 (mild cognitive impairment). A care plan titled self-care deficit had a goal of being clean, dry, and well-groomed and indicated Resident 13 had a problem with self-care and required physical assistance from staff to complete bathing and dressing tasks. A current policy titled Bathing-Complete Bed Bath last revised on 2/20/21 was provided on 5/26/23 at		Resident 13 affected with no adverse effects noted. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Any resident has the potential to be affected. No adverse outcomes were identified. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Staff re-educated on bed bath procedure. Audit of current resident population completed with any findings being addressed immediately. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place**? The responsible party for this plan of correction is the Director of Nursing/designee. Random audits of 2 residents will be completed 3 times weekly x 4 weeks, bimonthly x 2 months, monthly x3	

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	2:37 PM by the DON. The policy indicated staff should drape a resident to maintain dignity by not exposing the body. 3.1-3(a)		and then will be followed in QAPI thereafter. The results of these audits/interviews 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: 6/9/2023**	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:			

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	§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview, and record review, the facility failed to ensure follow up to improve the communication ability for 1 of 9 resident reviewed for hearing. (Resident 47). Findings include: On 5/24/23 at 10:59 AM Resident 47 was observed without a hearing aid. During an interview on 5/24/23 at 10:59 AM, Resident 47 indicated he was waiting for a hearing aid for his left ear. He indicated his hearing had been tested at the facility and he would like to know how long it would be until he received the hearing aid. The resident indicated he had difficulty hearing in group activities and in the dining room. A record review on 5/25/23 at 9:54 AM indicated a physician order for an audiology consult was signed on 5/31/22. The physician order indicated the resident was to have an audiology consult due to having had a recent fall and/or problems with balance.	F 0676	**F676 Activities Daily Living/Mntn Abilities** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 47 assessed with no adverse effects noted. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Any resident has the potential to be affected. No adverse outcomes were identified. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient**	06/09/2023

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	The resident's record indicated the resident had been evaluated by an audiologist on 9/9/22. The audiologist indicated the resident needed a hearing aid for the left ear. The audiologist indicated earmold impressions were not completed on 9/9/22 due to inability to remove the ear wax with a curette. The audiologist indicated ear mold impressions would be completed after wax removal. A quarterly MDS assessment dated 4/7/23 indicated the resident had adequate hearing ability with a hearing aid. During an interview on 5/25/23 at 10:34 AM, the Director of Nursing (DON) indicated the Social Service Director (SSD) was responsible for following up on audiologist consultations. The DON indicated the facility was possibly getting a new company to provide audiology services. During an interview on 5/25/23 at 10:56 AM, the SSD indicated she was unaware of the resident's audiologist evaluation on 9/9/22. The SSD indicated it is her responsibility to make staff aware of new orders or recommendations from outside consultations. She suggested perhaps the resident had been in the hospital and she would look in the office for more information. In an interview on 5/30/23 at 2:30 PM, the SSD indicated there was no further documentation related to the resident's audiology status. In an interview on 5/30/23 at 2:35 PM, the Administrator indicated the facility did not have a policy for audiology services. 3.1-38(a)(1)		**practice does not recur?** House wide audit of current resident population completed with any findings being addressed immediately. Facility contacted contracted provider and Educated on expectations of communication after visits prior to leaving facility, processing and completion of any orders / need for continued follow up. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place**? The responsible party for this plan of correction is the Director of Nursing/designee. Random audits of 5 residents will be completed weekly x 4 weeks, bimonthly x 2 months, monthly x3 and then will be followed in QAPI thereafter. The results of these audits/interviews 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: 6/9/2023**	

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	3.1-38 (a)(2)(A)-(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure wound care was provided as ordered and obtained for 1 of 2 residents observed (Resident 13). Findings include: During an observation and interview on 5/26/23 at 11:56 AM, Registered Nurse (RN) 4 applied a powder to Resident 13's reddened abdominal folds. The label on the bottle indicated it contained nystatin powder and the name on the bottle corresponded with Resident 17 instead of Resident 13. RN 4 indicated he should not have applied another resident's medication to Resident 13. Resident 13's record was reviewed on 5/23/23 at 1:03 PM. Diagnoses including multiple sclerosis, pressure area of the sacral region, stage 4, neuralgia, and neuritis, unspecified. A current quarterly Minimum Data Set (MDS) dated 4/25/23 indicated Resident 13 had a Basic Interview for Mental Status (BIMS) score of 11 (mild cognitive impairment).	F 0684	**F684 Quality of Care** 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 13 assessed with no adverse effects noted. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Any resident has the potential to be affected, full house audit completed with no adverse effects identified. **3) What measures will be put**	06/09/2023

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	A review of Resident 13's current physician's orders did not include an order for nystatin powder. In an interview on 5/23/23 at 3:04 PM, the Director of Nursing (DON) indicated RN 4 should not have applied Resident 17's powder to Resident 13. A current policy titled Reducing Risk for Medication Errors last reviewed on 3/21/21 was provided on 5/26/23 at 2:45 PM by the DON. The policy indicated staff should verify orders in the electronic medical record and ensure they are administering to the right resident when administering medications.		**into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All Nurses and QMAs were re-educated on the five rights during medication pass. **4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The responsible party for this plan of correction is Director of Nursing/designee. Nurses/QMAs will be audited 3 times weekly x 4 weeks, weekly x 4 weeks, bimonthly x 2 months, monthly x3 and then will be followed in QAPI thereafter. The results of these audits/interviews 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: 6/9/2023**	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure hand hygiene was maintained during wound care for 1 of 2 residents observed (Resident 58). Findings include: During an observation on 5/26/23 at 10:32 AM, Registered Nurse (RN) 7 washed her hands and applied gloves. She removed the dressing in place over a stage 4 pressure wound on the sacrum of Resident 58. She tucked the dressing into the incontinence brief she removed from the Resident 58, sprayed the wound with wound cleanser, and used a gauze sponge to wipe the wound bed, touching the wound with her gloves. RN 7 did not perform hand hygiene and change her gloves after removing the dirty dressing and before touching the wound. In an interview on 5/30/23 at 8:59 AM, RN 7 indicated she should have removed her gloves	F 0686	**F686 Treatment/Svcs to Prevent/ Heal Pressure Ulcer** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Staff re-educated on Wound care procedure. Resident 58 assessed with no adverse effects noted. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Any resident with a wound and dressing change had the potential to be affected. No adverse outcomes were identified. **3. What measures will be put**	06/09/2023

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	after removing the dirty dressing, performed hand hygiene, and applied new gloves before cleaning the resident's wound. Resident 58's record was reviewed on 5/26/23 at 9:49 AM. Diagnoses included pressure ulcer of the sacral region, peripheral vascular disease, and type 2 diabetes with other circulatory complications. A current admission Minimum Data Set dated 4/28/23 indicated Resident 58 had a Brief Interview for Mental Status (BIMS) score of 15. This indicated he was alert, oriented and interviewable. A physician's order dated 5/24/23 indicated Resident 58's pressure ulcer of the sacrum should be cleansed with wound wash, silver alginate should be applied and covered with a foam dressing. A current policy titled Non-Sterile Wound Dressing Procedure, last revised 11/22 was provided on 5/26/23 at 11:24 AM by the Administrator. The policy indicated after a soiled dressing was removed, it should be placed in the trash. Gloves should be removed, hand hygiene should be performed, and new gloves should be applied before cleansing the wound. 3.1-40		**into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Staff re-educated on wound dressing change procedure, following physician orders and documentation of MAR as provision of treatment occurred. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place**? The responsible party for this plan of correction is the Director of Nursing/designee. Random audits of 2 residents will be completed weekly x 4 weeks, bimonthly x 2 months, monthly x3 and then will be followed in QAPI thereafter. The results of these audits/interviews 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: 6/9/2023**	

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F 0699 Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on record review and interview, the facility failed to ensure triggers were and resident specific approaches were identified for providing trauma informed care for 1 of 1 resident reviewed. (Resident 59). Findings include: Resident 59's record was reviewed on 5/30/23 at 12:21 PM. Diagnoses included unspecified dementia with severe anxiety, Alzheimer's disease, paranoid personality disorder, hallucinations, and abuse. A review of Resident 59's current comprehensive Minimum Data Set (MDS) assessment, dated 3/29/23, indicated her Basic Interview for Mental Status (BIMS) score was 5 (cognitive function was severely impaired). The MDS indicated the resident had mood concerns of feeling down, depressed, or hopeless 12-14 days, trouble falling or staying asleep, or sleeping too much/feeling tired or having little energy/ trouble concentrating on things, such as reading the newspaper or watching television 7-11 days, and feeling bad about themselves or that they are a failure or have let their family down 2-6 days in a 14 day period. The MDS indicated the resident had hallucinations, delusions, and received	F 0699	**F699 Trauma Informed Care** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 59 assessed for psychosocial behavior, treatments, orders, interventions, Triggers, and care plan reviewed and updated for all with physician notified of any findings. No adverse effects noted. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents in house with services for mental/ psychosocial concerns assessed by DON/designee. Education provided to staff and social service	06/09/2023

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	antipsychotic medication on a daily basis. An interdisciplinary team (IDT) meeting progress note, dated 3/20/23 at 11:01 AM, attended by the Social Service Director (SSD), Assistant Director of Nursing (ADON), Director of Nursing (DON), clinical support and SSD support was reviewed. The note indicated Resident 59's son indicated she was a victim of spousal abuse by her ex-husband. A review of Resident 59's current care plan, dated 3/20/23 and revised 4/6/23, indicated the resident had psychosocial well-being problems as a result of being a victim of spousal abuse per the resident with a goal she would identify the reasons for feelings of unhappiness, paranoia, anxiety. No resident specific triggers or approaches to care related to abuse from Resident 59's ex-husband were identified in the care plan. A review of a psychological assessment progress note dated 3/23/23 at 9:30 AM indicated Resident 59 came from a local hospital. She was transported to the hospital because she was confused, paranoid, hallucinating, wandering the halls and knocking on other doors in her apartment complex. Reportedly, the resident had visions of her ex-husband and felt threatened. The social section of the assessment indicated she was divorced. The assessment indicated on 3/18/23 the resident had delusions of danger, hid in dark spaces, behind chairs, doors, and was crawling on the floor. The assessment indicated the resident was aggressive with facility staff and hit staff with a linen cart, threw a card table and pushed a staff member against a bookshelf with a table resulting in the administration of Haldol 2.5mg intramuscular for paranoid delusions and distress on 3/18/23 at 10:49 PM.		director on appropriate triggers/monitoring. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Behaviors and new admissions will be reviewed daily during stand-up meeting/clinical meeting. Clinical record reviews/audits of 3 residents weekly to determine appropriate/accurate documentation of those residents exhibiting behaviors. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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: 6/9/2023**	

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	155596	A. BUILDING 00 B. WING	05/30/2023

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	A psychological assessment progress note dated 4/10/23 at 9:45 AM indicated Resident 59's delusions and hallucinations continued, were improving, but she became agitated at times when leaving the facility per the staff. The assessment indicated the resident said she had anxiety at times, "when I drive, I get weak," and the staff reported she was hearing things at times without anything or anyone in the vicinity. A progress note dated 4/12/23 at 17:58 PM indicated the resident was exit seeking and indicated her son was coming to pick her up. The note indicated she could be redirected short periods of time before she returned to exit seek. The resident indicated her son was speaking to her while she was talking to staff. Her son was not present at the facility. A psychological assessment progress note dated 4/22/23 at 9:45 AM indicated Resident 59 was experiencing delusions such as her son was coming to get her, the hospital had called her, said her mother had tried to commit suicide and she needed to come to the hospital. The assessment indicated the resident stated she had anxiety at times. A psychological assessment progress note dated 5/18/23 at 9:15 AM indicated Resident 59 had delusions and talked to herself at times. The assessment indicated staff reported resident does hear things at times without anything being within the near vicinity. In an interview on 5/30/23 at 2:05 PM, the SSD indicated the care plan should include resident specific triggers and approaches to care related to the abuse from Resident 59's ex-husband but			

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	resident specific triggers and approaches to care were not included in the care plan. In an interview on 5/30/23 at 2:12 PM, the Director of Resident Services indicated the care plan should include resident specific triggers and approaches to care related to the abuse from Resident 59's ex-husband but the resident specific triggers and approaches to care were not included in the care plan. She also indicated Resident 59 verbally related information concerning spousal abuse by the resident's ex-husband. A current policy titled "Baseline Care Plan," revised 2/19/21, indicated a comprehensive care plan follows a Baseline Care Plan. No further Care Plan policies were provided by the time of survey exit. Medicare and Medicaid Programs' final rule for reform of Long Term Care facilities had a requirement for each resident to receive and the facility to provide the necessary care and services for each resident to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being ... to be included, to the extent possible, the resident and/or their representative(s) participation with the IDT in the development of the resident's care plan ...and to be included trauma-informed care, triggers and approaches to minimize re-traumatization .... (Department of Health and Human Services, 2016). Reference: Department of Health and Human Services. (2016, February 4). Rules and Regulations. Federal Register. Retrieved May 31, 2023, from https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf#page=171			

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	No State tag is applicable.			
F 0812 SS=F 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 cleanliness of the kitchen floor, walls, surfaces, and the outside dumpster area. 66 of 66 residents who resided at the facility ate food prepared in the facility. Findings include: During a tour of the kitchen with the Food Service Director on 5/23/23 at 9:12 AM, the exterior of the handwashing sink and the faucets were covered with a grey feathery matter and debris. The wall behind the handwashing sink was soiled. There	F 0812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary** **1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents noted to be affected by deficient practice.	06/09/2023

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	was a stack of folded washcloths on top of the faucets. The dishwasher was leaking into a basin on the floor. The basin contained approximately 1 gallon of water. The floor surrounding the dishwasher was wet and sticky. The floor under the sinks and counters were littered with debris and black residue. The floor around the walls was covered with black residue. The kitchen walls were soiled with grey feathery matter and splash prints. The floor behind the ice machine and water cooler was littered with debris. The exterior of the ice machine was covered with a grey feathery matter. The sink and counter next to the ice machine were soiled. A cart beside the water cooler was covered in dust. The floor under the cart was littered with debris, a bath towel and a foam cup. The storage shelves were covered with a grey feathery matter and food debris. The edges of stored steam table pans contained food debris. The ground surrounding the outside dumpster area was littered with medical gloves, a bed pad, foam cups, and water bottles. During an interview on 5/23/23 at 9:39 AM, the Food Service Director indicated all kitchen surfaces needed deep cleaning. She indicated she was unaware of who was assigned to clean the walls and floors. During an interview on 5/23/23 at 2:25 PM, the Administrator indicated the kitchen needed to be thoroughly cleaned. She indicated she was unaware of a dishwasher leak. She indicated the		**2) How other residents having the potential to be affected by the same deficient practice will be identified.** All residents residing in facility had the potential to be affected, however, no one was identified. **3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Deep cleaning of kitchen and outside dumpster completed on 6/8/2023. Dishwasher leak fixed by outside contractor. Staff members educated related to continued deep cleaning schedule. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The responsible party for this plan of correction is Executive Director/designee. Audits will be conducted weekly x 4 weeks, bimonthly x 2 months, monthly x3 and then will be followed in QAPI thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6	

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	debris surrounding the outside dumpster was due to items being wedged under the dumpster. A current policy dated 9/1/21 titled "Cleaning and Sanitizing and proper Hair Restraints" provided by the Director of Nursing (DON) on 5/25/23 at 12:15 PM indicated non-food contact surfaces are to be washed according to the facility cleaning schedule or as visually necessary. A current policy dated 9/1/21 titled "Dispose of Garbage and Refuse" provided by the DON indicated the exterior dumpster area was to be maintained in a manner free of rubbish and other debris. 3.1-21(i)(1) and (3)		months or until an average of 90% compliance or greater 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.) DOC 6/9/2023**	