STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

(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 the Investigation of Complaints IN00422593, IN00422607, IN00421064, IN00420081, and IN00429331. Complaint IN00422593 - No deficiencies related to the allegations are cited. Complaint IN00422607 - Federal/state deficiencies related to the allegations are cited at F880. Complaint IN00421064 - No deficiencies related to the allegations are cited. Complaint IN00420081 - No deficiencies related to the allegations are cited. Complaint IN00429331 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: November 28, 29 and 30, 2023 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 113 Total: 113 Census Payor Type: Medicare: 5 Medicaid: 86 Other: 22 Total: 113	F 0000	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. This provider respectfully requests that this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review on, or after December 15, 2023. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric P. Ahlbrand	CEO-Administrator	12/14/2023

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 6, 2023.			
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 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,			

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	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 interview and record review, the facility failed to ensure a resident was treated with dignity for 1 of 3 residents reviewed for nursing services. (Resident G) Findings include: Resident G's clinical record was reviewed on 11/29/23 at 10:25 a.m. Diagnoses include muscle weakness (generalized) other reduced mobility, need for assistance with personal care, other abnormalities of gait and mobility, cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 8/22/23, indicated she was cognitively intact. A quarterly MDS assessment, dated 10/20/23, indicated her cognitive status was not assessed. She required substantial/maximal assistance for toileting hygiene, upper and lower body dressing and personal hygiene. She was dependent on staff to roll left and right. She was always incontinent of bladder and frequently incontinent of bowel. A facility investigation for Resident G, reviewed on 11/29/23 at 12:20 p.m., indicated the following:	F 0550	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 G skin assessment was completed with no areas of concern identified on 11/28/23. Resident G was assessed and had no psychosocial concerns noted on 11/28/23. Resident G received care by another staff member on 11/28/23.** **2 How the facility identified other residents:** **The facility interviewed all residents that were interviewable to ensure no resident had any dignity concerns. Any concerns identified will be followed by the facilities grievance policy.**	12/15/2023

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	A typed interview statement for Resident G, completed by the interim DON and dated 11/28/23, indicated Resident G stated CNA 6 came into her room assisted her into bed. Once she was in bed, CNA 6 left and she never returned. She stated she turned her call light back on, she was unsure of the time, the next person that entered her room was LPN 27. She stated she was upset and crying, but the nurse provided care to her and she was alright. A typed interview statement for LPN 27, dated 11/28/23, indicated around 10:00 p.m., CNA 6 completed report with the off going shift. After midnight, call lights were alerting on the hall and she went to look for CNA 6, whom she found in a vacant room laying in the bed. She woke her up and told her she had call lights going off and she needed to do her job. Around 1:00 a.m., CNA 6 told her she was going on break. Around 2:00 a.m., CNA 6 contacted the emergency medical services and they took her to the hospital. She, along with the assistance of another nurse, continued to oversee resident care. Around 4:30 a.m., Resident G was upset and told her that CNA 6 threw her in the bed and just left her and never came back. A typed interview statement for CNA 6 indicated on 11/28/23 at around 10:30 p.m., she entered Resident G's room and assisted her to bed. She denied throwing Resident G into the bed. Resident G stated she looked unhappy and asked her to get someone else to take care of her. CNA 6 left the room. She did not notify anyone Resident G wanted someone else to take care of her, as she was going to give Resident G time to calm down and reapproach her. She went into an empty room on the 400 hall and laid down in a bed. She later		**An audit of all residents was completed to ensure no residents were identified with any dignity concerns on 12/13/23. No residents were identified with any dignity concerns noted.** **3 Measures put into place/ System changes:** **All nursing staff will be educated related to the facility Resident Rights Policy to include dignity and following through with ADL care when providing care to the residents.** **How the corrective actions will be monitored:** ***Effective 12/13/23 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit the residents to ensure no dignity concerns identified. This audit will be completed 2 x weekly X 12 weeks. Any identified concerns will be immediately addressed with the responsible individuals.*** ***The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audit will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify***	

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	went down the hallway and answered the call lights. She re-entered Resident G's room and once again she told her she wanted her to get someone else to take care of her. She left the room and did not notify anyone of her request to take care of her. She left the unit to take a break, called 911 a little before 2:00 a.m., and then went to the emergency room for an evaluation. During an interview with Resident G, on 11/30/23 at 10:00 a.m., she indicated she asked CNA 6 to leave her room and find someone else to take care of her because she was rude to her. She left her room and left her uncovered. She turned on her call light, but no one came for hours. CNA 6 later returned to her room, but she had already struggled to get herself covered up with her blanket. During an interview with Unit Manager 12, on 11/30/23 at 10:45 a.m., she indicated the third shift nurse tried to text her between 9:30 p.m. and 10:00 p.m., and she text messaged the third shift nurse back around 4:00 a.m. that she would just talk to her when she came to work. She arrived to work at 6:00 a.m. on 11/28/23. She was told CNA 6 was found asleep in an empty room. There were call lights going off including Resident G's. CNA 6 answered Resident G's call light and then indicated she was going to lunch. CNA 6 came back from lunch, went into the bathroom, and called the ambulance to come to the facility to get her. Due to not having a CNA on the hall, the third shift nurse checked on the residents, and found Resident G with blankets down at her feet and her brief was wet. The third shift nurse was crying as she was telling her what had happened. After she spoke to the third shift nurse, she went to Resident G's room and spoke to her. She was also crying and upset about what had happened.		***any trends or patterns and make recommendations to revise the plan of correction as indicated.***	

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	She reported the incident to management once they arrived to work between 8:30 a.m. and 9:00 a.m. A current facility policy, dated 9/15/23, titled "Activities of Daily Living (ADLs), provided by the interim DON, on 11/30/23 at 12:13 p.m., indicated the following: "...For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of cares...." 3.1-3(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must			

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	ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify a resident' representative regarding an allegation of neglect in a timely manner for 1 of 2 residents reviewed for notifications. (Resident G) Findings include: Resident G's clinical record was reviewed on 11/29/23 at 10:25 a.m. Diagnoses include muscle weakness (generalized) other reduced mobility, need for assistance with personal care, other abnormalities of gait and mobility, cognitive communication deficit, unspecified dementia,	F 0580	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:**	12/15/2023

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	unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS), dated 8/22/23, indicated she was cognitively intact. A facility investigation for Resident G, reviewed on 11/29/23 at 12:20 p.m., indicated the following: A typed interview statement for Resident G, completed by the interim DON and dated 11/28/23, indicated Resident G stated CNA 6 came into her room assisted her into bed. Once she was in bed, CNA 6 left and she never returned. She stated she turned her call light back on, she was unsure of the time, the next person that entered her room was LPN 27. She stated she was upset and crying, but the nurse provided care to her and she was alright. During a interview with the Social Service Director (SSD), on 11/29/23 at 11:48 a.m., she indicated she interviewed Resident G between 4:00 p.m. and 4:30 p.m. on 11/28/23. She was not crying or tearful and she had no emotional distress. She seemed fine. Resident's G's family member entered the room when she was wrapping up her interview. The SSD informed her the resident had alleged neglect the night before. The SSD normally spoke to Resident G's other daughter, whom she contacted between 5:00 p.m. and 5:30 p.m. The facility normally sat down and talked about the incidents and then decided who contacted the family. During an interview with CNA 6, on 11/29/23 at 2:47 p.m., she indicated she put Resident G to bed around 10:30 p.m. Resident G told her she looked unhappy and wanted her to find someone else to		**Resident G Responsible party and provider was notified on 11/28/23. Resident G skin assessment was completed on 11/28/23 with no areas of concern identified. Resident G assessed and had no psychosocial concerns noted.** **2 How the facility identified other residents:** **The facility completed an audit for the last 30 days of change of condition event to ensure resident and or responsible party notification.** **Measures put into place/ System changes:** **All licensed nurses will be educated related to notification of the responsible party and or resident including but not limited to Notification of changes.** **How the corrective actions will be monitored:** ***Effective 12/13/23 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit the Facility Activity Report for any change of condition event to ensure that the resident and or the responsible party was notified. This audit will be completed daily (M-F) X 8 weeks. Any identified concerns will be immediately addressed with the responsible individuals. After 8 weeks, to ensure continued compliance the DON/ADON/SDC/Unit Managers***	

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	take care of her. She asked her if she wanted her brief changed and she told her no. She looked for someone else to take care of her and couldn't find anyone. She went back to her around midnight and she still didn't want her to take care of her. During an interview with the Administrator, on 11/29/23 at 3:56 p.m., he indicated the family should had been contacted prior to the incident being reported to the state agency. The DON or clinical staff would notify the physician and family. During an interview with Resident G, on 11/30/23 at 10:00 a.m., she indicated she asked CNA 6 to leave her room and find someone else to take care of her because she was rude to her. She left her room and left her uncovered. She turned on her call light but no one came for hours. CNA 6 came back into her room, but she had already struggled to get herself covered up with her blanket. During an interview with Unit Manager 12, on 11/30/23 at 10:45 a.m., she indicated the third shift nurse tried to text her between 9:30 p.m. and 10:00 p.m., and she text messaged the third shift nurse back around 4:00 a.m. that she would just talk to her when she came to work. She arrived to work at 6:00 a.m. on 11/28/23. She was told CNA 6 was found asleep in an empty room. There were call lights going off including Resident G's. CNA 6 answered Resident G's call light and then indicated she was going to lunch. CNA 6 came back from lunch, went into the bathroom, and called the ambulance to come to the facility to get her. Due to not having a CNA on the hall, the third shift nurse checked on the residents, and found Resident G with blankets down at her feet and her brief was wet. The third shift nurse was crying as she was telling her what had happened.		***or Clinical Consultant will continue to review the Facility Activity Report M-F for any change of condition to ensure proper notification and documentation completed. Any identified concerns will be immediately addressed with the responsible individual.*** ***The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audit will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required.*** ***The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.***	

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	After she spoke to the third shift nurse, she went to Resident G's room and spoke to her. She was also crying and upset about what had happened. She reported the incident to management once they arrived to work between 8:30 a.m. and 9:00 a.m. A current facility policy, revised on 9/15/23, titled "Notification of Change of Condition," provided by the interim DON, on 11/30/23 at 12:13 p.m., indicated the following: "...Guidelines: 1. The facility must inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident representative(s) when there is...b. significant change in the resident's physical, mental or psychosocial status...." 3.1-5(a)(2)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey			

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	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of neglect was immediately reported to the Administrator for 1 of 4 residents reviewed for abuse. (Resident G) Findings include: Resident G's clinical record was reviewed on 11/29/23 at 10:25 a.m. Diagnoses include muscle weakness (generalized) other reduced mobility, need for assistance with personal care, other abnormalities of gait and mobility, cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS), dated 8/22/23, indicated she was cognitively intact. A quarterly MDS, dated 10/20/23, indicated her cognitive status was not assessed. She required substantial/maximal assistance for toileting hygiene, upper and lower body dressing and personal hygiene. She was dependent on staff to roll left and right. She was always incontinent of bladder and frequently incontinent of bowel.	F 0609	=”” span=””> 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. **Immediate actions taken for those residents identified:** **Resident G was assessed by the Social Services Director and Director of Nursing and had no psychosocial concerns identified no mental anguish or distress on 11/28/23. Resident G had a skin assessment completed on 11/28/23 by the clinical manager and no areas of concern were identified.** **2 How the facility identified other residents:** **The facility interviewed all**	12/15/2023

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	During an interview with Unit Manager 12, on 11/30/23 at 10:45 a.m., she indicated the third shift nurse tried to text her between 9:30 p.m. and 10:00 p.m., and she text messaged the third shift nurse back around 4:00 a.m. that she would just talk to her when she came to work. She arrived to work at 6:00 a.m. on 11/28/23. She was told CNA 6 was found asleep in an empty room. There were call lights going off including Resident G's. CNA 6 answered Resident G's call light and then indicated she was going to lunch. CNA 6 came back from lunch, went into the bathroom, and called the ambulance to come to the facility to get her. Due to not having a CNA on the hall, the third shift nurse checked on the residents, and found Resident G with blankets down at her feet and her brief was wet. The third shift nurse was crying as she was telling her what had happened. After she spoke to the third shift nurse, she went to Resident G's room and spoke to her. She was also crying and upset about what had happened. She reported the incident to management once they arrived to work between 8:30 a.m. and 9:00 a.m. During an interview with the interim DON, on 11/30/23 at 12:10 p.m., she indicated LPN 27 should have contacted the Administrator immediately. A current facility policy, revised on 10/17/22, titled "Abuse, Neglect and Misappropriation of Property," and provided by the interim DON, on 11/29/23 at 10:23 a.m., indicated the following: "...Other definitions...Deprivation of Goods and Services by Stakeholders: Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these		**residents that were interviewable to ensure no resident had any dignity concerns/allegation of neglect.. Any concerns identified will be followed by the facilities grievance policy and or abuse prohibition policy and procedure.** **3 Measures put into place/ System changes:** **All staff will be educated on the facility Abuse Prohibition Policy and Procedure. The Director of Nursing, Unit Managers, Shift Supervisor, Clinical consultant, Assistant Director of Nursing and Staff Development Coordinator will be responsible to interview staff on abuse prohibition to include if there had been any situation not reported immediately to the abuse coordinator 3 x week for 4 weeks 2 x a week for 4 weeks and then weekly for 4 weeks and monthly for 3 months. Any issues identified will be immediately corrected 1:1 re-education completed for stakeholder as identified, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing.** **How the corrective actions will be monitored:** ***Effective 12/11/23 the Administer will review the***	

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	cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s)...Reporting/Response: 1. Every Stakeholder shall immediately report any "allegation of abuse...to the facility Administrator or designee as assigned by the facility administrator in his/her absence...." 3.1-28(c)		***audits completed on a weekly basis. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly x 3 months and then quarterly for 3 quarters. Based on evaluation of audits and observations, the QAPI Committee will determine if the facility is in substantial compliance, the QAPI Committee reserves the right to modify or extend monitoring times in accordance to outcomes. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.***	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that			

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	must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			

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	(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure staff practiced appropriate infection control practices while providing care for a resident in transmission-based precautions during a random observation. Findings include: The clinical record for Resident J was reviewed on 11/30/23 at 10:04 a.m. Diagnoses include dementia, hypertension, and COVID-19. During an observation on 11/29/23 at 11:37 a.m., CNA 1 was delivering lunch room trays. The CNA entered an isolation room (Resident J's room) without donning additional PPE. The door to the resident's room displayed signage for appropriate PPE use. An isolation cart was located outside the door. CNA 1 exited the room carrying an empty tray (from breakfast). During an interview, at the time of the observation, CNA	F 0880	/p> **1 Immediate actions taken for those residents identified:** **Resident J was assessed ON 11/29/23 and had no adverse outcome from the staff member not utilizing the appropriate PPE when entering the resident room. Resident J has since ended off transmission-based precautions on 12/01/23. CNA 1 received education by the DON on use of PPE when entering resident room to provide care on 11/29/23.** **2 How the facility identified other residents:** **The facility completed an audit of all other residents who were on transmission-based precautions to ensure proper**	12/15/2023

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	1 indicated they did not don the appropriate PPE, but should have. During an interview on 11/29/23 at 11:42 a.m., The Rehab Unit Manager indicated CNA 1 should have donned the appropriate PPE before entering an isolation room. During an interview on 11/29/23 at 3:34 p.m., LPN 3 indicated all staff were educated on PPE use and isolation protocol. The appropriate PPE should have been donned prior to entering an isolation room. On 11/29/23 at 12:53 a.m., the DON provided staff education materials and attendance records for an inservice related to infection control, COVID -19 and the use of PPE, completed on 10/19/23. CNA 1's name was on the attendance sheet. Inservice materials included the Center for Disease Control instructions on how to don/doff PPE, and a diagram, last revised 5/12/23, titled "PPE Use During COVID-19". This citation relates to complaint IN00422607. 3.1-18(a)		**use of PPE when entering the resident rooms with no further concerns identified. All residents on transmission-based precaution have since ended off transmission-based precautions.** **3 Measures put into place/ System changes:** **All staff will be educated on the use of PPE when entering the resident room to ensure proper PPE application.** **How the corrective actions will be monitored:** ***Effective 12/13/23 the DON/ADON/Unit Managers/SDC or Clinical Consultant will audit any resident receiving transmission-based precaution to ensure that the proper PPE when entering the resident room has been donned. This audit will be completed 2 x weekly X 12 weeks. Any identified concerns will be immediately addressed with the responsible individuals.*** ***The facility through the QAPI program will review, update and make changes, as necessary to this plan of correction to ensure substantial compliance for 6 months. The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if***	

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			ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	