STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00458256. Complaint IN00458256 - No deficiencies related to the allegations are cited. Survey dates: May 27, 28, 29, 30 and June 2, 2025 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 2 Medicaid: 18 Other: 9 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/5/25.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 19th, 2025, to the Annual Survey completed on June 2nd, 2025. We respectfully request a desk review for paper compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the resident's physician was notified of medication being held for 1 of 5 residents reviewed for unnecessary medications. (Resident 183)	F 0580	F580[D] Notify of Changes It is the practice of this facility to consult with the resident's physician when there is a need to alter current treatment. What corrective action(s) will be	06/19/2025

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

Jennifer Short | Administrator | 06/19/2025

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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	Finding includes: Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, cellulitis of the right lower limb, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. She received diuretic, opioid, antiplatelet, and hypoglycemic medications in the 7-day look-back period. The current May 2025 Physician's Order Summary indicated the resident received Novolog FlexPen (insulin injection) subcutaneous solution pen-injector 100 unit/milliliter, inject 12 units subcutaneously three times a day with meals. The May 2025 Medication Administration Record indicated the Novolog medication was coded "11= blood sugar level below parameters" on the following dates and times: - At 8:00 a.m.: 5/1/25 blood sugar 97, 5/4/25 blood sugar 123, 5/8/25 blood sugar 80, and 5/9/25 blood sugar 75 - At 12:00 p.m.: 5/6/25 blood sugar 111, 5/8/25 blood sugar 106, and 5/9/25 blood sugar not applicable - At 5:00 p.m.: 5/6/25 blood sugar 107 and 5/8/25 blood sugar 89 There was a lack of any physician's orders for parameters for holding the medication, corresponding progress notes related to the medication being held, or documentation that the physician was notified when the medication was		accomplished for those residents found to have been affected by the deficient practice: ·Resident 183 physician was made aware of insulin being refused/held 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 who take insulin have the potential to be affected by the alleged deficiency. An audit was conducted on all residents with insulin orders. No further deficiencies were noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A performance improvement tool has been developed IDT reviewed policy for insulin administration In-service was conducted with all facility licensed nursing staff on the policy. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's physician is made aware if insulin is held/refused. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for	

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	held. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing indicated the resident often refused her insulin dose based on what the blood sugar levels were and the nurse should have documented refusals instead of holding the medications. She had no further information to provide. 3.1-5(a)(2)		three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was implemented for a resident with a diabetic foot ulcer for 1 of 12 resident care plans reviewed. (Resident 13) Finding includes: During an observation of wound care on 5/29/25 at 10:00 a.m., Resident 13's left foot diabetic foot ulcer treatment was observed with RN 1. The area was located on the lateral foot and was open, light red in color, and had minimal drainage. RN 1 performed the wound care per the physician's order and then adjusted the resident in bed for comfort with a round cushion noted to the right leg. Resident 13's record was reviewed on 5/28/25 at 3:08 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) affecting the right dominant side, cognitive communication deficit, and type 2 diabetes mellitus.	F 0656	F656 [D] Comprehensive Care Plan It is the practice of this facility to develop a person-centered comprehensive care plan for each resident that includes measurable objectives and timeframes to meet needs identified in the comprehensive assessment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 13 comprehensive care plan was revised to reflect the diabetic foot ulcer 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 who have skin issues have the potential to be affected by the alleged deficiency. An audit was conducted on	06/19/2025

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/25, indicated the resident was severely cognitively impaired. The resident had impairments in range of motion to one side of the upper extremities and both sides of the lower extremities. She was dependent on staff for all activities of daily living including, but not limited to, bed mobility and transfers. She had diabetic foot ulcer(s) and skin tear(s). A Physician's Order, dated 5/29/25, indicated cleanse with normal saline, apply calcium alginate, and cover with dry dressing to left foot (dorsal) every day shift. A Care Plan, revised on 10/2/23, indicated the resident was at risk for alterations in skin integrity. Interventions included, but were not limited to, adjust tubing to avoid skin breakdown, administer treatments as ordered, and turn and reposition as indicated. A Skin and Wound Note, dated 5/28/25 at 4:17 p.m., indicated the resident had a diabetic ulcer to the left lateral distal foot which measured smaller today. The resident had the wound on 9/11/24 and was receiving treatments at the time. The wound healed on 1/22/25, reopened on 3/5/25, healed on 4/16/25, and reopened on 5/28/25. The diabetic foot ulcer was a full thickness wound, measuring 1 centimeter (cm) long by 0.1 cm wide with 100% epithelial tissue, and had a scant amount of drainage. The recommendations were to continue ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. The record lacked a comprehensive care plan related to the diabetic foot ulcer.		all residents and care plans reviewed. No further deficiencies were noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; IDT reviewed policy for care planning Licensed nursing staff were educated on the policy for implementing care plans when a new wound occurs. Skin issues will be reviewed in morning clinical meetings. A performance improvement tool has been developed to ensure new wounds are addressed on the care plan How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) residents with wounds to ensure that residents comprehensive care plan is accurately completed related to skin issues. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance	

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	During an interview on 5/29/25 at 1:56 p.m., the Director of Nursing indicated there was no care plan at the time for the diabetic foot ulcer, as it was a wound that would heal out and then reopen again. The wound was currently open and being treated, so the care plan should have been initiated. 3.1-35(b)(1)		Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure a resident with a reddened sclera (white part of eyeball) of the eye was assessed and monitored for 1 of 2 residents reviewed for vision/hearing services. (Resident 20). Finding includes: On 5/28/25 at 11:02 a.m., Resident 20 was sitting in a recliner in her room. She indicated her right eye had been red for some time, but could not say exactly when it began. The nursing staff had pointed it out to her the other day as she was not even aware of the redness noted to her eye. The right eyeball was observed to be solid red in color on the bottom portion of the sclera. On 5/30/25 at 1:20 p.m., Resident 20 was observed in the common area. Her right eye was still red in color. Resident 20's record was reviewed on 5/30/25 at 2:45 p.m. Diagnoses included, but were not limited to, schizophrenia and neuromuscular dysfunction of the bladder.	F 0684	F684 [D] Quality of Care It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and resident choices. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents with acute eye conditions are subject to be affected by this deficiency An in-house audit was conducted of all residents with no negative outcomes What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A performance improvement tool has been developed to monitor that any resident with an acute eye condition is assessed	06/19/2025

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/25, indicated the resident was cognitively intact for daily decision making. The record lacked documentation of assessment or monitoring of the right eye discoloration. During an interview on 6/2/25 at 11:42 a.m., the Director of Nursing indicated she had no further information related to the resident's red eye. 3.1-37(a)		and monitored IDT reviewed the policy for notifying physicians of clinical problems In-service was conducted with all facility licensed nursing staff on the policy. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that all residents with acute eye conditions have been assessed and monitored. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services related to not obtaining	F 0686	**F 686 Treatments/SVCS to prevent/ heal pressure ulcer.** It is the practice of this facility to ensure residents with pressure	06/19/2025

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	treatment orders for a wound vac for 1 of 4 residents reviewed for pressure ulcers. (Resident 183) Finding includes: During an observation of wound care on 5/29/25 at 9:53 a.m. with RN 1, a dressing change was observed to Resident 183's proximal and distal left thigh. RN 1 indicated at the time that Resident 183 had a wound vac placed to her right heel the day before (5/28/25) and there was no treatment change due at the time. Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, cellulitis of the right lower limb, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. The resident had two unstageable pressure ulcers. A Skin and Wound Note, dated 5/28/25 at 6:23 p.m., indicated the resident had readmitted to the facility on 5/23/25. The right heel pressure injury was surgically debrided during the recent hospital admission due to purulent drainage and evidence of infection. The wound vac was to continue to the heel wound at 100 mmHg (millimeters mercury) per the surgeon's request and a rescue dressing of calcium alginate with silver. The plan was discussed with the wound nurse. The right heel wound was an open surgical full thickness wound measuring 9.8 centimeters (cm) long by 5.5 cm wide by 1.7 cm deep. Treatment recommendations for the right heel open surgical wound were to clean with wound cleanser, apply a wound vac at		ulcers have orders written to receive the necessary treatment and services for treatment of the wound. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident 183 physician orders were put into place for wound vac How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents with orders for treatments to pressure injuries have the potential of being affected by the deficient practice. Treatment documentation was reviewed for all residents having pressure injuries with no further negative findings. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: The facility policy for Skin and Wound Management was reviewed by the IDT. In-service was conducted with all facility licensed nursing staff on the policy. Performance improvement tool has been developed to audit all pressure ulcer treatments. How the corrected actions will be monitored to ensure the deficient	

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	100 mmHg, rescue dressing of calcium alginate with silver with abdominal pad and rolled gauze to the base of the wound, secure with transparent film, change three times per week and as needed. There were no treatment orders for the right heel wound vac or rescue dressing in the May 2025 Physician's Order Summary. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing (DON) indicated there should have been physician's orders entered for the wound vac. A policy titled, "Skin and Wound Management System," received on 6/2/25 at 1:05 p.m., indicated "...5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Wound location, characteristics and a physician's order for treatment are documented in the medical record. Wound status will be evaluated and documented in PCC [electronic record system] on the Wound Evaluation Flow Sheet form..." 3.1-40		practice does not recur: A performance improvement tool has been initiated that audits the treatments on residents with pressure injuries. The quality assurance audit tool will be completed by the Director of Nursing/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to ensure there were orders and/or monitoring completed for a resident on a fluid restriction. (Resident 183) Finding includes: During an observation and interview on 5/28/25 at 9:47 a.m., Resident 183 indicated she had returned	F 0692	**F-692-Nutrition/Hydration Status Maintenance.** It is the practice of this facility to ensure residents on fluid restriction have orders and monitoring completed. Resident 183 physician was made aware, and an order was obtained and monitoring for fluid	06/19/2025

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	to the facility the day before and had an infection, so she was now on antibiotic therapy. She had to have surgery on her leg. The resident indicated she has had to have fluid removed at the hospital before and was on a fluid restriction at the hospital; however, since being back in the facility, she was not required to be on a fluid restriction any longer. There was a large foam cup on her bedside table full of water. Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, chronic kidney disease, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. She received diuretic, opioid, antiplatelet, and hypoglycemic medications in the 7-day look-back period. The current May 2025 Physician's Order Summary indicated the resident received a carbohydrate controlled no added salt diet, received furosemide (diuretic medication) 40 milligrams (mg) daily, and spironolactone (diuretic medication) 100 mg daily. The Nursing Evaluation, dated 5/27/25 at 10:33 p.m., indicated the resident had readmitted to the facility. She had skin conditions noted to the right buttock, coccyx, groin redness, right elbow pressure, right hand bruising, right wrist bruising, left lower extremity healed surgical wound, left lower arm generalized bruising, left heel deep tissue injury, left thigh surgical wound, right heel surgical incision, left lower leg surgical wound, left lower leg lateral healed surgical wound, and was to receive a regular no added salt thin liquid diet with 1800 milliliter fluid restriction.		restriction was put into place How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents on fluid restriction have the potential to be affected by the alleged deficient practice. Audit was conducted on all residents on fluid restriction for the alleged deficient practice with no negative findings. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not occur: IDT reviewed policy on encouraging and fluid restrictions Nursing staff were in-serviced on policy A performance improvement tool has been developed to monitor orders were received and documentation for fluid consumption was completed on those residents with restrictions How the corrective actions will be monitored to ensure the deficient practice does not recur.: A Quality Assurance tool has been developed and implemented that audits that all fluid restrictions have orders and are being monitored. The tool will be completed by the Director of nursing/designee weekly times three, monthly times three, then	

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	There were no orders or documentation of fluid intake/restriction in the record. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing indicated she was going to add the order for the fluid restriction and monitoring now. A policy titled, "Encouraging and Restricting Fluids," indicated "...General Guidelines...1. Follow specific instructions concerning fluid intake and restrictions...Restricting Fluids: 1. Remove the resident's water pitcher and cup from the room. Store in designated area....6. Record the amount of fluid consumed on the intake side of the intake an output record. Record fluid intake in mLs..." 3.1-46(b)		quarterly times three. In the event any concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility quality Assurance Program at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen administration for 1 of 1 resident reviewed for respiratory care. (Resident 9) Finding includes: On 5/27/25 at 11:09 a.m., Resident 9 was observed in her room lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 2 liters. On 5/28/25 at 3:05 p.m., Resident 9 was observed in her room lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 2 liters.	F 0695	F695 [D] Respiratory/Tracheostomy Care and Suctioning It is the practice of this facility that we ensure that residents receive necessary care and services in relation to oxygen administration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 9 physician was notified, and the oxygen order was adjusted from PRN to continuous per resident medical need. How other resident having the potential to be affected by the	06/19/2025

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	Resident 9's record was reviewed on 5/29/25 at 10:38 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, heart failure, and hypertension. A Physician's Order, dated 4/3/25, indicated oxygen 2 L (liters) via nasal cannula as needed (PRN) for shortness of breath, maintain oxygen saturation above 90. The Quarterly Minimum Data Set assessment (MDS), dated 4/30/25, indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and had not received oxygen. A Care Plan, updated 5/14/25, indicated the resident was at risk for alterations in oxygen levels due to heart failure. The interventions included to administer oxygen as ordered. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2025, lacked any documentation the PRN oxygen had been signed out as administered or that the resident's oxygen saturation had been monitored. During an interview on 5/29/25 at 1:50 p.m., the Director of Nursing indicated the resident would get short of breath when staff was doing wound care or repositioning, so they would just keep the oxygen on at all times. She would update the oxygen orders. No further information was provided. A facility policy, titled, "Oxygen Administration," received from the Administrator as current, indicated "...Steps in the Procedure...10. Adjust		same deficient practice will be identified and what corrective action(s) will be taken; Any resident with oxygen has the potential to be affected by the deficient practice. Facility audit conducted of patients with oxygen to ensure their order was correct, oxygen administered as ordered and saturation completed as indicated. No negative outcomes noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; IDT reviewed policy and procedure for oxygen administration Clinical staff have been in serviced on checking 02 and assuring they are on proper settings per the physician order and saturation monitored as indicated. A performance improvement tool has been developed to monitor that oxygen orders are followed correctly How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly checks (5) residents on oxygen to assure administration is followed per physician orders. This Quality Assurance Audit Tool will be completed by the Director of Nursing/ Designee weekly for	

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	155733	A. BUILDING 00 B. WING	06/02/2025

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	the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered...Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: ...3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. administration..." 3.1-47(a)(6)		three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure a sanitary kitchen related to testing the dishwasher sanitation level with faulty test strips in 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect the 26 of 29 residents in the facility who received food from the kitchen. Finding includes: During the initial kitchen tour on 5/27/25 at 9:10 a.m. with the Dietary Food Manager (DFM), the dishwasher was observed and noted to be a low temperature, chemical system. The DFM obtained a testing strip, dipped it into the dishwasher water and compared it to the results on the side of the testing strip container. The strip did not have a readily discernable color change. He indicated they always used those strips and was unsure why they were not changing. He opened a new package of test strips and attempted to get another reading, however the strips still did not have a discernable color change. He indicated he would call the service company to address the dishwasher and go get another new package of	F 0812	F812 [F] Food Procurement, Store/Prepare/Serve- Sanitary It is the practice of this facility to ensure a sanitary kitchen environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The service company was immediately notified and recalibrated the dishwasher. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who consume food in the facility have the potential to be affected by the alleged deficient practice. Dishwasher was fixed immediately by vendor and has been working properly. What measures will be put into	06/19/2025

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	strips. During a follow up interview on 6/2/25 at 11:45 a.m., the DFM provided a test strip that was the appropriate sanitation level for the dishwasher (50 parts per million). He indicated the other test strips were not working and was not sure the reason why. He had called the service company and they recalibrated the dishwasher on 5/27/25 and it had been working appropriately since that time. 3.1-21(i)(3)		place and what systemic changes will be made to ensure that the deficient practice does not recur. IDT policy on Steps in Providing Safe Food The dietary staff were in-serviced on the use of the sanitation test strips and procedure to follow in the event the test strips are found to be faulty. (not sure if you wanted to limit this to the manager?) A performance improvement tool has been developed to monitor the test strips and dishwasher are working properly. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) days in the kitchen that all sanitation requirements with the dishwasher are being met. This Quality Assurance Audit Tool will be completed by the Food Service Director /Designee (5) times/week X four weeks. Then (3)/week x4, then (1) X4 for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control practices were in place and implemented related to the disposal of used lancets into the garbage can for 1 of 1 glucometer (machine used to test blood sugar levels) testing observed. (Resident 183, RN 1) Finding includes: On 5/30/25 at 11:02 a.m., RN 1 indicated he was going to check Resident 183's blood sugar. The nurse washed his hands, applied gloves, and wiped the resident's left first finger with an alcohol wipe. He then poked the resident's finger with the lancet. Blood was observed on the resident's finger and he then proceeded to check the blood sugar with the glucometer. He discarded the lancet into the garbage can next to the resident's bed. He then proceeded back to the medication cart. During an interview at that time with RN 1, he indicated he should not have discarded the lancet into the garbage can, but instead into the sharps container. He was unsure what the blood sugar reading was and he would have to re-check the resident's blood sugar. The nurse then proceeded to wash his hands again, applied gloves, and wiped the resident's second finger with an alcohol wipe. He then poked the resident's finger with a lancet. Blood was observed on the resident's finger and then he proceeded to check the blood sugar again with the glucometer. He then discarded the lancet into the garbage can next to the resident's bed again.	F 0880	F880 [D] Infection Prevention and Control It is the practice of this facility that infection control practices and standards are maintained related to the disposal of used sharps equipment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident 183 primary physician was made aware of the alleged deficient practice. · 1:1 in-service occurred with RN 1 How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Person who work and reside in the facility have the potential to be affected by the alleged deficiency All staff who check blood sugars were observed to ensure that proper infection control practices were followed in disposal of lancets. No further alleged deficiencies were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The policy and procedures for obtaining a fingerstick glucose level (was the policy given to	06/19/2025

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	During an interview after the second observation with RN 1, he indicated he had thrown the lancet away again into the garbage can and he was aware it needed to be discarded into the sharps container. He also wrote down the blood sugar at that time so he would remember what it was. During an interview on 5/30/25 at 2:00 p.m., the Director of Nursing indicated the nurse should have discarded the lancets into the sharps container and not into the garbage can. A facility policy titled, "Obtaining a Fingerstick Glucose Level" and received as current from the Administrator, indicated, "...Steps in the Procedure..." "...16. Dispose of the lancet in the sharps disposal containers..." 3.1-18(b)		state) was reviewed by the IDT Nurses were in serviced on proper sharp disposals specifically for lacets A performance improvement tool has been developed to audit glucometer checks to ensure infection control practices are followed with disposal of sharps equipment. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits (5) glucometer checks to assure infection prevention is being followed properly. This Quality Assurance Audit Tool will be completed by the Director of Nursing/ Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on observation, record review, and interview, the facility failed to provide at least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single	F 0912	F912 [E] Bedrooms Measure Least 80sq FT/Resident It is the practice of this facility to ensure that rooms with a variance	06/19/2025

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	occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208) Findings include: 1. The floor area of the following single resident room measured: a. Room 111 - 1 resident, 96.2 SQ FT. NF. 2. The floor areas of the following multiple resident rooms measured: a. Room 101 - 0 residents, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. Room 104 - 1 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. Room 201 - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF. d. Room 202 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. e. Room 204 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. Room 206 - 0 residents, 140.0 SQ FT, 70.0 SQ FT per bed. NF. g. Room 208 - 0 residents, 146.9 SQ FT, 73.4 SQ FT per bed. NF. The facility rooms with room variances were observed on 5/28/25 at 2:50 p.m. The rooms were observed with the following number of beds: Room 101 - 1 bed Room 104 - 1 bed Room 111 - 1 bed Room 201 - 1 bed Room 202 - 1 bed Room 204 - 1 bed Room 206 - 1 bed Room 208 - 1 bed		have single occupancy. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. All rooms have single occupants. Facility records indicate existence of room waiver variance letters from ISDH dating from June 5, 2003, to present ownership. 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: No other residents are affected by this waiver practice. No other resident's safety is affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Residents in waived rooms will continue to occupy as single occupants, not double, therefore ensuring their environmental safety. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) of waivered room to assure they are only being occupied by one person. This Quality Assurance Audit Tool will be completed by the Maintenance	

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	During an interview on 5/27/25 8:53 a.m., the Administrator indicated these were the rooms which had the room variance waivers and did not have the required square footage. 3.1-19(l)(2)		Director / Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 6/19/2025	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to dirty kitchen walls and floors in the kitchen. (Main Kitchen) Findings include: During the initial kitchen tour on 5/27/25 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed: a. The wall next to stove top was covered in splashed food and debris. b. The floor and baseboard underneath the dishwasher was dirty and covered in a build up of debris. During an interview at the time, the DFM indicated the above areas were in need of a deep clean. He was not supposed to be the main cook today, so he had not had time to get to those areas yet.	F 0921	F921 [E] Safe/Functional/Sanitary/ Comfortable Environment It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Wall next to the stove top was cleaned The floor and baseboard underneath the dishwasher was cleaned 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 who reside in	06/19/2025

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	3.1-19(f)		the facility have the potential to be affected by the alleged deficient practice. Environmental concerns will be repaired when reported or identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A performance improvement tool has been developed to monitor the rooms to ensure that environmental concerns are reported and addressed. How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool has been initiated that randomly audits five (5) days to ensure that the kitchen is free from splashed foods, dirt, and debris. This Quality Assurance Audit Tool will be completed by the FSD/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic	

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			changes will be made: 6/19/2025	