STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF WASHINGTON	297 S 100 E WASHINGTON, IN 47501

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: October 23, 24, 25, 2023 Facility number: 004904 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 6, 2023.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karla Siewers	HFA, Executive Director	11/21/2023

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	shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to perform fire drills in conjunction with the local fire department at least every 6 months for 12 of 12 months reviewed. Finding includes: On 10/23/23 at 2:05 P.M., the facility log of fire drills was reviewed and lacked an invitation to the fire department from October 2022 until October 2023. During an interview on 10/25/23 at 9:57 A.M., the Maintenance Supervisor indicated she was not aware that the fire department needed to be invited twice yearly. A current non dated Fire Safety Training policy was provided by the Maintenance Supervisor on 10/25/23 at 11:42 A.M., and indicated " ... A fire drill or in-service staff training session is required on each shift, every month ..." but the policy lacked information regarding the invitation to the fire department to attend. At that time, the Maintenance Supervisor indicated they should follow the residential regulation.	R 0092	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** Re-education provided to Environmental Services Director for need to invite local fire department to participate in drill at least every 6 months. Fire Department to be invited to November 2023 fire drill. ESD provided documentation of invitation. (Attach. A) ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** Education provided to all staff of the requirement to invite the fire department to participate in fire drills at least every 6 months. (Attach. B) ***3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** ESD & ED will review fire drills monthly to monitor invitations	11/08/2023

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			to the fire department for participation. ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** ED & ESD will review fire drills quarterly to ensure that at least every 6 months the fire department is invited to participate in our fire drills. Regional ESD will review compliance biannually. ***Dates when corrective action will be completed: 11/08/2023.***	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice			

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	hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to ensure dementia inservices were completed for 3 of 5 employee files reviewed. (QMA 24, CNA 26, LPN 28). Findings include: 1. On 10/25/23 at 10:00 A.M., Qualified Medication Aide (QMA) 24's employee file was reviewed. The file lacked 2.5 hours of inservices related to dementia. 2. On 10/25/23 at 10:05 A.M., Certified Nurse Aide (CNA) 26's employee file was reviewed. The file lacked 2.5 hours of inservices related to dementia. 3. On 10/25/23 at 10:10 A.M., Licensed Practical Nurse (LPN) 28's employee file was reviewed. The file lacked 1.5 hours of inservices related to dementia. During an interview on 10/25/23 at 12:35 P.M.,	R 0120	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** Additional dementia training requirements were created in employees' Relias learning platforms to ensure compliance with educational requirements. (Attach N). ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** Audit of all (clinical) staff to ensure required dementia training has been completed. Re-education provided to	10/26/2023

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	QMA 5 indicated that no other documentation of inservice training could be found, and that QMA 24, CNA 26, and LPN 28 should have had a total of 3 hours of dementia in-services every year. On 10/25/23 at 12:49 P.M., QMA 5 provided the regulation related to dementia in-services that indicated, "...staff who have contact with residents shall have a minimum of six (6) hours of dementia- specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents..."		all staff for educational requirements on 10/25/2023. (Attach. B). ***3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** Audit of all facility staff to ensure that all educational requirements, clinical & operational, comply. Weekly review of completion rates of monthly educational requirements for company by ABOM &/or ED. (Attach C). Alerts sent to staff for approaching due dates. ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** ED &/or ABOM will review educational completion report monthly to ensure all staff are following state and company educational requirements. ***Dates when corrective action will be completed: 10/26/2023***	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation			

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	shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a self-administration of medications evaluation was completed for 1 of 5 residents reviewed during medication administration and 1 of 3 residents interviewed. Respiratory medications were observed in resident rooms that should not self administer medications. (Resident 18, Resident 45) Findings include: 1. On 10/23/23 at 11:33 A.M., Resident 18 was observed in her room while LPN (Licensed Practical Nurse) 22 was passing her noon medications. At that time, a Trelegy Ellipta 200 mcg (microgram) inhaler (steriod inhaler), dated 7/23/23, and an undated Alvesco (steriod) inhaler were laying on the resident's table. The resident indicated to the nurse "I have one of those [Trelegy inhalers] here", as she held it up for the nurse to see. On 10/24/23 at 10:48 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but was not limited to, COPD (Chronic Obstructive Pulmonary Disease) and depression. Resident 18	R 0216	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** Inhalers removed from rooms of the tenants who had inhalers not approved through a self-administration assessment. Education provided to tenants & staff of requirement for their inhalers to be kept in locked med cart. (Attach D). ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** Audit of all residents with inhalers to ensure that their inhalers are stored & locked in med cart if nursing is managing their meds. If the tenant is assessed and is a	10/26/2023

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	was admitted on 12/27/22. Current Physician Orders included, but were not limited to, the following: Trelegy Ellipta 200 mcg inhaler, administer 1 puff by mouth one time a day and rinse mouth after use with water, dated 12/27/22 Current Physician Orders for Resident 18 were reviewed and lacked orders for an Alvesco inhaler and self administration of medication. Resident 18's clinical record lacked a self-administration of medication evaluation. During an interview on 10/24/23 at 10:11 A.M., Resident 18, identified by staff to be interviewable, indicated she was not sure where the 2 inhalers came from in her room but she used them occasionally for an emergency and she kept them on the table so she had easy access to use them. During an interview on 10/25/23 at 11:06 A.M., the DON (Director of Nursing) indicated Resident 18 did not self administer medications because of her memory and should not have either inhaler in her room. At that time, she indicated both the inhalers she needed were kept in the medication cart and she wasn't sure where they came from and she was not aware they were in her room. 2. On 10/24/23 at 9:56 A.M., Resident 45 was observed in her room sitting in her recliner next to her nightstand table. At that time, 2 packages (one opened) of ipratroprium 0.5 mg (milligram)/albuterol 3mg ampules (used in nebulizer for breathing treatment) and 1 albuterol 90 mcg inhaler were observed on Resident 45's		self-administration tenant, their inhaler is locked in their medicine cabinet. ***3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** All clinical staff educated on the requirement of self-administration of medications includes inhalers. All clinical staff are educated in the self-administration assessment process to determine ability to self-administer meds. (Attach D). All facility staff are educated to alert nursing staff if they have observed a medication or inhaler in a tenant room & not locked in medicine cabinet or nurses' medication cart. (Attach B). DON &/or designated staff will complete a weekly audit of inhaler storage and weekly audit of self-administration tenants to ensure medications & inhalers are appropriately stored. (Attach E.) ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** ED & DON will review weekly medication storage audits to ensure medications & inhalers are appropriately stored. (Attach	

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	nightstand table. A nebulizer machine was observed on the floor by the resident's recliner. On 10/24/23 at 12:30 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but was not limited to, COPD diabetes mellitus type II. Resident 45 was admitted on 1/8/21. Current Physician Orders included, but were not limited to, the following: Albuterol HFA Inhaler 90 mcg, administer 2 puffs by mouth every 6 hours as needed for wheezing, dated 11/2/22 Current Physician Orders for Resident 45 were reviewed and lacked orders for Duoneb (ipratropium/albuterol) and self administration of medication. Resident 45's clinical record lacked a self-administration of medication evaluation. During an interview on 10/24/23 at 9:56 A.M., Resident 45 indicated that she typically uses the albuterol inhaler twice a day and she was supposed to do her breathing treatments three times a day, but she didn't always. During an interview on 10/25/23 at 11:06 A.M., the DON indicated Resident 45 did not self administer medications and should not have medications in her room. At that time, she indicated she she was not aware they were in her room. A current Self-Administered Medication policy, dated February 23, 2022, was provided on 10/23/23 at 1:30 P.M. by the administrator and indicated " ...it is [name of company]'s policy to ensure residents are assessed to determine independence with managing their medications as well as ensure		E). This will also be reviewed with the regional team on a quarterly basis. ***Dates when corrective action will be completed: 10/26/2023.***	

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	safe storage and delivery ..."			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure that medications were administered according to manufacturer's guidance. Insulin was administered from a Novolog Flexpen without it being primed (eliminating air bubbles) prior to insulin being administered to the resident for 1 of 1 residents reviewed for insulin administration. (Resident 45) Finding includes: On 10/23/23 at 11:45 A.M., LPN (Licensed Practical Nurse) 22 was observed preparing insulin for Resident 45. They failed to prime the Novolog Flexpen with 2 (two) units of insulin prior to administering 8 units of insulin to Resident 45. On 10/24/23 at 12:30 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but was not limited to, COPD and diabetes mellitus type II. Resident 45 was admitted on 1/8/21. Current physician orders included, but were not limited to, the following: Aspart (Novolog) Flexpen 100 units/ml (milliliter) subcutaneously four times daily per sliding scale; 180-199=2 units, 200-249=6 units, 250-299=8 units,	R 0241	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** Re-education was conducted immediately by DON to LPN 22 on administration of medications, specifically including priming of the Novolog Flexpen prior to administering insulin. (Attach D). ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** Return demonstration performed successfully on the following shifts of LPN 22: Re-education provided to all clinical staff on administration of insulin with the Novolog Flexpen. (Attach D). ***3. The measures the facility will***	10/26/2023

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	300-449=10 units, 450-499=10 units, 500+=12 units and call MD (Medical Doctor), dated 8/29/23 On 10/23/23 at 11:38 A.M., Resident 45's blood sugar reading was 294. During an interview on 10/25/23 at 11:06 A.M., RN (Registered Nurse) 8 indicated they weren't sure what "priming a pen" meant, had never primed the pen, and were not aware it needed to be done prior to administering insulin to residents. A current Novolog Flexpen manufacturer's guide, revised February 2023, indicated " ... Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen ... " A current Insulin Administration Policy was requested but not made available during the survey.		***take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** DON will monitor compliance with insulin administration with random return demonstrations weekly. (Attach F). Medication administration education is included with new hire nurse orientation. (Attach G). ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** ED and DON to review compliance during weekly ED/DON meetings. This will also be reviewed with the regional team on a quarterly basis. ***Dates when corrective action will be completed: 10/26/2023***	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			

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	Based on interview, observation, and record review, the facility failed to ensure food was stored in accordance with professional standards for 2 of 2 kitchen observations. The staff lacked knowledge that the dishwasher failed to rinse in 1 of 2 observations of dishwasher use. Foods were not labeled properly, cans were dented, open bags of food were taped shut, the ceiling was peeled off and hung above a sink that was not able to be turned off. Findings include: On 10/23/23 at 9:15 A.M., the following was observed in the kitchen: 1. A large piece of the ceiling was peeled off and a black substance was on the part of the ceiling that was missing. The same was observed on 10/25/23 at 9:20 A.M. 2. A sink in the kitchen constantly ran and was unable to be turned off. At that time, the Dietary Manager indicated he was told that the sink was unable to be shut off and had been running for months. The same was observed on 10/25/23 at 9:20 A.M. 3. Refrigerator: cherry cheesecake-- use by 10/17 coconut cream pie-- use by 10/18/23 a clear bag of bologna-- use by 10/22/23 a tray of 5 plastic cups of peaches-- undated a large rectangle container of peaches covered with plastic wrap-- undated, and no use by date a clear bag of sliced bologna-- undated 4. Freezer: pepperoni bag covered in plastic wrap-- undated, and no use by date clear bag of frozen carrots with a visible hole in	R 0273	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** Whole kitchen audit for food storage was conducted on 10/24/2023. Any expired, non-dated, or inappropriately stored food was discarded. All kitchen staff were re-educated on proper food storage and date marking to ensure knowledge & application. Also educated on Dishwashing Policy/Procedure. (Attach H). All facility staff were educated in food storage & date marking requirements. (Attach B). Kitchen sink repairs were completed on 11.9.2023. (Attach L). Kitchen ceiling repair estimates submitted for approval. (Attach M). ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** Whole kitchen audit for food storage was conducted on 10/24/2023. Any expired, non-dated, or inappropriately stored food was discarded. Temperatures for high temp dishwasher water are logged daily in AM & PM to ensure	11/08/2023

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	the bag-- undated, and no use by date 4 bags of onion rings-- undated, and no use by date 4 bags of tater tots with ice crystals and holes in the bag-- undated, and no use by date 3 bags of french fries with ice crystals-- undated, and no use by date 2 rectangle packages of macaroni and cheese-- undated, and no use by date 1 unsealed eggroll box with ice crystals on the eggrolls-- undated, and no use by date 1 box of yeast dinner rolls with the bag open to air-- undated, and no use by date 3 bags of broccoli-- undated, and expired 11/22/22 4 bags of collard greens with ice crystals-- undated, and no use by date 1 box of Tilapia-- unreadable date, and no use by date 1 clear bag of chicken-- undated, and no use by date 1 container of oven roasted sliced turkey-- dated 7/31/23, and expired 8/27/23 1 pork butt-- undated, and no use by date 4 containers of 20 biscuits-- undated, and no use by date 1 strawberry surf ice cream container-- undated, and no use by date 10 pie crusts-- undated, and no use by date 6 bags of hamburger buns with ice crystals-- undated, and no use by date 3 bags of bread-- undated, and no use by date The same was observed on 10/25/23 at 9:20 A.M. 5. Dry storage: 1 dented can of sliced carrots 1 dented can of applesauce 1 plastic container of cereal-- use by 10/15 1 open bag of cake mix that was taped shut-- undated, and no use by date 1 open plastic bag of cereal that was taped shut--		compliance. (Attach I). ***3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** Weekly food storage audit initiated & completed weekly by DSD to maintain compliance with food storage. (Attach J). DSD to review dishwasher temp log daily. (Attach I). This will be reviewed with ED weekly. ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** Quarterly walk-through conducted by Regional Director of Dining Services to ensure compliance with food storage. ***Dates when corrective action will be completed: 11/8/2023***	

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		A. BUILDING 00 B. WING	10/25/2023

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	dated 10/16, no other date 1 bag of macaroni noodles that was taped shut with 4 pieces of tape-- dated 6/10/23, no other date 1 box of potatoes-- undated, and no use by date 1 box of sweet potatoes-- undated, and no use by date 1 bag of enriched macaroni products that was tied shut-- undated, and no use by date 1 bag of enriched macaroni products that was taped shut-- undated, and no use by date 1 open bag of powdered sugar-- undated, and no use by date 1 open clear bag of pecans-- dated 6/28/23, use by 7/28/23 1 box of 900 pieces of real semi-sweet chocolate chips that was in a bag open to air-- dated 12/11/22, use by 5/10/23 The same was observed on 10/25/23 at 9:20 A.M. 6. The following spices sat on a shelf under the ceiling that was peeled off: open container of ground cloves-- dated 2/1/23, use by 3/31/23 open container of ground nutmeg-- dated 2/5/22, use by 3/4/23 open container of extra fancy paprika-- undated, and no use by date open container of ground cumin-- unreadable date, and no use by date open container of ground cinnamon-- dated 12/19/22, no other date open container of ground cinnamon-- dated 6/22/23, no other date open container of poultry seasoning-- dated 5/2/22, no other date open container of lemon and pepper seasoning salt-- dated 11/14/22, no other date open container of chopped chives-- undated, and no use by date open container of ground sage-- dated 4/11/23,			

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	use by 5/10/23 open container of ground mustard-- unreadable date, and no use by date open container of dill weed-- undated, and no use by date open container of whole celery seed-- dated 5/2/22, no other date Mediterranean style oregano leave-- undated, and no use by date open container of dill weed-- undated, and no use by date open container of basil leaves-- undated, and no use by date open container of onion powder-- unreadable date, and no use by date open container of granulated garlic-- dated 6/27/23, no other date The same was observed on 10/25/23 at 9:20 A.M. 7. Dishwasher: On 10/23/23 at 11:08 A.M., the Dietary Manager attempted to wash dishes in the dishwasher. The dishwasher initially rose to a wash temperature of 160 degrees Fahrenheit. At 11:30 A.M., it was still stuck at that same temperature and failed to rinse the dishes. At that time, the Dietary Manager indicated he was not sure why it was not rinsing. He further indicated he had not verified the temperature for the temperature logs since he started on the previous Tuesday. On 10/25/23 at 9:15 A.M., the following was observed: 1. Refrigerator: 2 trays of peach crumble in plastic cups-- undated, and no use by date. During an interview on 10/25/23 at 9:37 A.M., the Dietary Manager indicated that food needed to be thrown in the garbage if the following was			

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	observed: ice crystals in the bag, holes in the bag, undated food, food that was open to air, food that was taped shut, and anything that was expired. At that time, he indicated that all food should be labeled and dated, and spices should be disposed of after 30 days. On 10/23/23 at 1:30 P.M., the Administrator provided an undated Infection Control: Dining Services Policy and Procedures that indicated, "In all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection, ensure the provision of a safe, sanitary, and comfortable environment for Residents and are in compliance with the CDC [Centers for Disease Control] guidelines, including providing sanitary conditions for dining service...3) dispose of any questionable food items. 4) Label, date, cool and store any left-over food..." During an interview on 10/25/23 at 11:00 A.M., Cook 7 indicated they did not have a policy for when food was received, but it was their policy to label the food with the date it was received and the expiration date. At that time, she indicated they did not have a policy or manufacturer's book for the dishwasher, but it was their policy to ensure that the dishwasher worked properly. During an interview on 10/25/23 at 11:42 A.M., the Maintenance Supervisor indicated the sink in the kitchen had not been able to be shut off for 6 months and that she received the okay to order parts to fix it, but she had not ordered the parts yet. She indicated the ceiling had been peeled off with the black exposed for 3 years. At that time, she indicated they did not have a policy related to that, but it was the facility's policy to ensure the sink worked properly and the ceiling was fixed.			

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R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of diseases and infection for 2 of 2 residents observed for wounds and 2 of 5 residents observed for medication administration. Facility staff failed to utilize gloves when handling soiled wound dressings and failed to sanitize hands before and after medication administration. (Resident 26, Resident 32, Resident 18, Resident 45) Findings include: 1. On 10/23/23 at 9:35 A.M., Resident 26 was observed sitting in her recliner with her feet elevated. At that time, RN (Registered Nurse) 8 put on gloves that were laying on the cabinet without sanitizing her hands and proceeded to lift the blanket off the resident's left foot and take down the undated, soiled bandage that was covering her left heel. She indicated there was drainage on the bandage and requested that LPN (Licensed Practical Nurse) 22 re-dress the wound. RN 8 took off her gloves and disposed of them. RN 8 did not sanitize her hands after taking off her gloves. On 10/24/23 at 1:00 P.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and pressure ulcer to	R 0406	***1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice.*** LPN 22 & RN 8 immediately educated on proper hand sanitation and glove usage policy/procedure. (Attach D). ***2. How the facility will identify other residents having the potential to be affected by the same deficient practice.*** All staff were re-educated on proper hand sanitation & glove usage. (Attach B). Random audit of clinical staff for proper handwashing techniques, hand sanitation, & glove usage. (Attach K). ***3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.*** DON will monitor compliance with proper hand	10/26/2023

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	left heel. Current Physician's Orders included, but were not limited to, the following: skin prep wipes topically applied to left heel blister three times a day, ordered 5/15/23 A Wound Care Note, dated 10/11/23, indicated " ... Pressure Ulcer, Left Heal(sic) ... measures 0.5 cm (centimeters) x 1.2 cm x 0.1 cm. The Pressure Ulcer has moderate amount of yellow or brown exudate. The Pressure Ulcer has exposed subcutaneous tissue ... " A Wound Care Note, dated 10/25/23, indicated " ... Pressure Ulcer, Left Heal(sic) ... measures 0.3 cm x 1.2 cm x 0.1 cm. The Pressure Ulcer has moderate amount of yellow or brown exudate. The Pressure Ulcer has exposed subcutaneous tissue. The plan for the pressure ulcer is to cleanse the area with normal saline ... " During an interview on 10/25/25 at 12:30 A.M., the DON (Director of Nursing) indicated that the resident sees wound care for her wound and was seen by a home care agency and they did dressing changes every other day. 2. On 10/23/23 at 9:42 A.M., RN 8 went directly into Resident 32's room after leaving Resident 26's room. Resident 32 was sitting in her recliner with her legs elevated. RN 8 did not sanitize her hands or put on gloves. RN 8 pulled down the soiled bandage, dated 10/21/23, on the resident's right lower leg to show the wound. Resident 32 asked the nurse if she needed gloves. The nurse indicated "As long as I'm not touching the wound, it's ok". RN 8 then reapplied the bandage and left the room. RN 8 did not sanitize her hands after touching the soiled bandage..		sanitation & glove usage during care and treatments. (Attach K). This will be reviewed weekly with ED. ***4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.*** ED and DON to review compliance during weekly ED/DON meetings. This will also be reviewed with the regional team on a quarterly basis. ***Dates when corrective action will be completed: 10/26/2023***	

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	On 10/25/23 at 10:00 A.M., Resident 32's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II and MRSA (Methicillin-resistant Staphylococcus aureus, a bacteria that can case staph infection that is difficult to treat because of resistance to some antibiotics). Current Physician's Orders lacked an order for wound treatment to Resident 32's right lower leg. A Wound Care Note, dated 10/12/23, indicated " ... Ulcer, right anterior lower leg ... The ulcer measures 1.0 cm x 0.6 cm x 0.1 cm. The Ulcer has moderate amount of serosanguinous exudate. The Ulcer has exposed subcutaneous tissue ... The plan for the ulcer is to cleanse the area with normal saline ... " During an interview on 10/25/23 at 11:06 A.M., the DON indicated hands should be sanitized after staff removed gloves for sure, but she wasn't sure about sanitizing before gloves are put on. Gloves should be worn if touching dirty bandages of wounds. At that time, she indicated that anytime a staff member leaves a resident's room, they should be sanitizing their hands. During an interview on 10/25/25 at 12:30 A.M., the DON indicated that the resident sees wound care for her wound and when she comes back from the appointment, the staff will place her note from the wound clinic in her chart so that if needed, they can use it as an order to dress the resident's wound if needed. 3. On 10/23/23 at 11:33 A.M., LPN 22 was observed during medication preparation and administration for Resident 18. LPN 22 failed to			

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	sanitize hands prior to prepping the medications and after administering the medications. On 10/24/23 at 10:48 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but was not limited to, COPD (Chronic Obstructive Pulmonary Disease) and depression. 4. On 10/23/23 at 11:45 A.M., LPN 22 was observed prepping and administering insulin to Resident 45. LPN 22 failed to sanitize her hands prior to prepping the insulin, to put gloves on while administering the insulin, and to sanitize her hands after administering the insulin. On 10/24/23 at 12:30 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but was not limited to, COPD diabetes mellitus type II. During an interview on 10/25/23 at 11:06 A.M., the DON indicated hands should be sanitized between residents when administering medications and the nurse should wear gloves when administering insulin to a resident. At that time, she indicated that anytime a staff member leaves a resident's room, they should be sanitizing their hands. A current Universal/Standard Precautions Policy, dated June 30, 2023, was provided by the DON on 10/25/23 at 11:34 A.M., and indicated " ... Hands will be washed before and after touching the Resident ... Hands will always be washed before and after removing gloves ... Gloves will be worn when contact is likely with blood body fluids, excretions, and broken skin ... Gloves will be worn when any article is contaminated with any of the above ... "			