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	11/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00363742. Complaint IN00363742 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580. Survey dates: November 8, 9, 10, 12, 15 and 16, 2021 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 113 Total: 113 Census Payor Type: Medicare: 14 Medicaid: 78 Other: 21 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 19, 2021.	F 0000	This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 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			

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

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	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 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)			

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	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 interview and record review, the facility failed to ensure that a resident's representative was promptly notified of a wound, for 1 of 7 residents reviewed for representative notification, when pressure areas developed (Resident B). Findings include: Resident B's clinical record was reviewed on 11/10/21 at 11:01 a.m. Current diagnoses included, but were not limited to, dementia and hypertension. A 9/3/21, Quarterly, Minimum Data Set assessment (MDS) indicated the resident was moderately cognitively impaired and required assistance for decision making. A 9/10/21,1:22 p.m.,Progress Note indicated "CNA [Certified Nurse's Aide] staff alerted writer of area on resident buttock area. per assessment there is a reddened area that has opening starting. cleansed area with normal saline. covered w/ gentle foam. DON [Director of Nursing] and NP [Nurse Practitioner] made aware; waiting for orders." A 9/15/2021, 1:52 p.m., Progress Note, (5 days after the first observation of a wound) indicated "Wound rounds performed this day and new area	F 0580	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Residents B's family has been notified of their previous changes in condition and this has been documented in the medical record.* 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that has had a change of condition could be affected by the deficient practice. All residents skin sheets and progress notes have been reviewed for changes of condition related to skin for the last 30 days. All changes of condition have been reported to physicians and family.* 3. What measures will be put into place and what systemic changes	12/06/2021

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	noted coccyx. Wound was assessed by NP and new order was received for Santyl... Family and resident was made aware." A 9/15/2021, 1:30 p.m., wound assessment document indicated the resident had a wound on their buttocks which measured 1.5 centimeters by 0.7 centimeters with a depth that could not be measured do to slough and/or eschar resulting in the wound being unstageable. The clinical record lacked any documentation regarding family/representative notification when the compromised skin was first observed on 9/10/21. During an interview on 11/15/21 at 8:56 a.m., Resident B's family member indicated they were not notified of the resident having any wound on their buttocks until the area was open and required a treatment. The representative indicated they felt the wound was advanced when they were made aware. During an interview on 11/15/21 at 4:08 p.m., the DON indicated the facility had no documentation regarding Resident B's representative being notified when a wound was identified on 9/10/21. She indicated the first documentation of notification of the wound was 9/15/21. A current, 11/6/19, policy titled, "Change of Condition", which was provided by the DON on 11/15/21 at 9:07 a.m., indicated the following: "The facility will evaluate and document changes in a resident's health...7. Notify the resident's representative, consistent with his or her authority, of change and follow through completed by the facility, and documented in the EMR [electronic medical record]."		will be made to ensure that the deficient practice does not recur: N*ursing staff has been educated on family notification and proper documentation practices to ensure all skin changes of condition are reported to the family in a timely manner per company policy. IDT will monitor resident skin sheets and progress note documentation to ensure appropriate family notification has been made.* 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will audit all documentation for appropriate family notification M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review for a minimum of 3 months to ensure substantial compliance for at least 2 consecutive months. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.*	

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	This Federal tag relates to complaint IN00363742. 3.1-5(a)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to complete assessments ordered by a physician for weekly weights for 3 of 4 residents reviewed for nutrition. (Residents 32, 33 and 46) Findings include: 1. Resident 32's clinical record was reviewed on 11/12/21 at 10:20 a.m. The resident's diagnoses included, but were not limited to, dysphagia, cerebral palsy, need for assistance with personal care, and epilepsy. A current physician's order, dated 9/24/21, indicated resident was to be weighed weekly with special instructions to notify the medical doctor (MD) or nurse practitioner (NP) of a weight gain of greater than five pounds in one week. The medication administration record for October and November of 2021, indicated the	F 0684	1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** *Residents 32, 33, and 46 have been weighed and physician notification has been made as appropriate.* 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** *Any resident that has a new treatment order for weights could be affected by the deficient practice. All resident's treatment orders for weights and Medical Administration records have been reviewed for accuracy and*	12/06/2021

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	resident had refused obtaining weights on 10/3/21, 10/10/21, 10/17/21, 10/24/21, 10/31/21, 11/7/21, and 11/14/21. A behavioral care plan, dated 7/22/21, indicated the resident had refused treatment, including weights, and included, but was not limited to, an intervention to inform MD/NP as needed. A nutritional care plan, dated 4/15/21, indicated the resident had a history of skin impairment and refusing weights, and included, but was not limited to, an intervention to weight resident as ordered. The clinical record lacked notification or documentation of physician contact regarding refusal of weights. 2. Resident 33's clinical record was reviewed on 11/10/21 at 10:59 a.m. The resident's diagnoses included, but were not limited to, need for assistance with personal care, nutritional deficiencies, abnormal weight loss, vitamin deficiency, and gastro-esophageal reflux disorder (GERD). A current physician's order, dated 9/24/21, indicated resident was to be weighed weekly with special instructions to notify the medical doctor or nurse practitioner of a weight gain of greater than five pounds in one week. The medication administration record for October and November of 2021, indicated the resident had refused obtaining weights on 10/3/21, 10/10/21, 10/17/21, 10/24/21, 10/31/21, 11/7/21, and 11/14/21. A care plan, dated 7/3/21, indicated the resident		*omissions for last 14 days. Any treatments that have not been administered have been reported to physicians for appropriate follow up.* 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** *Nursing staff has been educated on following physician orders and documentation practices to ensure all orders are being followed and treatments are performed and documented per physician orders. IDT will monitor resident treatment administration records and orders to ensure treatment orders have been followed and physician notification has been made.* 4. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** *DON or designee will audit all documentation for treatment administration 7 days a week x 4 weeks, Monday thru Friday x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review for*	

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	had a diagnosis of GERD, and included, but was not limited to, an intervention to report weight loss. The clinical record lacked notification or documentation of physician contact regarding refusal of weights. 3. Resident 46's clinical record was reviewed on 11/10/21 at 10:17 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus II, need for assistance with personal care, chronic kidney disease, and edema. A current physician's order, dated 10/1/21, indicated resident was to be weighed weekly with special instructions to notify the MD or NP of a weight gain of greater than five pounds in one week. The medication administration record for October and November of 2021, indicated the resident had refused obtaining weights on 10/3/21, 10/10/21, 10/17/21, 10/24/21, 10/31/21, and 11/14/21. No documentation was present for the date of 11/7/21. A nutritional care plan, dated 8/9/21, included a problem date of 9/29/21 that resident's weight was down in 27 days, and weight continued downward trend on 10/1/21. The care plan included, but was not limited to, an intervention to obtain weights per MD/NP order. The clinical record lacked notification or documentation of physician contact regarding refusal of weights. During an interview on 11/15/21 at 3:12 p.m., the DON indicated the MD/NP was not notified		*a minimum of 3 months to ensure substantial compliance for at least 2 consecutive months. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.*	

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	regarding resident 46's refusal to weigh. A facility policy, undated, titled, "Weight Monitoring Program," provided by the DON on 11/15/21 at 1:48 p.m., included, but was not limited to,"AT-A-GLANCE....1. New Admissions (Weekly Weights)....f. Residents with special weight needs i.e., 3 times a week, will be weighted according to the MD order." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to			

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	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure the resident's suprapubic catheter was changed, as ordered by the physician, on a resident at risk for urinary tract infections, for 1 of 3 residents reviewed for urinary catheters (Resident 52). Findings include: During an interview on 11/10/21 at 10:58 a.m., Resident 52 indicated he had a recent urinary tract infection approximately three weeks ago. The clinical record for Resident 52 was reviewed on 11/10/21 at 1:51 p.m. The diagnoses included, but were not limited to the following: neuromuscular dysfunction of bladder, retention of urine, other specified disorders of the prostate, urinary tract infection site not specified, and need for assistance with personal care. Medications included, but were not limited to, Cipro (antibiotic) 500 milligram twice daily for urinary tract infection and was completed on 10/15/21. Orders included, but were not limited to the following: change suprapubic catheter every 4 weeks starting on 10/20/21. This was ordered on	F 0690	1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** *Residents 52's catheter has been changed as ordered by the physician and documented appropriately.* 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** *Any resident that has new treatment order for a catheter could be affected by the deficient practice. All resident's treatment orders for catheters have been reviewed for accuracy and omissions for last 14 days. Any catheter changes and treatments that have not been administered have been reported to physicians for appropriate follow up.* 3. **What measures will be put into place and what systemic**	12/06/2021

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	11/11/21. A care plan for indwelling urinary catheter, edited 10/15/21, indicated the resident required an indwelling urinary catheter related to a neurogenic bladder. Interventions included, but were not limited to, change catheter per Medical Doctor (MD) order. During an interview on 11/12/21 at 1:36 p.m., Licensed Practical Nurse (LPN) 8 indicated she could not find any documentation that Resident 52's suprapubic catheter had been changed since the physician changed it outside the facility on 9/22/21. LPN 8 indicated Resident 52's suprapubic catheter should have been changed each month according to the physician order and it was due to be changed again on 11/16/21. During an interview on 11/12/21 at 2:04 p.m., Resident 52 indicated it had been quite awhile since his suprapubic catheter had been changed. Review of the Treatment Administration Record lacked any documentation of a suprapubic catheter change. During an interview on 11/15/21 at 9:17 a.m., the Director of Nursing indicated Resident 52's suprapubic catheter had not been changed since 9/22/21. The DON indicated Resident 52's suprapubic catheter should have been changed on 10/20/21. She indicated Resident 52 was at risk for urinary tract infections and had a urinary tract infection prior to 10/20/21. Review of a Nurse's Note, dated 9/22/21 at 2:33 p.m., indicated Resident 52's suprapubic catheter was changed in the Physician's office on this date. Resident 52's suprapubic catheter was to be		**changes will be made to ensure that the deficient practice does not recur:** N*ursing staff has been educated on following physician orders for catheter changes and documentation practices to ensure all orders are being followed and catheter changes are performed and documented per physician orders. IDT will monitor resident administration records and orders to ensure treatment orders have been followed and physician notification has been made.* 4. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** *DON or designee will audit all documentation related to catheter changes for 7 days a week x 4 weeks, Monday thru Friday x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review for a minimum of 3 months to ensure substantial compliance for at least 2 consecutive months. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.*	

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	changed every 3 to 4 weeks in the nursing home. An appointment was scheduled to return to the clinic on 3/23/22, and it was recommended to call the office regarding any issues with the suprapubic catheter changes. A current policy, titled "Suprapubic Catheter Care," provided by the Director of Nursing on 11/15/21 at 4:10 p.m., indicated the following: "PURPOSE: Suprapubic catheter care is provided to: Maintain catheter patency....and prevent infection. GUIDELINE STEPS 1. Check physician's orders for catheter... DOCUMENTATION: 1. Date, time (or shift), as appropriate. 2. Procedure... and how well the resident tolerated the procedure. 3. Any signs of infection, obstruction or irritation observed or related by the resident...." 3.4-41(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure secure storage of medications, including loose pills, for 1 of 4 medication carts reviewed. (100 hall medication cart) Findings include: During an observation on 11/16/21 at 11:13 a.m., with RN 6, the second drawer was observed with eight loose pills lying on the bottom of the medication cart drawer, and the third drawer had 15 loose pills observed lying on the bottom of the medication cart drawer. During an interview, RN 6 indicated loose pills should not be in the drawers. A current facility policy, dated 1/2021, titled, "Medication Storage," provided by the DON on 11/16/21 at 3:15 p.m., included, but was not limited to, "POLICY...Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration...PROCEDURES...1. The provider pharmacy dispenses medications in containers that meet stated and federal labeling requirements...Medications are to remain in theses containers and stored in a controlled	F 0761	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: *Medication carts were immediately audited for loose medications, and no resident was found to have been harmed.* 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: *Any resident that receives medication from a medication cart has the potential to be affected by the deficient practice. Audits will be performed to ensure medication carts are free of loose medications.* 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: *Nursing staff has been educated on keeping medication carts free*	12/06/2021

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

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	environment." 3.1-25(o)		*of loose medication. DON or designee will perform an audit of all medication carts daily to ensure Medication Carts are free of loose medication.* 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: *DON or designee will perform a Medication Cart Audit daily, M-F x 4 weeks, weekly x4 weeks, then monthly for 4 months. Results will be submitted to QAPI for review for a minimum of 3 months to ensure substantial compliance for at least 2 consecutive months. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.*	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility	F 0804	**1. What corrective action will**	12/06/2021

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	failed to ensure food palatability for 4 residents interviewed regarding food palatability (Residents 34, 9, 38 and 45) and 5 of 5 residents interviewed in a group setting (Residents 58, 35, 3, 305, and 26). Findings include: During an interview on 11/08/21 at 03:21 p.m., Resident 34 indicated the following dissatisfaction with food palatability: broccoli/vegetables were mushy, fried and scrambled eggs were runny, and the food had no flavor. During an interview on 11/09/21 at 2:56 p.m., Resident 9 expressed the following concerns regarding food palatability: her breakfast was always cold. She indicated she has reported that the breakfast was cold to the Certified Nurse's Aides, and dietary before they changed staff but the breakfast still remained cold and this has been going on since she has been here. During an interview on 11/09/21 at 11:11 a.m., Resident 38 indicated the following concerns regarding food palatability he received foods he didn't like. During an interview on 11/10/21 at 10:01 a.m., Resident 45 indicated she did not like the food and it did not taste good. During an 11/10/21, 11:30 a.m., Group interview with 5 facility residents (Residents 58, 35, 3, 305, and 26) the residents expressed the following concerns regarding food palatability. a. Food was not good and there were not many choices		**be accomplished for those residents found to have been affected by the deficient practice:** The dietary manager has reviewed food preference and choices with the residents 34, 9, 38, 45, 58, 35, 3, 305 and 26 to ensure that they receive palatable and attractive food that meets their preferences. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. The dietary manager has reviewed choices and preferences with all residents, and the resident food council has met with the dietary manager to address and resolve concerns. The dietary manager has trained dietary staff of food palatability, recipes, tray card and preference accuracy and service presentation and temperatures. **3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur:** The dietary manager or designee will audit tray temperatures, food texture and taste, meal preferences and resident satisfaction daily. The dietary manager will meet with the	

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	b. Four of five residents indicated hot food was cold 3 times a week or more. c. Five of five residents indicated vegetables were overcooked or mush 3 times a week or more. d. Five of five residents indicated baked potatoes were undercooked and hard. e. Five of five residents indicated food is bland or lacking flavor 3 times a week or more. f. The group indicated the facility was aware that food dissatisfaction was an ongoing problem that had not been resolved. A test tray was obtained and tested with the Dietary Manager on 11/15/21 at 11:28 a.m. The brussel sprouts were soft, bland and lacked flavor. Under the observation of the Dietary Manager a brussel sprout was smashed into a soft mush with the texture of mashed potatoes. During an interview on 11/15/21 at 11:30 p.m., the Dietary Manager indicated the brussel sprouts should not be able to be smashed flat and should instead have texture. 1.3-21(a)(1)		resident food council monthly. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The Dietary Manager or designee will audit tray temperatures, food texture and taste, meal preferences and resident satisfaction daily for 30 days, then weekly for 4 weeks, then monthly ongoing. The dietary manager or designee will meet with the Resident food committee monthly. Results of these audits and meetings will be submitted to QAPI monthly for 3 months then quarterly ongoing to ensure substantial compliance.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review the facility failed to operate a dish washer in a manner to ensure proper sanitation of dishware and the facility failed to prepare food in a method to prevent cross contamination. Findings include: During the 11/8/21, 8:42 a.m., initial kitchen sanitation tour, the following concerns regarding the functioning of the dishwasher were observed: On 11/8/25 at 8:54 a.m., Dietary Aide 2, who was operating the dishwasher, was interviewed regarding dishwasher temperatures, chemical sanitation, and testing for required levels of sanitizing solution. Dietary Aide 2 indicated she was unsure what temperature the rinse cycle had to reach to ensure proper sanitation. She then attempted to test the level of the sanitizer the dish washer was releasing into the rinse cycle. She obtained the test strips that measured the level of "Quat" in the water. The aide indicated she did not know where any directions or information was located to give her direction about temperature and sanitation levels for dishwasher function. Dietary Aide 2 indicated she did not know how many parts per million (measurement for level of sanitizer in the water)	F 0812	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Dietary staff have been trained on proper dishwasher operation and food preparation to prevent cross contamination. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. Dietary staff have trained on proper dishwasher operation and food preparation to prevent cross contamination. **3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur:** Dietary staff have been trained on proper dishwasher operation and food preparation to prevent cross	12/06/2021

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	should register on the test strip. The test strip did not measure any agent in the rinse cycle. Dietary Aide 2 then called the Dietary Manager for assistance. On 11/8/21 at 9:01 a.m., the Dietary Manager entered the dishwasher room to assist the dietary aide. The Dietary Manager indicated she would obtain a new container of sanitizer solution test strips. The Dietary Manager returned with a different brand of test strips which measured bleach/chlorine levels in the rinse water. When she attempted to test the rinse water, the Dietary Manager did not get a result on the test strip. The manager then indicated she did not know what brand/type of test strip was needed to test the dishwasher rinse level nor did she know the recommended level. When asked if there were dishwasher sanitation instructions anywhere the dietary employees could use to ensure they were using the dish machine properly, the manager said there were no known directions in the dietary department. An 11/8/21, 9:04 a.m., observation found no posted operation instructions for dishwasher sanitation in the dish room. A "Dish Machine Log" for November 2021 was observed hanging on the wall in the dish room. The Dish Washer Log had a notation which indicated "Manufacture Recommended PPM_____." The area following PPM (Parts Per Million) was left blank and had not been filled in by the facility. The bottom section of the log indicated " Always defer to manufacture's guidelines regarding temperatures and correct chemical concentration for use." During an interview on 11/8/21 at 9:05 a.m., the Dietary Manager indicated she did not have any		contamination. All new staff will be trained on proper dishwasher operation and food preparation to avoid cross contamination before assuming duties in the dietary department. Staff will be retrained quarterly to ensure any deficient practice does not recur. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The dietary manager or designee will audit dishwasher operation and food preparation daily for 30 days, then weekly for 4 weeks, then monthly ongoing. Results will be submitted to the QAPI for review monthly for at least 6 months and then quarterly ongoing to ensure compliance.	

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	information regarding the temperature levels or chemical concentration levels for sanitation. She indicated she would have to contact the service provider for direction. During an interview on 11/8/21 at 1:00 p.m., the dishwasher service provider indicated the facility had a dishwasher that operated with a chlorine/bleach agent in the final sanitizing rinse. He indicated the machine should be tested with the Chlorine test strips. During an 11/15/21, 10:00 a.m., observation of the meal preparation and puree process the following concerns were observed: On 11/15/21 at 10:04 a.m., Cook 3 took a tray of rolls that were resting on top of the oven to the food preparation table. She had one hand with a glove and one hand was bare. With her gloved hand she picked up and rearranged the rolls. She then went to the oven touching the oven handle, oven knobs, and next tray of rolls with both her gloved and bare hand. She again used her soiled gloved hand to again rearrange the second tray of rolls touching many rolls. She then repeated the process with the third tray of rolls touching rolls with her soiled gloved hand. On 11/15/21 at 10:07 a.m., she used the same soiled gloved hand to stir food, cover a pan with foil, touch knobs and handles on the oven. She then left the area and entered the dry storage room. When she returned she was not wearing any gloves. She was carrying an empty pitcher. On 11/15/21 at 10:10 a.m., Cook 3 washed her hands and applied clean gloves. She then touched slices of pork loin with her gloved hands to count slices. The cook then went to the food processor			

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	, pulled out the processor with her soiled gloved hands. She added the pork to the food processor with her soiled gloved hands, She pushed the processor button with her soiled gloved hands. After the food chopped for awhile, she used her soiled gloved hand to turn off the processor. She removed the processor lid and wiped food from the processor blade with her soiled glove hands. On 11/15/21 at 10:14 a.m., the cook then entered the dry storage room. She returned with pans. She placed new gloves on both hands without washing before donning them. She then moved back to the food processor where she broke up pork loin with her gloved hands and placed the broken pieces in the food processor. A buzzer sounded, Cook 3 went to the oven and touched the handle, knobs and hot pads while turning roll pans in the oven all with her soiled gloved hands. On 11/15/21 at 10:17 a.m., the cook left the room and went to the dry storage area. She returned without gloves. She did not wash her hands when she returned to the food preparation area. She continued pureeing food without any gloves. She did not touch food with her bare hands. She did touch the food processor, utensils, and pans that had all been previously touched which her soiled gloved hands. She continued the process without gloves. She then left the are and went to dry storage for supplies. On 11/15/21 at 10:21 a.m., the cook returned to the food preparation area. She did not wash her hands when she returned to the food preparation area. She was not wearing gloves. She then touched the oven handles and knobs which she had previously touched with her gloves that had been soiled with pork. She returned to the food			

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	preparation area and continued to puree food. She was not wearing gloves during the process. She finished the preparation with bare hands that were touching handles, knobs, utensils and a food processor which had all been touched with soiled gloved hands. During an interview on 11/15/21 at 3:10 p.m., the Dietary Manager indicated the facility had no policy for food handling or glove use. She indicated she only had a policy for food preparation. She indicated she did not know how to obtain any other food services policies and procedures. During an interview on 11/16/21 at 11:00 a.m., the Administrator indicated he would contact the contracted food services provider, for whom the Dietary Manager is employed, and obtain policies and procedures. During an interview on 11/16/21 at 3:45 p.m., the Administrator indicated the facility census had been 113 when the survey began on 11/8/21. He additionally indicated every resident in the facility received meals from the facility kitchen. A facility provided document, titled "Pots and Warewashing Inservice", which was provided by the Administrator on 11/16/21 at 1:31 p.m. indicated the following: "Low Temp Dish Machine-A chemical sanitizing agent is mixed in with the final rinse water and sprayed onto the Ware during the final rinse cycle. The temperature of the water and sanitizer mixture must be maintained at a temperature no lower than 120. Note: Please defer to manufacture's guidelines and state/federal regulations."			

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	A facility provided document, titled " Glove Usage Inservice", which was provided by the Administrator on 11/16/21 at 1:31 p.m. indicated the following: "How to properly put of gloves: start with properly washed and dried hands... When to change or remove your gloves: When they are dirty, torn, damaged, discolored or contaminated." A facility provided document, titled "Cross Contamination Inservice", which was provided by the Administrator on 11/16/21 at 1:31 p.m. indicated the following: "Purpose: To educate all new hires and current employees of the importance of identifying and addressing situating or conditions where potential cross contamination could occur ...Cross contamination is the process where bacteria or other microorganisms are transferred from one substance or object to another which can result in harmful effect. ...wash hands and change gloves before and after handling raw food, ready to eat food, after using the restroom, when changing tasks, or after touching your skin, hair or clothes." 3.1-21(i)(1) 3.1-21(i)(3)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:	F 9999	1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** *Staff members SSD, CNA 10, CNA 11 an LPN 7 have completed the dementia and*	12/06/2021

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	(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an employee had training in dementia care completed for 5 of 10 employees reviewed (SSD, CNA 10, CNA 11, CNA 12, and LPN 7), and training in the facility abuse prevention policy for 2 of 10 employees reviewed. (CNA 10 and CNA 11) Findings include: Employee records were reviewed on 11/15/21 at 9:30 a.m., indicating the following: a. The SSD completed 1.5 hours of the 3 hours required for dementia training. b. CNA 10 lacked any education for the required abuse policy training or the 3 hours of required dementia training for year 2021. c. CNA 11 lacked any education for the required abuse policy training or the 3 hours of required dementia training for the year 2021. d. CNA 12 completed 1.5 hours of the 3 hours required for dementia training. e. LPN 7 completed 1.25 hours of the 3 hours required for dementia training.		*facility abuse prevention policy training.* 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have a potential to be affected. All staff members have been audited for completed dementia and facility abuse prevention policy training. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff members will receive all required training upon hire and annually. The staff development coordinator or designee will audit all employee files for completion of all required training. 4. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** *The Staff Development Coordinator or designee will audit all employee files monthly for 4 months, then quarterly ongoing to ensure all employees have completed all required training.*	

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	On 11/16/21, the Staff Development Coordinator (SDC) indicated she had no other documentation regarding the requested employee training. A current facility policy, reviewed 1/1/21, titled, "Stakeholder Training," provided by the SDC on 11/15/21 at 1:06 p.m., included, but was not limited to, the following: "Procedure...7. Annual training requirements are expected to be completed by all Stakeholders in accordance with local, state, and federal guidelines, laws, and requirements by the due date established by their facility or department."		*The Staff Development Coordinator will submit the results of the audits to QAPI monthly for 4 months, then Quarterly for 4 quarters to ensure continued compliance for at least 2 consecutive quarters.*	