STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 00 B. WING	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00414172, IN00414472, IN00415145, IN00418496, and IN00423579. Complaint IN00414172 - No deficiencies are cited. Complaint IN00414472 - No deficiencies are cited. Complaint IN00415145 - No deficiencies are cited. Complaint IN00418496 - Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00423579 - Federal/State deficiencies related to the allegations are cited at F550. Survey dates: December 11, 12, 13, 14 and 15, 2023. Facility number: 013280 Provider number: 155826 AIM number: 201270670 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 4 Medicaid: 78 Other: 5 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	Administrator	01/11/2024

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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	Quality review completed on December 28, 2023.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to care for a resident in a manner that preserved the resident's dignity when she did not receive incontinence care in a timely manner for 1 of 5 residents reviewed for quality of care (Resident F). Findings include, During a random observation on 12/11/23 at 11:52 a.m., Resident F was observed lying in bed, head of the bed in high position, the resident had slid down, pink silk-like nightgown bunched around her waist, and covers over her lower legs. The resident was observed wearing a saturated adult brief, and there was a strong smell of urine permeating the room. The resident indicated she had used her call light to summons staff at 8:30 a.m. before breakfast was served to assist her as she was incontinent of both urine and stool, but she was still waiting to be changed. The television (tv) remote was observed on the floor on the back side of the bed with the back off and batteries on the floor, she was holding the remote to the bed, and her call light was hanging down from the top of the right beside rail out of sight and reach of the resident. On 12/12/23 at 9:30 a.m., Resident F was observed lying in bed wearing a pink silk-like gown, awake and talkative. The resident's breakfast tray was observed to be on an over-the-bed tray in front of the resident, resident indicated she had just already finished eating. Resident F indicated she	F 0550	**Requesting a Desk Review for this Survey Let me know when you would like audits etc. submitted to you via email.** **F 550 Resident Rights/Exercise of Rights** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident F was provided with incontinence care on 12/11/23. Licensed nursing staff completed a skin assessment this same date with no new skin findings. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?/** All residents who require incontinence care have the potential to be affected. Licensed and certified nursing staff will be provided with education by the DON/designee ton the requirement to receive timely incontinence care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	01/16/2024

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	was wet with urine and dirty with stool and had used her call light and requested to be changed since 4:45 a.m. but was still waiting. A packet of peri wipes was observed on the bed near the residents left hip. On 12/12/23 at 3:24 p.m., Resident F was observed sitting in an electric wheelchair at the foot of her bed. The resident was wearing a pink silk-like gown and had a strong smell of urine. The resident indicated she was sleepy, ready to lay back down, and she needed her brief changed. Resident F's record was reviewed on 12/12/23 at 11:23 a.m. Diagnoses on Resident F's profile included, but were not limited to, acute kidney failure (condition in which the kidneys can't filter waste from the blood), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily routine). Physician's orders, dated 9/16/23, indicated resident was capable of understanding rights and responsibilities, resident was capable of making her own health decisions, and maintain comfort and dignity. A physician's history and physical, dated 8/16/23, indicated the resident had a diagnosis of dysuria (painful or difficult urination). A nurse practitioner (NP) progress notes, dated 10/9/23, indicated the resident had no dysuria, and frequency and urgency of urination was normal. Nursing progress notes, dated 10/1/23 - 12/12/23, lack documentation of the resident being incontinent of bladder and bowel, or nursing care provided.		**practice does not recur?** Licensed and certified nursing staff will be provided with education by the DON/designee to the requirement to receive timely incontinence care per Resident Right Policy . Random observations will be completed by the DON/designee as noted below to ensure residents have received timely incont care according to facilities bed check schedule. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Random observations will be completed by the DON/designee as noted below to ensure residents have received timely incont care according to facilities bed check schedule. Observations to occur: 4 random residents daily x's 4 weeks, then 4 random residents weekly x's 4 weeks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be immediately addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of six months.	

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	A 7-Day admission assessment, completed on 9/22/23, indicated the resident was alert and oriented times 3 (person, place and time), incontinent of urine daily with some control, and wore pull ups. There was no apparent pattern for bowel elimination, and no bowel incontinence. Resident required extensive assistance (assist) or total dependence for transfers and was independent or modified independence with cognitive skills. A care plan, dated 9/29/20, indicated the resident had occasional bowel/bladder incontinence related to impaired mobility. Interventions included check and change, or toilet as needed. An annual MDS (Minimum Data Set) assessment, completed on 11/6/23, assessed the resident as having the ability to make herself understood and to understand others. BIMS (Brief Interview for Mental Status) score 13/15 indicated the resident was cognitively intact. The resident was frequently incontinent of bladder and bowel. A care plan, dated 11/17/23, indicated the resident had a self-care performance functional deficit. Interventions included the resident required substantial/maximal assist with toileting hygiene. During a conversation with a family member on 12/13/23 at 9:28 a.m., she indicated in her opinion there was not enough CNAs to change the resident's brief timely, she had not observed nurses answering the call lights, and the resident was not strong enough to self-transfer safely. There were times when the resident would call the daughter at work and ask her to call the nurse as her pull up would be full and spilling urine and/or stool onto the bed.		Re-education, increase in frequency and/or duration of monitoring will be increased as needed if areas of ongoing non compliance are identified through the auditing process.	

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	During an interview on 12/13/23 at 10:20 a.m., the Electronic Health Record Coordinator (EHRC) 122 indicated she did not routinely work in the facility, but she had seen Resident F's call light on in the past few days when the resident was in bed so assumed she could use it to call for assistance as needed. On 12/13/23 at 11:26 a.m., the Vice President (VP) of Risk Management and Performance Improvement provided a Routine Resident Care policy, undated, and indicated to policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility...Licensed staff will include the following services based upon their scope of practice, but not limited to...h. Maintain nursing skills for appropriate areas of care management including, but not limited to: i. bowel and bladder management...2. Provide routine daily care by a certified nursing assistant...h. toileting, providing care for incontinence with dignity and maintaining skin integrity...3. Unlicensed staff b. routine care by a nursing assistant including but is not limited to the following...4. toileting..." On 12/13/23 at 11:26 a.m., the VP of Risk Management and Performance Improvement provided a Resident Rights policy, undated, and indicated to policy was the one currently being used by the facility. The policy indicated, "1. Residents will be treated with dignity and respect including but not limited to...c. To have a method of communicate needs to staff i. Call light or bell access will be within reach of the resident as one			

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	method to communicate needs to staff 1. Staff will answer call needs promptly 2. Any staff within the vicinity will answer a call light a. Notify the appropriate personnel for care needed that may not be immediately remedied including by not limited to 1. toileting..." This citation relates to Complaint IN00423579. 3.1-3(t) 3.1-3(v)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. A. Based on observation, interview, and record review, the facility failed to ensure effective interventions were in place to prevent a resident, (Resident E) from developing new pressure ulcers for 1 of 3 resident reviewed for pressure ulcers. B. Based on observation, interview, and record review, the facility failed to ensure appropriate hand hygiene and application of the correct treatment were provided during a wound	F 0686	**F686-Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No resident was harmed by the alleged deficient practice. Resident E no longer resides at the facility. Resident 18's wounds were assessed by wound nurse on 12/12/23 and the treatments were	01/16/2024

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	treatment observation (Resident 18) for 1 of 3 resident reviewed for pressure ulcers. Findings include: A. An anonymous complaint indicated, " ...Resident E admitted to the facility with no skin issues and left with 5 wounds." On 12/13/23 at 10:08 a.m., Resident E's medical record was reviewed. She admitted to the facility on 9/21/23 with diagnoses which included, but were not limited to, end stage hypertensive kidney disease and heart failure. An admission nursing assessment dated 9/21/23 indicated, Resident E did not have and open areas, but was at risk for the development of pressure ulcers. Interventions in place/will be out in place indicated, "NA." Her mattress type was coded as a low air-loss mattress. An admission nursing progress note dated 9/21/23 at 10:14 p.m., indicated, Resident E was "bedfast." An admission skin and wound note dated 9/22/23 at 1:34 a.m., indicated, " ...noted to have no wounds or skin concerns at this time ... Resident E preferred a bed bath at least three times a week ...." A baseline care plan, initiated 9/22/23, indicated Resident E was at risk for skin integrity related to fragile skin and the interventions in place at that time were; off-loading cushion to chair and mattress to bed, nutritional consult and complete skin assessments. A nursing progress note, dated 9/29/23 at 10:38		competed per orders. The nurse who completed the dressing change on 12/11/23 was immediately educated on wound care utilizing the procedure for Simple dressing changes. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents whom are at risk for developing pressure wounds or whom are identified as having pressure wounds have the potential to be affected. The facility reviewed the medical record of all resident having the potential to be affected to ensure preventative interventions are in place for development of pressure wounds. Any discrepancies were corrected. The facility conducted observations of all wound treatments on 12/12/23 to ensure the treatments were completed per MD orders and no discrepancies were noted. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to licensed nurses utilizing the Wound Care and Management Overview policy and Simple Dressing change procedure with emphasis on implementing preventative interventions for developing pressure wounds and	

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	p.m., indicated, "Open areas found on patient's buttock this evening by CNA [certified nursing aide] and reported to writer ... area cleaned and applied heavy barrier house cream to area ... wound care consult requested ...." Corresponding Skin Grid Pressure details, dated 9/29/23, indicated: a. New area, left buttock, pressure, 4.0 cm (centimeters) long (L), by 4.0 cm wide (W), stage II (loss of partial thickness of the skin including epidermis and part of the superficial dermis). b. New area, right buttock, pressure, 1.0 cm L, by 0.5 cm W, stage II. c. New area, right buttock, pressure, 0.2 cm L, by 0.5 cm W, stage II. Four days after the areas were found, the Wound Consult assessed Resident E on 10/3/23 at 5:31 a.m., and revealed the areas were larger, " ...Resident consulted for continued care and management of stage III [loss of full thickness of the skin that might involve the subcutaneous fat] pressure injury to the coccyx, stage III pressure injury to left lateral buttock and stage III pressure injury to left medial buttock ..." a. Wound #1: Stage III pressure ulcer, left medial buttock. Measured: 3 cm L, by 2 cm W and 01. Cm deep (D). Calculated area is 6 square (sq) cm. b. Wound #2: Stage III pressure ulcer, left lateral buttock. Measured 3 cm L, by 3 cm W. Calculated area is 9 sq cm. c. Wound #3: Unstageable (stage is unclear due to the base of the wound being covered by dead skin) pressure ulcer, right buttock. Measured 4 cm L, by 9.5 cm W and 0.1 cm D. d. Wound #4: Stage III pressure ulcer, coccyx. Measured 4 cm L, by 0.5 cm W and 0.1 CM D. Calculated area is 2 sq cm. " ...patient continues on an alternating air/low air		technique when completing dressing changes. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/Designee will complete observations of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks then 1 resident per week for 4 weeks to ensure preventative interventions are implemented for residents whom are high risk for developing pressure wounds or have pressure wounds. The DON/Designee will observe 5 dressing changes per week for 4 weeks, then 3 dressing changes per week for 4 weeks , then 1 dressing change per week for 4 weeks to ensure the dressing changes are completed per policy. Any discrepancies will be immediately corrected and re-education will be conducted. **The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus. The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. The Patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continued ongoing interventions and protocols for swift incontinence management." Resident E's Point of Care (POC) responses were reviewed from the time of her admission on 9/21/23 until the discovery of the new pressure areas on 9/29/23, which revealed the following: a. A completed bed bath was provided on 9/25/23 and 9/28/23. b. Bed Mobility lacked documentation for 9 of 27 observations and an additional 9 of 27 observations indicated she required extensive assistance and/or total dependence. c. Bowel & Bladder lacked documentation for 9 of 27 observations. 16 of the 27 observations indicated she had been incontinent of both bowel and bladder while she used an incontinent brief. d. on 9/28/23- 2 of 3 observations for section GG for personal hygiene indicated she was totally dependent; the third observation was black. General POC documentation for personal hygiene lacked documentation for 10 of 23 observations. e. on 9/28/23- 1 of 3 observations for section GG indicated she required total assistance to roll left and right. The second observation was coded, "NA," and the third observation was left black. The record lacked documentation of Resident E being turned and repositioned, per shift, as			

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	needed, every two hours ...etc. On 12/13/23 at 2:20 p.m., the Vice President of Risk Management (VPRM) provided copies of Resident E's shower sheets, which were reviewed at that time. Shower sheets dated 9/25/23 at 11:30 a.m., and 9/28/23 at 10:45 a.m., corresponded to the POC response above. A shower sheet dated 9/29/23 at 8:35 p.m., indicated, Resident E's family was present and gave bed bath and provided care." The record lacked documentation of education provided to the family for proper and appropriate skin care to prevent skin breakdown. A shower sheet dated 10/1/23 at 8:30 p.m., indicated, Resident E's family gave her a bed bath and night care. The record lacked documentation of education provided to the family for proper and appropriate skin care to prevent the worsening of skin breakdown for the newly acquired skin breakdown. Resident E's baseline care plan and/or comprehensive care plans, lacked revision to include education provided to resident and/or family for proper and appropriate skin care to prevent new/worsening areas. New physician's order was placed on 9/29/23 which indicated, a. Right buttock; cleanse with soap and water. Pat gently, apply triad twice a day and as needed, leave open to air.			

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	b. Left buttock; cleanse with soap and water. Pat gently, apply triad twice a day and as needed, leave open to air. c. Intergluteal Cleft; cleanse with soap and water. Pat gently, apply triad twice a day and as needed, leave open to air. Resident E's Medication/Treatment Administration Record (MAR/TAR) were reviewed: a. 2 of 6 treatments for the right buttock were not checked off. b. treatment for the left buttock was not checked off for 10/3/23 day shift. c. treatment for the intergluteal cleft was not checked off for 10/3/23 day shift. During an interview on 12/13/23 at 2:27 p.m., the VPRM indicated, Resident E received facility protocol interventions upon admission which included a pressure reducing cushion to her wheelchair and a low air-loss mattress for her bed. Assistance with turning and repositioning at least every two hours was standard practice. On 12/13/23 at 3:11 p.m., the VPRM provided a copy of current but undated facility policy titled, "Skin Care & Wound Management Overview." The policy indicated, " ...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds ... Skin care and wound management program includes, but is not limited to ... application of treatment protocols based on clinical "best practice" standards from promoting wound healing ... develop a care plan with individualized interventions to address risk factors, communicate risk factors and interventions to the care giving team ...document treatment on the TAR ...."			

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	This citation relates to Complaint IN00418496.B. On 12/12/23 at 2:44 p.m., Resident 18's record was reviewed. She was admitted on 2/3/23. Her diagnoses included, but were not limited to, stage four (bone exposed) pressure ulcer of the sacral region, it was present on admission. A physician order, dated 7/26/23, indicated to cleanse her sacrum with wound cleanser or normal saline (NS) and pat dry. Apply collagen particles (spherically designed particles of collagen) to wound bed, cover with calcium alginate AG (sterile antimicrobial fiber-structured alginate with high absorbency) and cover with bordered foam daily and as needed (PRN) for soilage. A physician order, with no date, indicated wound care consult. A physician order, dated 9/30/23, indicated Resident 18 had a skin sub (skin substitute dressing) placed on sacrum. The Healing Partner Nurse Practitioner (NP) to changed weekly on Tuesday. If dressing becomes soiled may remove top layer and replace calcium alginate and bordered foam. A skin care plan, dated 9/8/23, indicated she was a risk for altered skin integrity related to fragile skin. Resident 18 had wounds to her sacrum. An intervention was to administer treatments as ordered by the medical provider. A care plan, dated 9/8/23, indicated she had wounds to her sacrum. An intervention was to treatments as ordered by the medical provider. On 12/11/23 at 3:44 p.m., Licensed Practical Nurse (LPN) 95 and Qualified Medical Aide (QMA) 37 were checking Resident 18. Her brief was			

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	observed very full with urine and feces (BM). LPN 95 indicated the BM was up between her legs on her mons (skin above the pubic protuberance). She wiped some of the BM away and changed gloves. BM was observed down her posterior (back) thighs to the mid-thigh area. LPN 95 was observed to wipe the BM toward the sacral dressing that was open at the bottom. She removed the dressing. When the BM was no longer visible, she wiped the bilateral (both) legs, between the legs at the vulva, and then, blotted the wound with the soiled wash cloth. She did not change gloves, and did not complete hand hygiene. She laid a towel on the resident's bed. She pulled an already open package of calcium alginate AG (provides stimulation and speeds wound repair), gauze squares, a sealed, sterile collagen square (for wound healing), and a border dressing from the wound treatment drawer and laid them on the towel. She changed gloves, but did not complete hand hygiene. She sprayed DermaKlenz directly on the pressure ulcer, blotted it with a gauze square, then put on the collagen square and the border dressing. The calcium alginate was not used. On 12/11/23 at 4:01 p.m., after placing the border dressing, she did not change gloves or perform hand hygiene, and changed the half sheet under the resident with the help of QMA 37. Her heels were floated with a pillow, her blanket was replaced, and her call light was provided. Then, she removed her gloves and did not performed hand hygiene. She placed Resident 18's top blanket on her. On 12/11/23 at 4:07 p.m., LPN 95 was observed washing her hands in Resident 18's bathroom. She turned the water off with her bare hand and dried her hands on paper towels.			

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	On 12/13/23 at 11:44 a.m., the Assistance Director of Nursing (ADON) indicated hand washing should have been completed after every glove change. She indicated during hand washing, the faucet should have been turned off with a paper towel. A current policy, titled," Standard Precautions," dated 6/24/21, was provided by the Vice President of Risk Management and Performance Improvement (VP RMPI), on 12/13/23 at 3:11 p.m. A review of the policy indicated, " ...Hand hygiene is a simple but effective way to prevent the spread of infections ...Handwashing with soap and water ...The second most effective method for reducing the number of germs on the hands of healthcare workers ...When to perform Hand Hygiene ...after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings ...Examples include by not limited to use after dressing change ...When hands move from a contaminated body site to a clean body site during patient care ...Examples include but not limited to performing a dressing change ...perineal (peri) care then performing a dressing change ...after glove removal ...Using liquid soap and water ...dry hands thoroughly with a clean paper towel ...turn off faucet with clean dry paper towel - discard .... 3.1-40(a)(2)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure all medications and wound treatment solutions were secured in the public hallway and in the resident rooms (Resident 11, 18, 5, and 21). Findings include: 1. On 12/11/23 at 9:40 a.m., Dakin's solution (denatures protein, loosening slough and rendering it more easily removed from the wound ...improves the mechanical debridement due to the desiccative nature of Dakin's solution and adhesion of tissue to each gauze used) bottle was observed on her bedside table. On 12/12/23 at 2:44 p.m., Resident 18's record was reviewed. She was admitted on 2/3/23. Her diagnoses included, but were not limited to, stage four (bone exposed) pressure ulcer of the sacral region, it was present on admission. A physician order, dated 7/26/23, indicated to cleanse her sacrum with wound cleanser or normal saline (NS) and pat dry. Apply collagen particles to wound bed, cover with calcium alginate AG and cover with bordered foam daily and as needed (PRN) for soilage. A physician order, with no date, indicated wound care consult. A physician order, dated 9/30/23, indicated Resident 18 had a skin sub (skin substitute	F 0689	**F689-Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by the alleged deficient practice. A facility wide search was conducted on 12/11/23 for any medications or wound treatments left at bedside and were immediately stored per policy or discarded and re-ordered at facility cost. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected. A facility wide search was conducted on 12/11/23 for any medications or wound treatments left at bedside and were immediately stored per policy or discarded and re-ordered at facility cost. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to direct care staff utilizing the Medication Storage Policy with emphasis on medications and biologicals being	01/16/2024

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	dressing) placed on sacrum. The Healing Partner Nurse Practitioner (NP) to changed weekly on Tuesday. If dressing becomes soiled may remove top layer and replace calcium alginate and bordered foam. A skin care plan, dated 9/8/23, indicated she was a risk for altered skin integrity related to fragile skin. Resident 18 had wounds to her sacrum. An intervention was to administer treatments as ordered by the medical provider. On 12/12/23 at 2:59 p.m., the Vice President of Risk Management and Performance Improvement (VP RMPI) indicated Resident 18 did not have an assessment for medications in her room. 2. On 12/11/23 at 9:51 a.m., hydrophilic wound dressing cream (to manage low to moderate levels of exudate to facilitate autolytic debridement) was observed on Resident 5's bedside table. On 12/12/23 at 3:27 p.m., Resident 5's record was reviewed. She was admitted on 10/25/21. Her brief interview for mental status (BIMS) indicated she had severe cognitive impairment. Her diagnoses included, but were not limited to, dementia (progressive, degeneration brain disorder) and chronic obstructive pulmonary disease (COPD) (lung disease). A physician's order, dated 1/6/22, apply barrier cream to bilateral (both) buttocks and sacrum every shift and PRN for impaired skin and prevention. A physician's order, dated 8/5/22, Resident 5 was incapable of understanding rights and responsibilities.		stored safely, securely and properly, following manufacture's recommendations. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/Designee will conduct observations of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, then 1 resident per week for 4 weeks to ensure medications and biologicals being stored safely, securely and properly, following manufacture's recommendations. Any discrepancies identified will be immediately corrected and re-education will be completed as needed. **The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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A physician's order, dated 8/5/22, Resident 5 was incapable of making her own health decisions.

A physician's order, dated 4/19/23, Calmoseptine external ointment 0.44-20.6 % (Menthol-Zinc Oxide (moisture barrier), apply to buttock topically every shift for preventative care.

A care plan, dated 1/12/23, indicated Resident 5 had impaired cognitive function related to dementia.

A care plan, dated 4/19/23, indicated Resident 5 was at risk for altered skin integrity.

On 12/12/23 at 2:59 p.m., the VP RMPI indicated Resident 5 did not have an assessment for medications in her room.

3. On 12/11/23 at 10:04 a.m., a bottle of Tylenol (pain reliever) was observed in Resident 21's room on a table near her Christmas tree.

On 12/11/23 at 4:13 p.m., a bottle of Tylenol was observed in Resident 21's room on a table near her Christmas tree.

On 12/12/23 at 3:15 p.m., Resident 21's record was reviewed. She was admitted on 1/31/23.

Her diagnoses included, but were not limited to, dementia and psychotic disturbance.

Her care plan, dated 10/18/23, indicated she wandered aimlessly from place to place. Her goal indicated she would wander without injury.

On 12/12/23 at 2:59 p.m., the VP RMPI indicated Resident 21 did not have an assessment for

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	medications in her room. 4. On 12/11/23 at 10:01 a.m., an unopened single-packet of cyclosporine ophthalmic 0.05% (an immunomodulator to decrease eye swelling) was observed on the floor beside the treatment cart in the Lofts 2. The medication cart was down the hall, the Qualified Medication Aide (QMA) was administering medications. She was not aware of the medication on the floor. On 12/13/23 at 9:52 a.m., Resident 11's record was reviewed. She was admitted on 11/3/23. Her diagnoses included, but were not limited to, retinal detachments (layer of tissue at the back of the eye pulls away from the layer of blood vessels that provides it with oxygen) and bipolar disorder (both maniac and depressives episodes). A physician's order, dated 11/3/23, indicated to used cyclosporine ophthalmic emulsion 0.05%, instill 1 drop in both eyes every morning and at bedtime for eye health. On care plan, dated 12/12/23, indicated Resident 11 used anti-psychotic medication. On 12/11/23 at 10:50 a.m., QMA 90 was observed at the medication when it was put back into place, next to the treatment cart. The cyclosporine ophthalmic was observed underneath it. She was asked about the medication under the cart, she indicated she did not know it was on the floor. She indicated it was Resident 11's eye treatment drops. She picked it up and placed it back in the dated and labeled box in the medication cart. On 12/12/23 at 2:59 p.m., the VP RMPI indicated Resident 21 did not have an assessment for			

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	medications in her room. On 12/13/23 at 2:59 p.m., Resident 63's record was reviewed. He was admitted on 5/1/20. His diagnoses included, but were not limited to, schizoaffective disorder (disorder that causes altered thinking, feeling, and behavior) and borderline intellectual functioning (decreased reasoning and judgment). A physician's order, dated 1/11/22, indicated Resident 63 used psychotropic medication related to schizoaffective disorder, bipolar affective disorder, and borderline intellectual functioning. A care plan, dated 1/11/22, indicated Resident 63 wandered aimlessly from place to place. A goal was for him to wander without injury. A care plan, dated 10/7/20, indicated Resident 63 had impaired cognitive function, poor short-term and long-term memory and poor decision making skills related to impaired cognition. On 12/11/23 at 11:49 a.m., Resident 52's record was reviewed. She was admitted on 3/6/23. Her brief interview of mental status (BIMS) indicated she had severe cognitive impairment. Her diagnoses included, but were not limited to, dementia (progressive and degenerative brain disorder) and psychotic disturbance. Her care plan, dated 10/18/23, indicated she wandered aimlessly from place to place. The goal was for her to wander without injury. A current policy, titled, "Routine Resident Care," with no date, was provided by the Vice President			

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	of Risk Management and Performance Improvement (VP RMPI), on 12/13/23 at 3:11 p.m. A review of the policy indicated, "...It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotion, mental, social, and spiritual needs and honor resident lifestyle preference while in the car of this facility...." On 12/13/23 at 3:11 p.m., the Vice President of Risk Management (VPRM) provided a copy of current facility policy titled, "Storage of Mediations," revised 8/2020. The policy indicated, "Medications and biologicals are stored safely, securely and properly, following manufacture's recommendations or those of the supplier ...." 3.1-45			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;			

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	§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 41) who had a history of weight loss was provided with the appropriate supplemental health shake and was served meals according to her preferences for 1 of 3 residents reviewed for nutrition. Findings include: On 12/11/23 at 10:09 a.m., Resident 41 was observed in her room. She sat of the edge of her bed with an over-bed table in front of her. Resident 41 indicated she did not like breakfasts because she always got eggs, or stuff with gravy and she did not like gravy. She was supposed to get a milkshake twice a day, but sometimes she didn't and did not like the flavor they had. She would prefer strawberry, or banana flavored. No supplement shake or banana was observed at that time. On 12/11/23 at 12:06 p.m., Resident 41 had a visitor, and she indicated she had offered her lunch since she did not like what it was. Resident 41 and her visitor indicated she had not been offered an alternative when she complained and gave the tray to her visitor. No supplement shake or banana was observed at that time. On 12/12/23 at 9:26 a.m., Resident 41 was observed in her room, seated at the edge of her	F 0803	**F 803 Menus Meet Residents Nds/Prep in Adv/Followed** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 41 was re-interviewed to obtain an updated list of food preferences to include food likes/dislikes and. Residents' plan of care and meal ticket have been reviewed and updated to reflect these preferences. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who receive meals from the dietary dept have the potential to be affected. All residents who receive nutritional shakes have the potential to be affected. Current residents have been re-interviewed to obtain updated food preferences to include likes, dislikes, and nutritional shake flavor preferences for residents with nutritional shake orders. The plan of care and meal ticket have	01/16/2024

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	bed. Her over-bed table and breakfast tray remained. She indicated she had been given eggs, but she did not like eggs. The ground meat was too spicey, and the pancakes were O.K. Approximately 50% of her plate appeared to have been eaten. No supplement shake or banana was observed at that time. On 12/12/23 at 2:17 p.m., Resident 41 remained seated on the edge of her bed with her over-bed table in front of her. Less than 50% of her lunch appeared to have been consumed. Resident 41 indicated she did not like the lunch. There was brown gravy observed on her chopped meat, and Resident 41 indicated she did not like brown gravy. No supplement shake or banana was observed at that time. On 12/12/23 at 2:22 p.m., Qualified Medication Aide (QMA) 29 indicated Resident 41 was a picky eater and if there was one thing on her plate she did not like, she would probably not eat the rest of it. On 12/23/23 at 9:27 a.m., Resident 41's breakfast tray was observed. She had been given eggs, toast, and biscuits with sausage gravy. She had eaten less than 25% of the meal and indicated she did not like it. Her meal ticket was observed and indicated that morning's breakfast was supposed to have been, cottage cheese, hot cereal and a hashbrown. She indicated she would have liked to have the cottage cheese. Her meal ticket indicated, her preferences were "no gravy, no eggs, no oatmeal." No supplement shake or banana was observed at that time. On 12/13/23 at 2:44 p.m., Resident 41'a lunch tray was observed. It appeared she had eaten less than 25% and she had not been provided an ice cream.		been reviewed and updated to reflect these preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED/designee will provide education to the CDM on the requirement to complete resident interviews to obtain and honor food preferences, and to ensure the plan of care and meal tickets reflect food and nutritional shake flavor preferences. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CDM/designee will complete routine auditing to ensure that personal food likes/dislikes preferences and nutritional shake flavor preferences for residents with nutritional shake orders have been updated in the plan of care, can Kardex, and meal ticket when indicated within 72 hours of new and readmissions, quarterly and as voiced by the resident and/or responsible party. Auditing to occur: 5 new admissions weekly of they occur x's 4 weeks, 5 residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be	

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	An Ensure supplement shake was observed on her tray but remained full at that time, and no banana was observed. On 12/14/23 at 12:03 p.m., Resident 41's over-bed table was observed with a bowl of old oatmeal. It had not been eaten. On 12/14/23 at 12:13 p.m., Resident 41's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, malignant neoplasm (cancerous tumor) of the colon, Type II Diabetes (a dysfunction of the body's ability to regular blood sugar levels) and high blood pressure (HTN). She had a carbohydrate consistent diet with dysphagia (trouble swallowing) texture and thin liquids. She had a diet order for provide Glucerna supplement shake to promote weight gain. An annual nutritional assessment, dated 9/22/23, indicated, she was at nutritional risk due to NSTEMI (Non-ST-elevation myocardial infarction (NSTEMI) is a type of heart disease involving partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart muscle), respiratory failure, colon cancer, atrial fibrillation (abnormal heartbeat), diabetes, hypertensive emergency, cognitive communication deficit, HTN, anemia, edentulous, therapeutic mechanically altered diet, cerebral infarction affecting right dominant side, and she was on a planned significant weight gain diet. A comprehensive care plan, dated 9/20/21, indicated, Resident 41 was at nutritional risk. Interventions for the plan of care included, but		discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of six months. Re-education, increase in frequency and/or duration of monitoring will be increased as needed if areas of ongoing non compliance are identified through the auditing process.	

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	were not limited to, provide meals per diet order and provide supplements per medical provider's orders. A comprehensive care plan, dated 1/10/22, indicated Resident 41 had diabetes. Interventions for the plan of care included, but were not limited to, provide diet as ordered, offer substitutes per preference. A comprehensive care plan, dated 9/5/22, indicated, Resident 41 had a behavior problem related to disease process and she would at sometimes refuse meals and alternatives ... Interventions included, but were not limited to, honor resident's preferred choices. On 12/14/23 at 3:11 p.m., the Vice President of Risk Management (VPRM) provided a copy of Resident 41's food preference assessment dated 12/14/23. The assessment indicated; Resident 41 disliked: scrambled eggs with an asterisk note to serve cottage cheese instead of scrambled eggs. She disliked brown gravy, sausage gravy and poultry gravy and she disliked oatmeal cereal. Special requests to be served everyday included, but was not limited to, a banana. On 12/14/23 at 3:11 p.m., the VPRM provided a copy of a current facility policy titled, "Dining and Food Preferences," revised 9/2017. The policy indicated, " ...Individualized dining, food, and beverage preferences are identified for all resident/patients ... the individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances and preferences ...." 3.1-20(i)(1) 3.1-20(i)(4)			

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. A. Based on observation and interview, the facility failed to distribute food under sanitary conditions by performing proper hand hygiene during meal service for 9 of 9 residents in the Lofts dining room (several unidentified residents and Resident 64). B. Based on observation and interview, the facility failed to distribute, serve food, and store used room trays under sanitary conditions and perform proper hand hygiene during meal service for 13 of 13 residents receiving meal tray in their room on the Lofts 2 hallway. C. Based on observation and interview, the facility	F 0812	**F 812 Food Procurement/Store/Prepare/Serve-Sanitary** **What corrective actions will be accomplished for those residents found to have been affected by the** Resident # 64 and 8 unidentified residents did not experience a negative outcome d/t CNA #9 not performing hand hygiene appropriately during meal service for residents eating in their rooms.	01/16/2024

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	failed to maintain sanitary conditions for use of an ice chest on the Lofts 2 hallway for 1 of 1 random observation (Resident 13). Findings include: A. On 12/11/23, during a continuous observation, from 12:44 p.m. to 12:59 p.m., Certified Nursing Aide (CNA) 89 was observed. At 12:44 p.m., she pulled up the sleeves on her clinical jacket. She did not gel or wash her hands. She was waiting for Dietary Aide (DA) 35 to fill a resident's plate. She received one food tray and then another food tray and placed them in the metal food cart on her left, for distribution to the resident's who chose to eat lunch in their rooms. She was observed placing a third food tray into the food cart. On 12/11/23 at 12:52 p.m., her right hand was observed to rest on the empty food cart to her right, fingers tapping on top. She was observed putting another food tray in food cart to her left. Her right hand was again resting on the resident-side food cart. Then placed another food tray on the food distribution cart. She pulled up the sleeve of her jacket again. She did not complete hand hygiene, and placed another food tray on the food cart. On 12/11/23 at 12:56 p.m., CNA 89's hand was resting on the food cart to her right. On 12/11/23 at 12:58 p.m., she did not complete hand hygiene before serving Resident 64 his lunch tray in the dining room. On 12/11/23 at 12:59 p.m., CNA 89 completed hand hygiene, then pulled her sleeve up again, and put		C.N.A #9 was re-educated during the survey process on 12/11/23 and successfully passed a hand hygiene return demonstration. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. The DON/designee will provide education to licensed and certified nursing staff on ensuring hand hygiene is completed appropriately during meal service and in-between resident tray pass to residents eating meals in their rooms to prevent contamination. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed and certified nursing staff on ensuring hand hygiene is completed appropriately during meal service and in-between resident tray pass to residents eating meals in their rooms to prevent contamination. The DON/designee will complete meal observations as noted below to ensure that hand hygiene is being completed appropriately during meal service and in-between resident tray pass	

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	another food tray on the food cart. Her right hand was observed on top of the food cart to her left, then to the food cart on her right. Then, put another food tray in the food cart on her left. Her right hand was again observed on the food cart to her right. With no hand hygiene, she provided lunch to Resident 35 in the dining room. On 12/11/23 01:07 p.m.., CNA 89 was observed to wash her hands, she turned the faucet off with her bare hand. Then, dried her hands on a paper towel. Her left hand was observed to touch the food cart on her left. Her right hand rested on her hip, then touched the food cart on her right side. She was not observed to wash her hands before leaving the area to distribute the food trays inside the cart. On 12/11/23 at 1:14 p.m., CNA 121 was observed to pull up her chair as she sat down to assisted Resident 60 with eating. Without hand hygiene, she provided ice cream, opened the green Jello. A current policy, titled," Standard Precautions," dated 6/24/21, was provided by the Vice President of Risk Management and Performance Improvement (VP RMPI), on 12/13/23 at 3:11 p.m. A review of the policy indicated, " ...Hand hygiene is a simple but effective way to prevent the spread of infections ...Handwashing with soap and water ...The second most effective method for reducing the number of germs on the hands of healthcare workers ...When to perform Hand Hygiene ...before feeding or assisting in dining room and tray pass ...Using liquid soap and water ...dry hands thoroughly with a clean paper towel ...turn off faucet with clean dry paper towel - discard ...."B. During a random observation of meal trays being served on the Lofts 2 hallway on 12/11/23 at 1:10 p.m., Certified Nursing Assistant		to residents eating meals in their rooms to prevent contamination. Any findings will be immediately addressed **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete meal observations to ensure that hand hygiene is being completed appropriately during meal service and in-between resident tray pass to residents eating meals in their rooms to prevent contamination. Observations to occur: 5 random associates passing room trays weekly x's 4 weeks, then 5 random associates passing room trays monthly x's 5 months for a total of 6 months of monitoring. Any findings will be immediately addressed through re-education, increase in frequency and/or duration of monitoring until compliance has been achieved. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of six months. Re-education, frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing	

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	(CNA) 89 was observed to distribute 13 meal tray in resident rooms. CNA 89 was observed to take meal trays from the metal kitchen cart, enter resident rooms, place meal trays on the over-the-bed tables, remove insulated plate covers, remove cling wrap from bowls, plastic lids from plastic cups, take paper wrappers off and place straws in drinks, unwrap silverware, and open salt and pepper and sprinkle onto resident food per request. CNA 89 was observed to place her hand in a spider-like position on top of bowls and drinks when she positioned them on the trays and contaminated them. CNA 89 and Qualified Medication Aide (QMA) 90 were observed to pull Resident 18 up in the bed when delivering her tray, the second one off the metal kitchen cart. CNA 89 was not observed to wear gloves, sanitize, or wash her hands during this time. CNA 89 was observed to enter Resident 46's room with the 3rd tray off the metal kitchen cart. As the aide placed his lunch tray on his over-the-bed table, Resident 46 was overheard stating he did not want the lunch tray as he had other food for lunch. CNA 89 was observed to leave the resident room with the tray and placed in back into the metal kitchen cart among other resident lunch trays not yet served. During an interview on 12/13/23 10:32 a.m., QMA 90 indicated, she routinely worked on the Lofts 2 hallway passing medications. Indicated, her hallway was routinely staffed with only her and an aide, therefore during mealtimes the CNA would pass meal trays, and she would assist with passing of meal trays only if she had time. Alcohol based hand sanitizer (ABHS) was supposed to be used on the staff hands between each resident when passing meal trays, hands should be washed versus ABHS if they got		process.	

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	contaminated with fluids. QMA 90 indicated, if bed linens were touched or a resident was assisted to position in bed, the hands should be washed. All resident meal trays were supposed to be passed before resident trays were picked up from their rooms and put back onto the metal kitchen cart to prevent cross contamination. On 12/13/23 at 3:11 p.m., the Vice President (VP) of Risk Management and Performance Improvement provided a Standard Precautions policy, dated 6/24/21, and indicated the policy was the one currently being used by the facility. The policy indicated, "Practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs...The facility will adhere to CDC guidelines and recommendations for hand hygiene unless otherwise explicitly stated...When to perform hand hygiene A. Before eating/before feeding or assisting in dining room and tray pass B. Before and after direct contact with resident's intact skin 1. Examples include but not limited to taking B/P, lifting, repositioning in bed...D. After contact with inanimate objects including medical equipment in the immediate vicinity of the residents..." C. On 12/11/23 at 11:28 a.m., Resident 13 was observed to propel her wheelchair down the hallway and position herself in front of an ice chest stand in the middle of the Loft 2 hallway. The resident stood up using the ice chest stand for leverage, took her blue plastic personal cup that had been placed beside her hip when sitting in the wheelchair, lifted the split igloo ice chest lid, dipped 2 scoops of ice from the ice chest, and when pouring ice into her cup tapped the scoop on top of her cup. CNA 89 was observed to walk			

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	past Resident 13 getting ice on her own three times, she was not observed to assist the resident or attempt to stop the resident from getting ice on her own. When Resident 13 had finished filling her plastic glass and motioned for visitor to assist with closing the ice chest lid, CNA 89 stopped and indicated to resident she should not be getting ice out of the ice chest by herself. Resident 13 sat back down in her wheelchair, wedged the plastic cup back beside her hip in the wheelchair, and wheeled herself away. CNA 89 was observed to continue passing meal trays, she was not observed to report resident contaminating the ice or taking the ice chest to have the ice replaced. During an interview on 12/11/23 at 10:35 a.m., the Wound Nurse indicated, residents were not allowed to get ice out of the ice chest by themselves to prevent contaminating the ice chest and for safety reasons. On 12/15/23 at 9:05 a.m., the VP of Risk Management and Performance Improvement provided a General Hydration Services policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to promote resident centered care by providing adequate fluids for hydration in consideration of health needs and resident preference...3) Observe eating and drinking providing modifications as needed 4) Provide fresh water at bedside in the proper consistency, if appropriate...6) Provide resident preferences as able to promote adequate hydration..." On 12/15/23 at 9:48 a.m., the Administrator indicated, the facility did not have a specific policy regarding the ice chests used to provide ice			

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	and ice water to the residents on the hallway. 3.1-21(i)(3)			