STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEW HAVEN	1201 DALY DRIVE NEW HAVEN, IN 46774

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00429186, IN00429187 and IN00429228. Complaint IN00429186 - No deficiencies related to the allegations are cited. Complaint IN00429187 - No deficiencies related to the allegations are cited. Complaint IN00429228 - No deficiencies related to the allegations are cited. Survey dates: March 3, 4, 5, 6, 7, and 8, 2023. Facility number: 000114 Provider number: 155207 AIM number: 100266640 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 3 Medicaid: 61 Other: 19 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 12, 2024	F 0000		
F 0567 SS=D	483.10(f)(10(i)(ii) Protection/Management of Personal Funds			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Shane McFall	Executive Director	03/21/2024

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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Bldg. 00	§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty			

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	cash fund. Based on interview and record review, the facility failed to ensure monies available to the resident were accessed and paid to the resident for 2 of 3 residents reviewed. (Resident 67 and Resident 66) Findings include: 1. In an interview on 3/6/24 at 1:00 P.M., Resident 67 indicated she had received a lump sum payment from Social Security on 11/20/23 related to underpayment. She indicated on 12/29/23, the facility levied a care cost of $4600.00 without warning or explanation. Resident 67's record was reviewed 3/6/24 at 3:00 P.M. Resident 67's diagnoses included: diabetes, morbid obesity, and hypertension. A most recent quarterly MDS dated 10/01/2023 indicated Resident 67 had no cognitive impairment. A Resident Fund Management Service form, dated 8/10/22, indicated Resident 67 agreed to a Resident Fund account. This would allow her $52.00 each month from her Medicaid account. An Authorized Representative for Health Coverage Form dated 6/20/23 indicated Resident 67 agreed to have the facility manage her monies. Resident Statement dated 5/23/23 indicated care cost was $248.00 monthly. A review of the statement indicated no care costs had been taken out of the account for the months 6/23, 7/23, 8/23, 9/23, 10/23, or 11/23. This would amount to a cost of $1,488.00. The form indicated on 12/29/23, an amount of $4,600 had been debited from Resident 67's account. The statement indicated Resident 67 had no insurance costs.	F 0567	A Resident 67's Medicaid coverages and RFMS account with Majestic Care at New Haven were reviewed by Center BOM and Home Office specialists on 3/7. Resident 66 VA coverages and RFMS accounts with Majestic Care at New Haven were reviewed by BOM on 3/7. A request for Nursing Home information with Claim for Aid was filed with VA on 3/8. B All residents with RFMS accounts have the potential to be affected by the deficient practice. An audit was completed on 3/21. Any discrepancies were corrected appropriately by 3/21. C Education was provided to the facility BOM by the Executive Director related to documentation of conversations related to management of resident funds. Further education was provided to BOM and ED related to transactions in RFMS and communication with VA. D Audits of RFMS accounts will be completed weekly by BOM/ED for 1 month at 100% accuracy. Audits will be completed Monthly at 100% accuracy for an additional 6 months. Results of these audits will be addressed monthly at QAPI meeting. Any issues that arise will be addressed promptly by Action Plan adopted by the QAPI committee.	03/26/2024

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	In an interview on 3/7/24 at 1:23 P.M., the Business Office Manager (BOM) indicated she was unsure why the amount of $4600.00 was taken except the facility had to spend that amount to keep Resident 67's insurance. 2. Resident 66 was interviewed 3/6/24 at 1:23 P.M. He indicated in the interview he was not receiving his VA Nursing Home Benefit. He indicated he was admitted to the facility with VA benefit in March, 2022. His VA benefit should have increased $90 per month due to an additional nursing home benefit. Resident 66's record was reviewed 3/6/24 at 2:45 P.M. Diagnoses included Hypertension, Chronic Obstructive Pulmonary Disease, and Diabetes. A most current quarterly MDS dated 2/7/24 indicated Resident 66 had no cognitive impairment. A Resident Fund Management Service form dated 5/25/22 indicated Resident 66 agreed to have his funds direct deposited into a facility account. A review of the Resident Statement, dated 11/1/23 through 2-1-24, indicated VA benefits of $1336.00 were paid on 11/1/23, 12/1/23, 12/29/23, and 2/1/24. The statement indicated the facility withdrew $1035.00, leaving $301.00 in the resident's account. insurance premiums were paid each month, but the VA Nursing Home premium had not been received. In an interview on 3/7/24 at 9:05 A.M., the Business Office Manager (BOM) indicated VA increased the benefit for residents residing in a Nursing Facility when VA was notified of admission. She indicated she was unsure why			

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	Resident 66's admission had not been communicated to the VA, but would file the form on his behalf. A Request for Nursing Home Information in Connection with Claim for Aid and Attendance form, dated 3/8/24, provided by the BOM on 3/8/24 at 9:17 A.M., indicated the BOM had completed the form for additional assistance. A policy dated 2023 titled Resident Personal Funds indicated the facility would ensure resident's choosing direct deposit would have their monies managed, held and safeguarded. 3.1-6 (b)			
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 interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed. (Resident 10) Findings include: Resident 10's record was reviewed on 03/05/24 at 01:23 P.M. Diagnoses included paraplegia, COPD, diabetes, morbid obesity, and arteriosclerotic heart disease. A physician's order, dated 2/6/24	F 0684	A Daily weights for resident 10 were initiated on 3/5/2024. B B. All residents with daily weights have the potential to be affected by the alleged deficient practice. An audit of all residents for daily weights was completed. C Education provided to nursing staff by DNS to ensure daily weights are completed and entered into PCC correctly.	03/26/2024

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	indicated to obtain daily weights; and notify the physician if weight gain was greater than 3 pounds in a day or 5 pounds in a week. A care plan, dated 2/20/24, indicated to obtain weights as ordered and to notify the physician of weight changes. A review of Vital Signs indicated only the admission weight had been documented. Progress notes dated 2/6/24 through 3/7/24 indicated Resident 10 had no refusals of care. The Medication Administration Record (MAR), dated 2/24, indicated no weights had been documented. In an interview on 3/5/24 at 1:46 P.M., the DON indicated the staff did not check the box for the weight to be entered in the MAR, so it was not recorded. A policy titled Provision of Physician Ordered Services, dated February 2023, indicated care and services should be provided according to physician's orders and accepted standards of practice. 3.1-37		D Audits of all daily weights will be completed each business day to ensure completed. Audits will be reviewed by DNS/Designee weekly for thoroughness and accuracy. These weekly audits will be reviewed for 100% accuracy for 6 months at monthly QAPI meetings. Any issues that arise will be addressed promptly by action plan adopted by the QAPI committee.	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.			

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	§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was onsite for an 8 hour shift 5 days of 90 reviewed. Findings include: A record review began on 3/6/24 at 10:04 AM, of staffing data report for quarter 4 2023 (July 1-September 30). This staffing data report identified areas of concern. No RN hours were recorded for the following dates: 7/1/23, 7/2/23, 7/30/23, 8/5/23, and 9/10/23. A review of the schedule dated July 1, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10 PM., or night shift 10 PM -6 AM. A review of the schedule dated July 2, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10 PM., or night shift 10 PM -6 AM. A review of the schedule dated July 30, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10 PM., or night shift 10 PM -6 AM. A review of the schedule dated August 5, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10	F 0727	A The facility is unable to correct the deficient practice of RN coverage in the 4th quarter. B All residents have the potential to be affected by this practice. C An audit was completed of Majestic Care of New Haven staffing with no fewer than 8 hours of RN coverage daily since 9/10/2024 Education was provided the facility scheduler and Director of Nursing Services by the Executive Director emphasizing the RN coverage requirement. D Daily staffing will be audited daily at morning stand-up meeting utilizing the required CMS form. 8 uninterrupted hours of RN coverage will be assured in that way. Audits will be reviewed by DNS/Designee weekly for thoroughness and accuracy. These weekly audits will be reviewed for 100% accuracy for 6 months at monthly QAPI meetings. Any issues that arise will be addressed promptly by action plan adopted by the QAPI committee	03/26/2024

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	PM., or night shift 10 PM -6 AM. A review of the schedule dated September 1, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10 PM., or night shift 10 PM -6 AM. A review of the schedule dated September 10, 2023, indicated there were no RN hours documented for day shift 6 AM- 2 PM., evening shift 2 PM - 10 PM., or night shift 10 PM -6 AM. An interview on 3/7/24 at 9:58 A.M. the Director of Nursing indicated there were no RNs on those dates. A current facility policy, Nursing services and sufficient staff, dated February 2023, was provided by the Regional Nurse on 3/8/24 at 9:16 AM. The policy indicated..." Expect when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week...." 3.1-17(b)(3)			
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			

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	and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §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 medications were dated when opened for 4 of 21 residents residing on the 100 hall. (Resident 50, Resident 64, Resident 25, and Resident 37) Findings include: During an observation on 03/03/24 at 11:02 A.M., 4 injectable medications were observed to be opened, but without an opened date. In an interview on 3/3/24 at 11:02 A.M., RN 3 indicated Resident 50's insulin Glargine solution, Resident 64's Lispro insulin, Resident 25's Humalog insulin, and Resident 37's Lispro insulin were opened without open dates. RN 3 indicated she did not know when they were opened or if they were any good. 1. Resident 50's record was reviewed 3/4/24 at 12:19 P.M. Diagnoses included ischemic heart disease, and diabetes, A physician's order, dated 12/15/23 indicated to	F 0761	A Insulin vials for res # 50, 64, 25 and 37 were dated based on delivery date to the facility per pharmacy manifest. B All residents on insulin have the potential to be affected by this alleged deficient practice. All Med Carts were checked on 3/3/2024 for undated and improperly stored medications. C Education was provided to all nurses and QMA's by DNS related to dating medications when opened on 3/21. D Audits will be performed weekly on medcarts including by not limited to the dating of opened medications. Results of these audits will be compiled for review monthly at QAPI meeting for 100% compliance. Any issues that arise will be corrected via Action Plan adopted by the QAPI committee.	03/26/2024

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	give Resident 50 Glargine, 35 units, subcutaneously, 2 times daily. A Medication Administration Record (MAR) dated March 2024 indicated Resident 50 had been given Glargine, 35 units, subcutaneously on 3/4/24 at 7:00 A.M. 2. Resident 64's record was reviewed on 3/3/24 at 11:06 A.M. Diagnoses included respiratory failure and diabetes. A physician's order, dated 12/18/24, indicated to give Resident 64 Lispro 15 units subcutaneously before meals. An MAR, dated March 2024, indicated Resident 64 was given Lispro, 15 units, subcutaneously on 3/4/24 at 7:00 A.M. and at 11:00 A.M. 3. Resident 25's record was reviewed 3/4/24 at 11:25 A.M. Diagnoses included atrial fibrillation and diabetes. A physician's order, dated 10/5/22, indicated to give Resident 25 Humalog insulin in a sliding scale according to his blood sugar result before meals and at bedtime. An MAR, dated March 2024, indicated Resident 25 had received 4 units of Humalog insulin in response to blood sugar results at 7:00 A.M. and 4 units at 11:00 A.M. 4. Resident 37's record was reviewed 3/5/24 at 11:34 A.M. Diagnoses included hypertension and diabetes. A physician's order, dated 6/19/23, indicated to give Resident 37 Lispro insulin in a sliding scale			

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	according to his blood sugar result before meals and at bedtime. An MAR, dated March 2024, indicated Resident 37 received Lispro insulin 2 units at 7:00 A.M. and 4 units at 11:00 A.M. In an interview on 3/3/23 at 2:46 P.M., the DON indicated they did a mock survey on 2/29/24, therefore they did not waste the insulins that were not properly labeled. A policy, dated February 2023, indicated medications must be labeled with an opened, date, discarded within 28 days of opening, and discarded according to manufacturer's recommendations. 3.1-25 (m)			
F 0814 SS=E Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview the facility failed to ensure 2 out of 2 garbage receptacles in kitchen were covered. 81 of 83 residents residing in the facility ate meals prepared in the kitchen Findings include: During an observation on 03/03/2024 at 9:00 A.M. two garbage receptacles were observed open, without a lid in the kitchen; one was located in the main kitchen next to handwashing station, the other in the dishwashing area. The receptacles were 80 percent full with plastic material, carboard, and food scraps. During an observation on 03/03/2024 at 10:33	F 0814	A Lids were replaced on both trash cans on 3/3. B All residents have the potential to be affected by this deficient practice. New trash receptacles have been ordered to replace the existing bins. C Education was provided to all culinary staff and managers by the Executive Director related to sanitary handling of refuse. Culinary contractors were provided education by the Executive Director related to sanitary handling refuse. D Audits will be completed	03/26/2024

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	A.M. two garbage receptacles were observed open, without lids in the kitchen. The receptacles were 95 percent full with no changes to contents. In an interview on 03/03/2024 at 10:45 A.M., the Dietary Manager indicated the garbage receptacles needed to be covered and instructed a dietary employee to cover them with lids. The Ditary Manager indicated 81 residents ate food prepared in the kitchen. A current policy dated 08/2017 provided by the Administrator on 03/04/2024 at 10:30 A.M. indicated appropriate lids should be provided for all containers. Staff should be responsible for ensuring the lid is placed on garbage receptacles after each use. 3.1-21(i)(5)		daily by the ED/Designee ensuring that refuse handling is compliant with sanitation standards. Audits will be completed be completed daily for 3 months at 100% compliance. Audits will continue weekly for 3 additional months at 100% compliance. Results of these audits will be compiled for monthly QAPI meeting. Any issues identified will be addressed by Action Plan adopted by the QAPI committee.	
F 0867 SS=E Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.			

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	§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;			

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	155207	A. BUILDING 00 B. WING	03/08/2024

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	(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in			

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	paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on observation, interview and record review the facility failed to implement a compliance program to ensure prior identified medications labeling was complaint. This affected 4 of 4 residents reviewed (Resident 50, Resident 64, Resident 37, and Resident 25) Findings include: The facility annual survey completed on 5/5/23 identified noncompliance with medication labeling and storage. During an observation on 03/03/24 at 11:02 A.M., 4 injectable medications (insulin) were observed to be opened, but without an opened date. In an interview on 3/3/24 at 11:02 A.M.,	F 0867	A A change in Executive Management was concluded on 2/26. Insulin vial identified as not having an opened date were destroyed and replaced 3/332024. B All residents have the potential to be affected by the alleged deficient practice. The QAPI program at Majestic Care of New Haven was re-introduced to the management team by ED on 3/21/24. All residents on insulin have the potential to be affected by this alleged deficient practice. All MedCarts were checked on 3/3/2024 for undated and improperly stored medications. C The QAPI program at	03/26/2024

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	Registered Nurse (RN) 3 indicated Resident 50's insulin Glargine solution, Resident 64's Lispro insulin, Resident 25's Humalog insulin, and Resident 37's Lispro insulin were opened without open dates. RN 3 indicated she did not know when they were opened or if they were any good. In an interview on 3/3/24 at 2:46 P.M., the Director of Musing (DON) indicated the facility completed a mock survey on 2/29/24, but the facility did not waste the insulins that were not properly labeled. In an interview on 3/8/24 at 9:14 AM, the Administrator, DON, and Regional Nurse indicated the facility completed a mock survey on 2/29/24. The survey incuded an audit of the medications cart. Between the date they audited to the day the annual survey started, someone had opened the insulins, but not dated them. The observation of the undated, opened insulins was on 3/3/24 at 11:02 AM. The facility did not audit the medication cart for 4 days . A current facility policy, Quality Assurance and Performance Improvement (QAPI), dated February 2023, was provided by the Regional Nurse on 3/8/24 at 9:57 AM. The policy indicated..." it is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven, QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services of the facility provides..."problem-prone areas" refers to care or service areas that have historically had repeated problems...." 3.1-52(a)		Majestic Care of New Haven was re-introduced to the management team on 3/21/24 by ED. Education was provided to the QAPI committee by ED to provide an effective, comprehensive, date driven QAPI program. Education was provided to all nurses and QMA's related to dating medications when opened on 3/21. D Majestic Care of New Haven will schedule a monthly QAPI committee meeting on the 3rd Thursday of each month. Records of QAPI committee meetings and follow-up with it's current Action Plans will be documented and reviewed monthly.	
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, and interview, the facility failed to ensure masking, hand hygiene, and equipment disinfection practices were implemented and maintained. 41 residetns resided on the 300/ 400 hall. Findings include: 1. During an observation on 3/3/24 at 8:50A M, on the front door of the facility a sign indicated face	F 0880	A QMA 5 received education related to Glucometer sanitation on 3/3/2024. The facility is unable to correct the alleged deficient practice of improper mask wearing and wearing gloves in the hallway, touching pills with hands. B All residents have the potential to be affected by this alleged deficient practice.	03/26/2024

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	masks were required. Two unidentified employees walking past the front desk were not wearing face masks. During an observation on 3/3/24 at 9:00 A M, on the 300 hall an unidentified employee was observed to not be wearing a face mask. During an interview on 3/3/24 at 9:22 AM, the Director of Nursing (DON) indicated the facility had 2 staff members test positive for COVID-19, so everyone was to wear a mask as a precaution. An observation on 3/3/24 at 9:29 AM, an unidentified staff member was observed coming out room 301, bringing out a meal tray wearing blue gloves. The staff member placed the meal tray into a metal cart, then entered room 306 wearing the same blue gloves and without performing hand hygiene. The staff member came out of room 306 with the same gloves on and placed the meal tray into a metal cart. The staff member was observed to push the metal cart down the hall and entered the kitchen using a code without changing gloves or having performed hand hygiene. The staff member did not change gloves after each room or use hand hygiene. During an observation on 3/3/24 at 10:12 AM at the 300/ 400 hall nurses station, an unidentified employee was observed walking out of a resident's room with a mask below their chin. The employee continued to speak to another employee. In an interview on 3/3/24 at 11:00 AM, the Regional Nurse, indicated since the facility was not considered to be in outbreak, the staff would not have to wear a mask.		Outbreak status was confirmed to not be necessary, and that information relayed to staff 3/4/2024. C All staff received education related to policies and procedures for infection control by DNS including PPE donning and doffing, mask use, hand hygiene, and glove use. Nursing staff were provided education related to sanitation of glucometers by DNS. D Infection control audits will be conducted daily by DNS/Designee. The audits will include PPE donning and doffing, mask use, hand hygiene, glove use, and glucometer sanitation. These audits will be completed for 3 months at 100% accuracy. The audits will be continued weekly for an additional 3 months at 100% accuracy. Results of these audits will be addressed monthly at QAPI meeting. Any issues identified related to infection control will be addressed through Action Plan adopted by the QAPI committee.	

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	In an interview on 3/8/24 at 9:14 AM, the Administrator, DON and Regional Nuse, indicated staff should be wearing face masks properly. Even after staff were told they did not have to wear masks, there were still employees wearing masks below chins, and walking through out hallways. 2. During an observation on 03/03/24 at 09:45 AM, Registered Nurse (RN) 3 was observed popping two pills from medication cards into her ungloved hand, then putting them into a small medication cup. During an observation on 03/03/24 at 11:56 AM, RN 3 was observed with one gloved and one ungloved hand. RN 3 was pushing pills from medication cards into her hand, then put them into a cup During an observation on 03/03/24 at 11:19 AM, Qualified Medication Aide (QMA) 5, took Resident 136's blood sugar with a glucometer. QMA 5 used an alcohol wipe to clean the resident's finger, waited for it to dry, took the samle, then with a gloved hand, took the glucometer out to the cart, placed the glucometer on the medication cart and removed the gloves. QMA 5 obtained new gloves, another strip, another alcohol wipe and walked into Resident 15's room. QMA 5 did not perform hand hygiene, and did not disinfect the glucometer between uses. In an interview on 03/03/24 at 11:24 AM, QMA 5 indicated she was unsure what the procedure for glucometer disinfection was. QMA 5 indicated she did not have anything to clean the glucometer with. A current facility policy, Glucometer Disinfection,			

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	dated February 2023, was provided by the Director of Nursing on 3/4/24 at 10:06 AM. The policy indicated..." The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to resident and employees..."cleaning" is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic's products..."disinfection" is the process that eliminates many or all pathogenic microorganisms, excepts bacterial spores, on inanimate objects...the facility will ensure blood glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructions for multi-resident use...." A current facility policy, Policies and Practices-Infection Control, dated 2/2018, was provided by the 3/3/24 at 11:15 AM. The policy indicated..." The facility's infection prevention and control program (ICPC) is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections...All personnel will be trained on infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degrees of direct resident contact and responsibilities...." 3.1-18(a)			
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement			

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	policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or			

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	(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on Interview, and Record review, the facility failed to ensure the immunization for the COVID-19 vaccine was provided to 4 of 5 residents reviewed. (Resident 15, Resident 18, Resident 64, and Resident 69) Findings include: A record review began on 3/6/24 at 12:34 PM, Resident 15 diagnosis include, anemia and autistic disorder. A review of Resident 15's immunizations. There were no updated consents/declination for the COVID-19 vaccine. A consent form was provided by the Director of Nursing (DON) on 3/7/24 at 8:40 AM, indicated Resident 15 gave consent to receive vaccine dated 11/29/23. A record review on 3/6/24 at 12:45 PM for Resident 18, diagnosis include, acute and chronic respiratory failure with hypoxia.	F 0887	A Residents' 15, 18, 64, and 69 re-affirmed their consents to receive the COVID-19 immunizations. Arrangements for COVID-19 vaccination and were administered 3/20. B All residents who wish to receive the covid vaccination have the potential to be affected by this alleged deficient practice. All new admits from 3-3-24 were asked their consents for the COVID-19 vaccine. Arrangements were made for them to receive on 3-28-24. All residents and their representatives were offered the covid vaccine again and they were arranged for 3-28-2024 administration. C Education was provided to all members of the Nursing department, including nurse management by DNS related to the COVID-19 vaccination	03/26/2024

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	A review of Resident 18's immunizations. There were no updated consents/declination for the COVID-19 vaccine. A consent form was provided by the DON on 3/7/24 at 8:40 AM, indicated Resident 18 gave consent to receive vaccine dated 11/29/23. A record review on 3/6/24 at 12:55 PM for Resident 64, diagnosis include, age-related osteoporosis without current pathological fracture. A review of Resident 64's immunizations. There were no updated consents/declination for the COVID-19 vaccine. A consent form was provided by the DON on 3/7/24 at 8:40 AM, indicated Resident 64 gave consent to receive vaccine dated 11/29/23. A record review on 3/6/24 at 1:10 PM for Resident 69, diagnosis include, chronic obstructive pulmonary disease, unspecified. A review of Resident 68's immunizations. There were no updated consents/declination for the COVID-19 vaccine. A consent form was provided by the DON on 3/7/24 at 8:40 AM, indicated Resident 68 gave consent to receive vaccine dated 12/1/23. An interview on 3/7/24 at 8:40 AM, the DON, indicated, in December there was a miscommunication with the pharmacy that was given the clinic at the facility. So only 12 residents got the vaccine, there was going to be another clinic but that got canceled. The 4 residents were		protocol. D Audits of consents for new admissions will be conducted daily during clinical meeting and admission review. The audits will be completed daily at 100% for 3 months by the DNS/Designee. Further auditing will be conducted weekly for an additional 3 months at 100%. Results of these audits will be compiled and shared with the QAPI committee monthly. Any issues identified during the audits will be addressed with Action Plans adopted by the QAPI committee.	

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	missed and never received the vaccine. A current facility policy, SARS-CoV-2 resident vaccine, was provided by the DON on 3/7/24 at 8:40 AM. The policy indicated..." All residents who have no medical contraindications to the vaccine will be offered the SARS-CoV-2 vaccine and eligible booster doses to encourage and promote the benefits associated with vaccination...Upon approval and distribution, the SARS-CoV-2 vaccine shall be offered to residents, unless the vaccine is medically contraindicated or the resident is already up to date vaccinated...Administration of the SARS-CoV-2 vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination...."			