STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 25, 26, 27, 30 and October 1 and 2, 2024. Facility number: 000549 Provider number: 155510 AIM number: 100267470 Census Bed Type: SNF/NF: 57 SNF: 9 Residential: 45 Total: 111 Census Payor Type: Medicare: 4 Medicaid: 33 Other: 29 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 9, 2024.	F 0000	Allegation of Compliance Please accept the following plan of correction for the annual survey completed on October 2, 2024. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyors; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the physician was notified timely of a choking episode for 1 of 1 resident reviewed for respiratory infection. (Resident 12)	F 0580	Deficiency ID 580 Completion Date: 10/22/24 12 am Plan of Correction Text:	10/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael W.Gerig	Executive Director	10/18/2024

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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	Finding includes: The clinical record for Resident 12 was reviewed on 9/26/24 at 3:59 p.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, psychotic and mood disturbance, anxiety, and vascular dementia with psychotic behavior. A progress note, dated 9/20/24 at 11:07 p.m., indicated the resident choked on hamburger meat during dinner. The resident was breathing but coughing. The resident was unable to bring the food up. The resident was suctioned to remove phlegm and mucus. The resident continued to cough and when she spoke, she made a gurgling sound. The resident's daughter was notified. A triage form, dated 9/20/24 at 7:00 p.m., indicated the resident had a possible aspiration and requested the nurse practitioner (NP) to assess the resident's lung sounds on Monday (9/23/24). A nurse practitioner's progress note, dated 9/23/24, indicated the resident was seen for an acute visit for a recent coughing episode. The resident experienced an episode over the weekend, during which she required suctioning. The nursing staff reported changes in breath sounds following the episode. During the examination, wheezing was noted throughout the resident's lungs. The choking episode and wheezing raised concern for a possible respiratory issue. The plan was to obtain a 2-view chest x-ray to evaluate for potential pneumonia. Oxygen saturation (percentage of oxygen in the blood) and changes in respiratory exam would be continuously monitored. Follow-up would be scheduled when results were returned or sooner if necessary.		F580 Affected Resident: Resident #12 choked and was suctioned per coughing episode. Triage note on 9/20/24 for N.P. completed and N.P. saw in person on 9/23/24. A chest X ray was ordered 9/23/24 by N.P. Potential to be affected: All residents that may need care could be affected by the alleged deficient practice. A review of progress notes and risk events was conducted for the last 30 days to verify appropriate notifications to the Nurse Practitioner and/or Physician as necessary. Systematic Changes: Nurse management educated Nursing staff on physician notification policy for safety of residents on or before 10/18/24. Monitoring: The Director of Nursing and/or will check to insure proper and timely physician notification takes place. Daily checks will be done for 4 weeks on all shifts, then bi-weekly for 8 weeks, then monthly for 3 months. Any corrective action or education will be completed	

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	A progress note, dated 9/24/24 at 3:04 p.m., indicated the NP reviewed the chest x-ray results. New orders were received for Augmentin (an antibiotic) 800/125 milligrams (mg) for 5 days and to monitor oxygen saturation twice daily for a cough. A physician's order, dated 9/24/24, indicated Ipratropium-Albuterol solution (a medication used to treat lung conditions) 0.5-2.5 mg /3 milliliters (ml) 1 vial inhale orally twice daily for shortness of breath for 10 days. A care plan, dated 9/24/24, indicated the resident had pneumonia. The approaches included, but were not limited to, auscultate lung sounds, listen for crackle and breath sounds due to atelectasis (in aspiration pneumonia rhonchi and wheezing are also present), and monitor and document for mental changes, in the elderly, pneumonia may initially present as mental changes and cough only. During an interview, on 10/01/24 at 2:40 p.m., the Nurse Practitioner indicated she was notified of the episode by the triage note on Monday (9/23/24). A current policy, titled "Acute Condition Changes," dated as revised 2017 and received from the Assistant Director of Nursing (ADON) on 10/1/24 at 2:08 p.m., indicated "...the facility shall use defined protocol to evaluate and report changes in condition of its residents/patients...physicians shall help identify and manage causes of acute changes of condition (ACOC)...acute changes of condition will be identified and managed properly...residents/patients with acute changes of condition will not experience preventable		immediately. Results will be presented to the monthly Quality Assurance Performance Improvement committee meeting to validate 100% compliance. AOC 10/22/24.	

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	decline in condition while being treated in the facility...the nursing staff will contact the physician based on the urgency of the situation...for emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less)...." 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure the correct amount of oxygen was administered as ordered by the physician for 1 of 1 resident reviewed for respiratory care. (Resident 54) Finding includes: During an observation, on 9/25/24 at 2:23 p.m., Resident 54's oxygen concentrator (a device used to provide supplemental oxygen therapy) was set on 2.5 liters per minute (L). During an observation, on 9/26/24 at 12:20 p.m., the resident was sitting in the common area and his portable oxygen tank was set on 4L. The clinical record for Resident 54 was reviewed on 9/27/24 at 10:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and chronic kidney disease. A care plan, dated 6/18/24, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, monitor oxygen saturation,	F 0695	Deficiency ID 695 Complete Date 10/22/24 Plan of Correction Text F695 Affected Resident: Resident #54 was observed to have oxygen setting at incorrect level. Resident has order for 2 liters and his oxygen level was set at 2.5 on Concentrator and 4 on portable. The nurse practitioner was notified of the finding on 10/1/24 with no new orders or the nurse assessed the resident with no negative findings. Potential to be affected: All residents with oxygen orders have the potential to be affected by alleged deficient practice. An audit was done by the DON or	10/22/2024

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	monitor for signs and symptoms of respiratory distress, and administer oxygen by nasal cannula as ordered. A physician's order, dated 7/12/24, indicated the resident was to receive 2L of oxygen continuously. During an interview, on 9/25/24 at 12:24 a.m., LPN 4 indicated the resident's oxygen concentrator was on 2.5L. The resident's order was for 2 to 4L depending on the resident. During an interview, on 9/26/24 at 12:25 p.m., the Director of Nursing (DON) indicated the resident oxygen was set on 4L and she was not sure of the resident's order. During an interview, on 9/26/24 at 1:17 p.m., the DON indicated the resident's order was for 2L and the resident was on 4L. The staff should follow the physician's order. A current policy, titled "Oxygen Administration," revised 10/2010 and received from the DON on 9/26/24 at 10:40 a.m., indicated "...The purpose of this procedure is to provide guidelines for safe oxygen administration...Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...." 3.1-47(a)(6)		designee to ensure that settings were accurate to physician order for each resident with oxygen 10/1/24. Systematic Changes: Nurse management educated Nursing staff on the correct oxygen setting for resident Concentrators and portable oxygen tanks as ordered by the physician on or before 10/18/24. Monitoring: The Director of Nursing and/or will randomly check oxygen settings on all shifts for 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months. Any corrective actions will be completed immediately. The results of audits will be presented to Quality Assurance Performance Improvement committee meeting to validate 100% compliance and then ongoing QAPI reviews. Plan to be updated as indicated. AOC 10/22/24	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure the correct personal protective equipment (PPE) for contact	F 0880	Deficiency ID F 880 Completion date 10/22/24 12 am	10/22/2024

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	precautions was used, to perform hand hygiene after resident contact, to utilize enhanced barrier precautions (EBP) when required, to protect clean laundry from contamination, to perform hand hygiene and change gloves while performing wound care, and to keep the indwelling catheter tubing from touching the floor for 7 of 7 residents reviewed for infection control. (Resident 19, 33, 47, 18, 20, 38 and 48) Findings include: 1. During an observation, on 9/27/24 at 8:54 a.m., QMA 5 was giving medications to Resident 28. After finishing with Resident 28, she walked over to Resident 19 and touched the resident's blanket without wearing a gown or gloves as she asked if the resident needed anything. Resident 19 had an order for contact precautions with a sign on the door. QMA 5 exited the room and walked directly to her medication cart outside the dining room. No hand hygiene was observed while she was in the room, walking down the hall, or at the medication cart. She then wrote on her resident information paper, accessed her computer screen, and prepared Resident 18's morning medications. During an observation, on 9/30/24 at 9:23 a.m., LPN 4 was giving medications to Resident 19 who remained on contact precautions with no gown or gloves on while she was in the room. The clinical record for Resident 19 was reviewed on 9/27/24 at 9:32 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, personal history of malignant neoplasm of bronchus and lung, personal history of malignant neoplasm of brain, and history of Escherichia coli extended-spectrum beta-lactamases producing organism (ESBL) with current infection.		Plan of Correction Affected Residents: Residents 19,33, and 47 were all affected for lack of infection control barrier protection and correct PPE. 18 and 20 were affected for lack of infection control was garments were hung on prior to entry of resident room that was in isolation. Resident #38 was affected for lack of infection control with changing of gloves at appropriate time during wound care. Resident #48 was affected for lack of infection control with catheter tubing that was touching the floor. Potential Affected Residents: All residents that require barrier protection for direct care, infection control pursuant to clean clothing touching wall for any residents, resident requiring wound treatment and the accompanying glove changes for sanitation, and residents with catheter tubing that could touch floor have potential to be affected by the alleged deficient practices. Systematic Changes:	

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	A physician's order, dated 9/25/24, indicated contact isolation precautions for ESBL in urine culture every shift until 10/1/24. A care plan intervention, initiated 9/25/24, indicated contact isolation precautions for ESBL for Resident 19. A nurse's note, dated 9/25/24 at 12:57 p.m., indicated the Nurse Practitioner (NP) ordered contact precautions. During an interview, on 9/30/24 at 1:35 p.m., LPN 4 indicated for enhanced barrier precautions, staff should wear a gown and gloves when giving direct care or touching a resident, and contact isolation was basically the same thing. She indicated they had to wear gowns and gloves when they were going to be in contact with an area where the infection was but not every time you went into the room. During an interview, on 10/01/24 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated that all staff had been educated on hand hygiene and the correct use of PPE, including requirements for wearing gowns and gloves every time they enter a room under contact precautions. 2. During random observations, on 9/25/24, 9/26/24, 9/27/24, 9/30/24, 10/1/24 and 10/2/24, Resident 33 was not on enhanced barrier precautions and there was no sign on her door. The clinical record for Resident 33 was reviewed on 9/27/24 at 10:44 a.m. The diagnoses included, but were not limited to, frequent history of extended spectrum beta lactamase (ESBL) resistance infections, stage 3 chronic kidney		Nurse management educated Nursing staff in all 4 areas of infection control practices to insure understanding and compliance with infection control procedures and policy. Monitoring: The Director of Nursing and/or will audit infection control practices in the 4 areas listed. Audits for compliance will be done randomly for all shifts for 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months. Any corrective action will be completed immediately. The results of audits will be presented to Quality Assurance committee meeting to validate 100% compliance and then ongoing routine QAPI reviews. Plan to be updated as indicated. AOC10/22/24	

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	disease, overactive bladder, type 2 diabetes mellitus, spondylosis cervical region, and systemic lupus erythematosus. The resident was considered colonized (organism was frequently present in stool and urine) with ESBL. A urinalysis culture report, dated 4/14/24 at 2:32 p.m., indicated the resident's urine had ESBL present. A Minimum Data Set (MDS) quarterly assessment, dated 7/3/24, indicated the resident had a multi-drug-resistant organism (MDRO): ESBL. A urinalysis culture report, dated 7/9/24 at 1:36 p.m., indicated the resident's urine had proteus mirabilis ESBL present. A urinalysis culture report, dated 8/1/24 at 12:34 p.m., indicated the resident's urine had proteus mirabilis ESBL present. A MDS quarterly assessment, dated 9/30/24, indicated the resident was occasionally incontinent of urine and frequently incontinent of bowel. The clinical record did not include an order for enhanced barrier precautions. During an interview, on 9/26/24 at 11:35 a.m., CNA 6 indicated Resident 33 was not on enhanced barrier precautions. During an interview, on 10/01/24 at 2:26 p.m., the ADON indicated the resident was not on enhanced barrier precautions.			

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	During an interview, on 10/01/24 at 2:35 p.m., the NP indicated the resident had frequent urinary tract infection cultures which showed ESBL. A Centers for Medicare and Medicaid Services (CMS) memorandum QSO-24-08-NH, titled "Enhanced Barrier Precautions in Nursing Homes," dated 3/20/24, indicated "EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO... Centers for Disease Control and Prevention (CDC) website, https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, titled "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)," accessed on 9/26/24 at 11:00 a.m., indicated ESBL was a CDC-targeted MDRO. 3. During random observations, on 9/25/24, 9/26/24, 9/27/24, 9/30/24, 10/1/24 and 10/2/24, Resident 47 was not on enhanced barrier precautions (EBP) and there was no sign on her door. The clinical record for Resident 47 was reviewed on 9/30/24 at 9:25 a.m. The diagnoses included, but were not limited to, disorder of kidney and bladder and neuromuscular dysfunction of the bladder. A physician's order, dated 7/26/24, indicated foley catheter (indwelling urethral catheter) care every shift. A nurse's note, dated 9/12/24 at 11:59 a.m.,			

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	indicated the resident's indwelling urethral catheter was draining clear yellow urine. A MDS quarterly assessment, dated 9/6/24, indicated the resident had an indwelling urethral catheter. A care plan, initiated 7/25/24, indicated the resident had a foley catheter related to neurogenic bladder. The clinical record did not include an order for enhanced barrier precautions. During an interview, on 10/01/24 at 3:25 p.m., the Director of Nursing (DON) indicated the resident had an indwelling urethral catheter present and should be on EBP. She did not know why there was no signage on the door or an order. A Centers for Medicare and Medicaid Services (CMS) memorandum QSO-24-08-NH, titled "Enhanced Barrier Precautions in Nursing Homes," dated 3/20/24, indicated "EBP are indicated for residents with any of the following...indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO...Indwelling medical device examples include...urinary catheters...." 4. During an observation, on 10/01/24 at 11:02 a.m., there were three pairs of pants and one shirt hanging on the handrail outside of Room 302. Resident 18 and Resident 20 were in Room 302 with contact droplet isolation for Covid. During an interview, on 10/01/24 at 11:04 a.m., CNA 7 indicated the clothes were not supposed to be hanging on the hand railing outside.			

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	During an interview, on 10/01/24 at 11:32 a.m., the Housekeeping Manager indicated she told the staff to hang the clothes on the outside of the door so the nursing staff would take it in. Clothes should not be hung on the rails outside the rooms. 5. During a wound care observation, on 10/2/24 at 9:58 a.m., LPN 2 did not change her gloves and did not perform hand hygiene after removing Resident 38's shoe and dirty dressing before cleansing the wound with saline and gauze. She did not change gloves and perform hand hygiene after putting Resident 38's shoe back on and before re-capping the Santyl ointment. The clinical record for Resident 38 was reviewed on 9/26/24 at 3:25 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, muscle weakness, and abnormalities of gait and mobility. A care plan, dated 8/14/24, indicated the resident had an arterial wound on her left ankle. Interventions included, but were not limited to, administering treatments as ordered. A physician's order, dated 9/3/24, indicated the resident's left ankle wound was to be cleansed with normal saline, skin prep was to be applied around the wound, Santyl ointment was to be applied to the wound bed, and the area was to be covered with an island dressing once daily. 6. During an observation, on 9/27/24 at 11:31 a.m., Resident 48 was sitting in his wheelchair and the catheter tubing was on the floor. The clinical record for Resident 48 was reviewed on 9/27/24 at 10:52 a.m. The diagnoses included, but were not limited to, chronic kidney disease,			

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	congestive heart failure, hypertension, and major depressive disorder. A care plan, dated 4/9/24, indicated the resident had a foley catheter. Interventions included, but were not limited to, barrier precautions and checking the tubing for kinks each shift. A physician's order, dated 4/9/24, indicated the indwelling catheter tubing was to be secured using an anchoring device to prevent movement every shift. During an interview, on 9/27/24 at 11:34 a.m., the DON indicated the catheter tubing should not be on the floor. A current facility policy, titled "Catheter Care, Urinary," dated as revised 8/22 and received from the DON on 9/30/24 at 9:00 a.m., indicated "...The purpose of this procedure is to ensure bags are kept off the floor...Check the resident frequently...." A current facility policy, titled "Wound Care," dated as revised October 2010 and received from the Director of Nursing (DON) on 10/2/24 at 11:39 a.m., indicated "...Steps in the Procedure...Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves...." A current facility policy, titled "Isolation-Categories of Transmission-Based Precautions," dated 4/2/24 and received from Clinical Support on 9/27/24 at 1:50 p.m., indicated "...When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door...so that personnel and visitors are			

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	155510	A. BUILDING 00 B. WING	10/02/2024

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	aware of the need for and the type of precaution... (enhanced barrier precautions)...used for residents who...are infected or colonized with MDROs (or have risk factors for MDRO acquisition)...." A current facility policy, titled "Handwashing/ Hand Hygiene," dated 8/19 and received from the Administrator on 10/1/24 at 9:25 a.m., indicated "...Use an alcohol-based hand rub...or soap...and water for the following situations...Before and after direct contact with residents c. Before preparing or handling medications...After contact with objects...in the immediate vicinity of the resident...Before and after entering isolation precaution settings...." A current facility policy, titled "Isolation-Categories of Transmission-Based Precautions," dated 4/2/24 and received from Clinical Support on 9/27/24 at 1:50 p.m., indicated "...Contact precautions are implemented for residents...infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces...Staff...wear gloves...when entering the room...Gloves are removed, and hand hygiene performed before leaving the room...Staff...wear a disposable gown upon entering the room...." 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 25, 26, 27, 30 and	R 0000	Allegation of Compliance Please accept the following plan of correction for the annual survey completed on October 2, 2024.	

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	October 1 and 2, 2024. Facility number: 000549 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 9, 2024.		Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyors; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility failed to ensure the ice machine was free from debris for 1 of 1 ice machine reviewed. Finding includes: During the kitchen observation, on 10/1/24 at 11:18 a.m., the Food Service Director opened the door to the ice machine and across the top was a thick brown substance. The Food Service Director took a white rag, wiped the area, and a large among of brown substance was observed on the	R 0273	Deficiency ID R273 Completion Date 10/22/24 12 am Plan of Correction Text: R273 Affected Residents: no specific named Potential to be Affected: No residents were affected by the	10/22/2024

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	rag. During an interview, on 10/1/24 at 11:20 a.m., the Food Service Director indicated there was a large amount of brown substance on the rag which was not good. The brown substance could make the residents sick. She indicated the maintenance department was responsible for cleaning the ice machines. During an interview, on 10/1/24 at 11:50 a.m., the Resident Community Director indicated the maintenance department should clean the ice machine, and it should not have any buildup. The ice machine would need to be cleaned before using it. A current policy, titled "Infection Control Practice/Universal Precautions," undated and received from the Resident Community Director on 10/1/24 at 11:50 a.m., indicated "...Cleaning and disinfecting, an important part of cleaning equipment is to remove any organic matter. If matter is left on the equipment, the disinfectant will not reach the equipment, and the equipment could pass on the microorganism to someone else...."		substance noted on the ice machine door. The ice machine was cleaned on 10/2/24. Systematic Changes: The dietary manager was educated monitoring the ice machine for any substances requiring cleaning and the maintenance department for any extensive cleaning needs prior to the routine preventative maintenance cleaning by 10/17/2024. In addition, daily surface cleaning of the ice machine was added to the kitchen sanitation log and staff educated on the daily cleaning and required documentation by 10/17/2024. Monitoring: The Certified Dietary Manager or her designee will audit the ice machine 5 times per week to ensure that the machine is clean and that the documentation of cleaning is present on the kitchen sanitation log. Additionally, the complete machine will remain on Quarterly schedule for cleaning by Maintenance Dept. and recorded. Any corrective action or education will be completed immediately if needed. Results will be present to monthly Quality Assurance Performance Improvement meeting to validate 100% compliance.	

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			AOC 10/22/24	