STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155848	A. BUILDING 00 B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENMOTION RECOVERY CARE	1000 E MAIN STREET DANVILLE, IN 46122

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 10, 11, and 12, 2023. Facility number: 013667 Provider number: 155848 AIM number: 300002429 Census Bed Type: SNF/NF: 8 Total: 8 Census Payor Type: Medicare: 4 Other: 4 Total: 8 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 15, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to allegation of noncompliance cited during the annual Recertification and State Licensure Survey completed on April 10, 11 and 12, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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			

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

Lisa Imlay | Administrator | 04/30/2023

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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	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. §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 ensure a resident (Resident 162) had the right to be treated with dignity when bed and chair alarms were placed to ensure she was unable to get up without permission, and the facility failed to ensure she had the right to privacy when her door was required to remain open so staff could	F 0550	I. Steps taken to ensure deficiency involving resident being treated with dignity and privacy protected a. DON and clinical coordinator reviewed resident medical record and plan of care. Resident had a chair and/or bed	04/20/2023

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	continuously observed her so she did not get out of bed without permission. Using the reasonable person concept, it is likely that this would lead to an increase of frustration and agitation and expressions of anger, for 1 of 8 residents reviewed for resident's rights. Findings include: On 4/10/23 at 11:15 a.m., Resident 162 was initially observed. The head of her bed (HOB) was elevated so she sat at an approximate 60-degree angle, so she sat upright. Her legs were extended out straight, and a blanket was over her lap. She played a game of solitaire on a hand-held tablet. In conversation, she was unable to recall when, why, or how she ended up in the facility. She was pleasantly confused. There was a staff member in the room who sat in a visitor chair and identified herself as a "safety sitter." During an interview, on 4/10/23 at 11:20 a.m., the Safety Sitter indicated she was a Registered Nurse (RN) who worked in the pediatric unit of the hospital, but she had asked to come with Resident 162 to keep her from getting up without assistance. On 4/10/23 at 3:23 p.m., Resident 162 remained in her bed as she played games on her tablet. On 4/11/23 at 9:10 a.m., Resident 162 was observed. The HOB was elevated to a 90-degree angle as she sat upright and ate her breakfast. Resident 162 was pleasantly confused and asked what buildings outside her window were and why she was in the facility. A different Safety Sitter was observed as she sat in a chair directly outside of Resident 162's room within line of sight.		alarm in place for her safety due to impulsiveness and getting up on her own. At the time of the survey there was a 1:1 direct sitter observing patient who did not turn off the bed alarm. b. DON provided staff education that when there is a 1:1 sitter with patient, they are not permitted to have a bed or chair alarm in use at that time (education evidence uploaded into Gateway). c. Instituted a new practice that all patients with dementia diagnosis will have person centered interventions and activities discussed at clinical meeting Monday- Friday and instituted as part of their plan of care. d. Instituted a change to expand the SNF activity program flowsheet to include an assessment at time of admission if the resident preferred their room door open or closed. e. Evaluated patient preference form in electronic medical record for door open or closed, and work order placed with Information Systems department to modify the SNF activity program flowsheet to include asking all residents if they preferred their door to be open or closed. f. In-serviced activities coordinator of new process to ask all patients at time of admission if they prefer their room door to be	

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	During an interview, on 4/11/23 at 9:15 a.m., the Safety Sitter indicated she was a Unit Clinical Assistant (UCA) who worked in the Childbirth unit of the hospital but had been asked to come sit with Resident 162 as a fall precaution. UCA 18 indicated she had moved to a chair outside of the resident's room as Resident 162 had become upset with someone being in her room, and it made her frustrated, so she moved out of the room to give her more space but still needed to be able to see her to ensure she did not get out of bed without assistance. On 4/11/23 at 11:04 a.m., Resident 162 was observed as she remained seated upright in her bed. Although there was a puzzle and some other word game books, Resident 162 indicated she didn't want to do them because she had already looked at them all. She preferred to just play on her tablet. On 4/11/23 at 11:13 a.m., a Physical Therapist (PT) 20 entered Resident 162's room, (without knocking) and asked the resident if she was ready for therapy. Resident 162 indicated she did not know where she was supposed to go, but PT 20 assured her it was time to go to therapy and do some exercises. When PT 20 assisted her to stand up from the bed with her walker, a long, loud, and high-pitched alarm sounded, the box at the end of her bed began to blink red, and call light bell chimed and blinked. Resident 162 immediately began to smack at the head of her bed and pillow, and she moved the pillow to look under it. With a tone of annoyance and frustration, she grumbled, "oh that darn thing!" PT 20 moved to the end of the bed and pushed a button to turn the bed alarm off, and several other nursing staff entered the room to check and turn off the call light.		open or closed. g. DON educated all interdisciplinary team members to knock or ask permission prior to all patient rooms out of respect for their privacy (education document uploaded in Gateway). h. DON or clinical coordinator will round on all dementia patients a minimum of three times weekly until 100% compliant for 3 weeks to ensure appropriate person-centered interventions are in place, alarms are not in place if a sitter is being utilized to keep patient safe and to observe that all staff are knocking or asking permission before entering a resident's room (see dignity/privacy audit tool attached). i. Administrator and DON evaluated staff annual dementia education program and additional dementia training courses available. DON informed education department to add two dementia education courses to all enMotion staff members annually including: i. Dementia Care 1, Mental Decline and Caregiving Challenged ii. Dementia Care lll, Understanding and Managing Difficult Behavior (see email instruction to education department uploaded in Gateway).	

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	On 4/11/23 at 12:02 p.m., Resident 162 was observed back in her bed, seated upright, and ate her lunch. UCA Safety Sitter 18 remained in a chair outside of her room and watched through the open door. On 4/11/23 at 1:08 p.m., Resident 162 remained in her bed, seated upright, and played on her tablet. On 4/11/23 at 1:18 p.m., Resident 162 became restless and began to move around and reposition herself in her bed. UCA 18 stood up from her chair outside and entered the resident's room (without knocking) and indicated, "you're not trying to get up, are you?" On 4/11/23 at 1:26 p.m., Resident 162 asked the Safety Sitter UCA 18 when she was going to go home. UCA 18 indicated, "you already asked me that, I don't know, we need to ask your nurse." On 4/11/23 at 1:28 p.m., the Post-Acute Rehab Coordinator (PARC) entered Resident 162's room (without knocking) and brought a new pair of socks. During an interview, on 4/11/23 at 1:32 p.m., the PARC indicated Resident 162 was pretty confused most of the time, and with her increased confusion, she forgot she had surgery and would try to get up by herself, so alarms were placed on her bed and chair. It depended on the day she had if it bothered her or not. Some days she would get really frustrated with them and other days she didn't pay any attention to them. Staff started noticing she was getting more agitated and repeatedly asked when she was going home. She started to think staff had stolen her car and purse and was paranoid. So this was when it was decided to have a "sitter" with her to help keep		j. In order to protect patient dignity and privacy, DON or Administrator will provide then ongoing education with staff caring for dementia patients as needed based on monitoring findings. k. Citation monitoring will be presented and discussed in department meetings and enMotion Recovery Care QAPI meetings throughout 2023. II. How did facility review all patients in facility that could have been impacted? The remaining 7 residents being cared for during the survey were assessed by DON to see if chair or bed alarms were in use or if their doors were being left open without their permission and there were no other patients impacted by this deficiency. Of the remaining 7 residents, 0 of them were diagnosed with dementia or Alzheimer's disease.	

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	her from falling and to get help when she started to get upset, which was usually around 4:00 p.m., in the evening, which was very much like Sundowners, (restlessness, agitation, irritability, or confusion which can begin or worsen as daylight begins to fade, often just when tired caregivers need a break. Sundowning can also continue into the night, making it hard for people with Alzheimer's to fall asleep and stay in bed). During an interview, on 4/11/23 at 1:43 p.m., the Activity Director (AD) indicated EnMotion did not usually get a lot of residents like Resident 162 who had more advanced confusion. Yesterday she seemed to have a pretty bad day, and so the AD went down and tried to talk with her. Resident 162 had been asking about going home and had gotten upset she was not allowed to leave. The AD presented her with several options of activities to do in her room, but she refused everything and made self-harm statements like, "well if I have to live like this, I'll just kill myself!" Then she forgot she even said something like that. The safety sitters were good to have to help keep her from falling but could also help make sure she did not actually try to harm herself. The AD indicated Resident 162 was not super happy about the sitter either though, she didn't like them in her room, she'd say she didn't need one because, "I'm an adult person!" On 4/11/23 at 2:23 p.m., Resident 162 began to move around in her bed. The UCA Safety Sitter stood and entered her room (without knocking) as Resident 162 moved herself to a seated upright position on the edge of her bed. Resident 162 asked when she was going to be allowed to go home and UCA 18 indicated, "you have to stay in here," then assisted her to lay back and put her feet back in the bed.			

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	On 4/11/23 at 2:30 p.m., Resident 162 stood up from bed with UCA 18's assistance. The bed alarm sounded, and Resident 162 smacked at her pillow and looked for the sound to turn it off. UCA 18 turned off the alarm and assisted Resident 162 to stand by her window and look outside. She asked repetitive questions about where they were, why she was there, and when she could go home. On 4/11/23 at 2:32 p.m., RN 10 entered Resident 162's room (without knocking). He asked Resident 162 what kind of pain she had, but Resident 162 indicated she was ok, and did not have any pain she just wanted to go home. RN 10 asked if she would like to take a walk about the unit, and Resident 162 indicated, "not really, I'd just feel like I was wandering around," but a few moments later she was agreeable and was assisted to walk a lap around the unit, to the therapy gym where she sat down and completed some arm exercises. On 4/12/23 at 9:14 a.m., Resident 162 was observed in her bed with the HOB elevated as she ate breakfast. A Safety Sitter sat in the visitor chair beside her bed. During an interview, on 4/12/23 at 10:00 a.m., the Director of Nursing (DON) indicated during her stay at EnMotion, Resident 162 had become increasingly confused, and it had become apparent her cognition had significantly declined, and she would likely not return to her previous mental functioning. With her confusion and increased anxiety, she kept trying to get up and walk around on her own, so the alarms were placed as a fall precaution. There were times when she became frustrated with the alarms so staff would turn it off and place a sitter with her instead. Her short-term memory was so			

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	compromised she did not remember getting upset about the alarms, except the chair alarm, she was clearly getting agitated with it so it was removed. The alarms should be on if a sitter was too far away or if her door was closed, but it did not need to be on if someone was with her. During an interview, on 4/12/23 at 10:26 a.m., Resident 162's daughter was asked about the alarms on her mother's bed and chair. She indicated her mother hated them. In the couple of weeks, she was able to stay and visit with her mother, she observed her to get very mad and aggressive with the alarms. She would say things like, "oh I wish that thing would stop!" She understood it was there to help remind her mother not to get up without assistance, but it did not do any good because she would immediately forget. Her mother was not very happy with the sitters in her room either. Since she was so confused, she often thought she was at home, so she would be confused about why those strangers were in her house. Although the staff had been very willing and available to talk about her mother's condition, especially in conversation/determinations about whether this was still acute delirium or symptoms of her Alzheimer's, it just didn't seem like they were equipped to handle her confusion and behaviors. On 4/12/23 at 10:58 a.m., Resident 162 remained in bed and Safety Sitter RN 19 was seated in the visitor chair beside her bed. When asked if a private interview could be conducted, she indicated that was fine, as long as she was not allowed to get out of bed while the door was closed. On 4/11/23 at 10:00 a.m., Resident 162's medical record was comprehensively reviewed.			

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	She admitted to the facility on 3/28/23 following surgery to repair a broken hip. She had current diagnoses which included but were not limited to; left displaced femoral neck fracture (hip fracture), acute delirium, and Alzheimer's disease (a progressive and incurable brain disorder which slowly destroys memory and thinking skills). She had a care plan, initiated on 3/29/23, which indicated Resident 162 had an altercation in behavior described in a timeline format of her behaviors as follows: 3/28 impulsive and consistently jumping out of bed, bed alarm placed for safety. 3/28 physical towards others, threatening behavior, pushing. 3/29 physical towards others, threatening behavior, pushing. 3/30 found in hallway by room twice, reported by RN to MD, reoriented to room/unit. 4/1 wandering. 4/2 required a sitter for overnight due to confusion. 4/5 occasionally standing up without asking for assistance. 4/6 agitation throughout day, redirection provided each time. 4/7 patient had no signs/symptoms of fear or anxiety related to use of chair alarm. Patient continued to move freely with use of bed/chair alarm. Patient able to shut off bed/chair alarm. Patient up and down most of shift. Patient repetitively confused and wanting to go home. Patient in recliner at this time with family at bedside. 4/8 supervision due to noncompliant with bed/chair alarms and was not able to use her call			

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	light for assistance. Patient attempted to get out of bed per self and not use her walker. 4/8 patient continued to turn off chair and bed alarm. Patient noncompliant with asking for assistance with transfers. Patient had become increasingly confused over the day per her normal. Patient up ambulating around room with caregiver packing her things stating it was time to go home. Caregiver trying to redirect and reassure but patient agitated and walking around without walker regardless of education provided. 4/10 noncompliance with bed alarm, had 1:1 sitter at all times for supervision. 4/11 constant 1:1 supervision due to noncompliance with bed alarm and call light. Interventions for this plan of care included, but were not limited to, plan activities of interest with the resident as she enjoyed arts/crafts, puzzles, using her tablet, being with family, working in her yard, and reading the newspaper. A care plan, revised 4/10/, indicated Resident 162 had impaired moods and described, "4/10 note from MD: [Resident 162] has exhibited increased anger and agitation today. She told the nursing staff earlier today that she wanted to kill herself. Her daughter was contacted by phone. She informed us that her mother has made these comments in the past but never acted on them. They usually occur when she becomes angry or upset...Plan: discussed the situation with the daytime and nighttime nursing staff. I do not feel that [Resident 162] is at risk of harm to herself. We will continue to have a sitter with her day and night. Her door remains open. The room was surveyed looking for anything that would be potentially harmful. Will check urinalysis with reflex and culture. Continue Seroquel [an antipsychotic medication] to 50 mg [milligrams] at			

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bedtime. If symptoms persist, may consider a twice daily dose. Provide trazadone 50 mg as needed to achieve sleep. Prolonged duration of confusion would suggest that [Resident 162] is not experiencing acute delirium but instead is exhibiting symptoms of chronic dementia..."

A care plan, initiated 3/30/23, indicated Resident 162 was at risk for fall due to her impaired cognition/dementia, poor safety awareness, impulsivity, pain, and balance deficits. Chair/bed alarms were used to promote patient safety. The care plan lacked revision to include her agitation towards the alarms, when to use them and when to turn them off.

A physician's progress note, dated 3/30/23, indicated the MD made a visit at the request of nursing staff. "she remains confused. She had not slept the last 2 nights. She has been getting out of bed on her own and setting off the bed alarm. She was found in the hallway by her room twice. She has been restless. I evaluated her this afternoon. Her daughter was at the bedside. [Resident 162] remains confused. She is disoriented to place. I asked her about her hip, and she seems surprised to hear that she had a recent hip fracture. She denies pain...." At that time, the MD gave new orders to increase her Seroquel to 50 mg and prescribed 50 mg of trazadone as needed to achieve sleep.

An Interdisciplinary Team (IDT) progress note, dated 4/3/23 at 3:00 p.m., indicated "seems to have increased anxiety. Asking repeatedly where are my sisters. Does not recall having a fall or surgery...."

A nursing progress note, dated 4/4/23 at 11:47 p.m., indicated the alarm to Resident 162's bed

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	sounded throughout the shift as the resident attempted to transfer without assistance. During one episode, she was found to be entirely out of bed on her feet when the alarm sounded. She was at the end of the bed as she attempted to disarm the alarm, and the bed alarm sensitivity was increased. A nursing progress note, dated 4/5/23 at 2:09 p.m., indicated around 10:00 a.m., the resident started to get anxious and was fixated on thinking she was going to go get in her car and go home. Staff had either been in her room or just outside of the room to ensure her safety because the chair alarm was causing some slight anxiety earlier in the day. A nursing progress note, dated 4/6/23 at 3:51 p.m., indicated Resident 162's chair alarm sounded, then was quiet. Staff looked up to find Resident 162 walking by herself with no walker and no gait belt. As staff entered the room, she became agitated and stated she was ready to go home. Resident 162 was assisted to the bathroom, then put back to bed. Within a few minutes the bed alarm was heard, and the resident was noted as she stood at the side of the bed. She became agitated and anxious with staff and stated she wanted to go home. She was reassured and assisted back to bed. Again, within a few minutes the bed alarm sounded, and Resident 162 was anxious and agitated sitting on the side of the bed putting her shoes on. She stated she just needed to go home and attempted to persuade staff to take her home. She was not easily redirected and stated the staff were going to keep her here and she was going to die there as she began striking the bed. A nursing progress note, dated 4/6/23 at 6:19 p.m., indicated Resident 162 continued to be increasingly confused in the evenings. She got			

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	out of bed repetitively and expressed frustration about knowing she was confused and knew she was confused and kept forgetting things. She continued to think staff stole her car and purse. Staff continued to try and reassure her and redirect but most of the time was unsuccessful. A nursing progress note, dated 4/8/23 at 4:18 p.m., indicated Resident 162 continued to turn off the chair and bed alarms and was noncompliant with asking for assistance with transfers. She became increasingly confused over the day and was in her room packing her things as she stated it was time to go home. Caregiver tried to redirect and reassure her but she still continued to be agitated and walked around without her walker regardless of education provided. A nursing progress note, dated 4/10/23 at 4:08 p.m., indicated Resident 162 verbalized an intent to hurt herself. She stated she was very frustrated with having to be in a facility and related to her dementia she did not remember why she was there. She told the sitter staff better not leave anything in her room she could hurt herself with because she would. Resident 162 was already placed on 1:1 with a sitter prior to this incident related to her impulsiveness and dementia. The MD and family were notified. MD would be in later that evening to evaluate her, and the family member contacted indicated the resident had a history of making such statements out of frustration but with no intent to actually hurt herself. On 4/12/23 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Dementia- Clinical Protocol," revised 11/2018. The policy indicated, "...Treatment and Management: for individuals with confirmed dementia, the IDT will identify a			

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	resident-centered care plan to maximize remaining function and quality of life...." EnMotion was described as a "unique unit that provides a home-like atmosphere for patients to recover. Private accommodations are available, as is the delivery of all meals. Additionally, our associates schedule daily activities to get patients engaged...." On their website located at: https://www.hendricks.org/services/enmotionrecoverycare 3.1-3(a) 3.1-3(t)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to ensure person-centered, individualized dementia care services and activities were provided for a resident, (Resident 162) who experienced a decline in her cognition after surgery which resulted in increased frustration, agitation, and verbalized thoughts about self-harm for 1 of 1 resident reviewed for dementia care services. Findings include: On 4/10/23 at 11:15 a.m., Resident 162 was initially observed. The head of her bed (HOB) was elevated so she sat at an approximate 60-degree angle, so she sat upright. Her legs were extended out straight, and a blanket was over her lap. She	F 0744	**F744 Treatment/Service for Dementia** I. Steps taken to ensure deficiency involving resident who displays or is diagnosed with dementia receives appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being. a. DON reviewed resident medical record and plan of care and discussed resident behavior secondary to alarm with interdisciplinary team members and instructed all that no alarms	04/27/2023

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	played a game of solitaire on a hand-held tablet. In conversation, she was unable to recall when, why, or how she ended up in the facility. She was pleasantly confused, but exhibited some signs of embarrassment when she could not recall her grandchildren's names, which in turn made her frustrated. There was a staff member in the room who sat in a visitor chair and identified herself as a "safety sitter." During an interview, on 4/10/23 at 11:20 a.m., the Safety Sitter indicated she was a Registered Nurse (RN) who worked in the pediatric unit of the hospital, but she had asked to come with Resident 162 to keep her from getting up without assistance. RN 17 indicated she had been told Resident 162 was impulsive and forgot she should not get out of bed by herself since she had recently had surgery to repair a broken hip. RN 17 indicated she worked mainly in pediatric and did not have much experience and had no training on how to work or communicate with people who have dementia, and she was running out of answers to give Resident 162 for her repeated questions about where she was and when she could go home. On 4/10/23 at 3:23 p.m., Resident 162 remained in her bed as she played games on her tablet. On 4/11/23 at 9:10 a.m., Resident 162 was observed. The HOB was elevated to a 90-degree angle as she sat upright and ate her breakfast. Resident 162 was pleasantly confused and asked what buildings outside her window were and why she was in the facility. A different Safety Sitter was observed as she sat in a chair directly outside of Resident 162's room within line of sight. During an interview, on 4/11/23 at 9:15 a.m., the		are to be used with patient due to increased frustration and confusion while sitter present. b. DON provided staff education that when there is a 1:1 sitter with patient, they are not permitted to have a bed or chair alarm in use at that time (education evidence uploaded into Gateway). c. Instituted a new practice that all patients with dementia diagnosis will have person centered interventions and activities discussed at clinical meeting Monday- Friday and instituted as part of their plan of care to specify/detail what kind of sensory stimulation, how to provide, when to provide, or what to provide effective 4/27/2023. During interdisciplinary careplan meetings with resident family members or guardian, DON or clinical coordinator will seek typical patient preferences known in home setting. d. Instituted a change to expand the SNF activity program flowsheet to include an assessment at time of admission if the resident preferred their room door open or closed. e. Evaluated patient preference form in electronic medical record for door open or closed, and work order placed with Information Systems department to modify the SNF activity program flowsheet to include asking all	

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	Safety Sitter indicated she was a Unit Clinical Assistant (UCA) who worked in the Childbirth unit of the hospital but had been asked to come sit with Resident 162 as a fall precaution. UCA 18 indicated she had moved to a chair outside of the resident's room as Resident 162 had become upset with someone being in her room, and it made her frustrated, so she moved out of the room to give her more space but still needed to be able to see her. On 4/11/23 at 11:04 a.m., Resident 162 was observed as she remained seated upright in her bed. Although there was a puzzle and some other word game books, Resident 162 indicated she didn't want to do them because she had already looked at them all. She preferred to just play on her tablet. She made pleasant conversation about family but was unable to recall her grandchildren's names. After a few minutes of conversation in which she was observed to have trouble finding the right words, Resident 162 appeared to become sad and embarrassed, she indicated, "you'll have to excuse me, my mind is a bit confused." On 4/11/23 at 11:13 a.m., a Physical Therapist (PT) 20 entered Resident 162's room, (without knocking) and asked the resident if she was ready for therapy. Resident 162 indicated she did not know where she was supposed to go, but PT 20 assured her it was time to go to therapy and do some exercises. When PT 20 assisted her to stand up from the bed with her walker, a long, loud, and high-pitched alarm sounded, the box at the end of her bed began to blink red, and call light bell chimed and blinked. Resident 162 immediately began to smack at the head of her bed and pillow, and she moved the pillow to look under it. With a tone of annoyance and frustration she grumbled, "oh that darn thing!" PT 20 moved to the end of		residents if they preferred their door to be open or closed. f. In-serviced activities coordinator of new process to ask all patients at time of admission if they prefer their room door to be open or closed. g. DON educated all interdisciplinary team members to knock or ask permission prior to all patient rooms out of respect for their privacy (education document uploaded in Gateway). h. DON or clinical coordinator will round on all dementia patients a minimum of three times weekly until 100% compliant for 3 weeks to ensure appropriate person-centered interventions are in place, alarms are not in place if a sitter is being utilized to keep patient safe and to observe that all staff are knocking or asking permission before entering a resident's room (see dignity/privacy audit tool attached). i. Administrator and DON evaluated staff annual dementia education program and additional dementia training courses available. DON informed education department to add two dementia education courses to all enMotion staff members annually including: i. Dementia Care 1, Mental Decline and Caregiving Challenges	

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	the bed and pushed a button to turn the bed alarm off, and several other nursing staff entered the room to check and turn off the call light. On 4/11/23 at 12:02 p.m., Resident 162 was observed back in her bed, seated upright, and ate her lunch. UCA Safety Sitter 18 remained in a chair outside of her room and watched. On 4/11/23 at 1:08 p.m., Resident 162 remained in her bed, seated upright, and played on her tablet. On 4/11/23 at 1:18 p.m., Resident 162 became restless and began to move around and reposition herself in her bed. UCA 18 stood up from her chair outside and entered the resident's room (without knocking) and indicated, "you're not trying to get up, are you?" On 4/11/23 at 1:26 p.m., Resident 162 asked the Safety Sitter UCA 18 when she was going to go home. UCA 18 indicated, "you already asked me that, I don't know, we need to ask your nurse." On 4/11/23 at 1:28 p.m., the Post-Acute Rehab Coordinator (PARC) entered Resident 162's room and brought a new pair of socks. Resident 162 asked when she was going home. The PARC indicated she did not know when, but it was the plan for her to go home, but it would be up to her doctor. Resident 162 indicated she did not need to see a doctor because she was not sick. The PARC re-oriented by asking, "don't you remember you fell and broke your hip, so now you need to stay here and get stronger and better, then you can go home." Resident 162 shrugged her shoulders and indicated she did not remember the fall, the fracture, or her surgery. The PARC indicated "well, it's very normal to be confused when you are in a place like this, we have a lot of lights on all		ii. Dementia Care lll, Understanding and Managing Difficult Behavior (see email instruction to education department uploaded in Gateway). j. All hospital nursing staff who could potentially float to assist enMotion residents as a sitter will have revised onboarding and annual training to include Dementia Care 1, Mental Decline and Caregiving Challenges and are to complete by 10/31/2023. k. Broadened hand-off report process for all sitter staff to include patient mental and cognitive function, preferences for activity, door open or closed, interactive activities and most effective way to communicate with individual patient. l. Administrator in training and DON will attend IHCA workshop on Mastering the Art and Science of Dementia Care on May25, 2023 to learn and then educate interdisciplinary team and activities coordinator on best practices learned in workshop for caring for residents with dementia to include: i. The Vital 5 Pillars of Effective Dementia Care ii. New advances in our understanding of Alzheimer's iii. Non-pharmacological	

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	the time, and it's busy with a lot of people coming and going, it's very different than home." Even though the PARC spoke with a gentle and kind voice as she attempted to make Resident 162 feel better, the resident continued to look confused and insisted she was not sick and did not know why she needed to stay. During an interview, on 4/11/23 at 1:32 p.m., the PARC indicated Resident 162 was pretty confused most of the time. When she first came, they thought it was due to "acute delirium" from undergoing surgery, as her daughter indicated it had happened in the past. However, it had been too long since the surgery to still be acute delirium and this would likely be her new baseline due to her dementia. Because of her increased confusion, she forgets she had surgery and would try to get up by herself, so alarms were placed on her bed and chair. It depended on the day she had if it bothered her or not. Some days she would get really frustrated with them and other days she didn't pay any attention to them. Staff started noticing she was getting more agitated and repeatedly asked when she was going home. She started to think staff had stolen her car and purse and was paranoid. So this was when it was decided to have a "sitter" with her to help keep her from falling and to get help when she started to get upset, which was usually around 4:00 p.m., in the evening, which was very much like Sundowners, (restlessness, agitation, irritability, or confusion that can begin or worsen as daylight begins to fade, often just when tired caregivers need a break. Sundowning can also continue into the night, making it hard for people with Alzheimer's to fall asleep and stay in bed). During an interview, on 4/11/23 at 1:43 p.m., the Activity Director (AD) indicated EnMotion did		techniques to influence behavior iv. New research about how to improve symptoms of depression, anxiety, suicidality and other mental health challenges. How to make bathing, dressing, toileting and medication assistance more positive experiences. v. How to create effective physical environments m. In order to protect patient dignity and privacy, DON or Administrator will provide then ongoing education with staff caring for dementia patients as needed based on monitoring findings. n. Citation monitoring will be presented and discussed in department meetings and enMotion Recovery Care QAPI meetings throughout 2023.	

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	not usually get a lot of residents like Resident 162 who had more advanced confusion. Resident 162 was still high functioning enough to play puzzles and color, or she liked to play on her tablet, so she did not need more adaptive activities such as sensory stimulation or fidgets. The AD indicated staff kept several types of activities in Resident 162's room for her to use at her leisure and some days it seemed to be enough but other days, "like yesterday, she wouldn't accept anything and was like, 'get out of my face!' so it depended on how she was in the moment, which could change quickly too." Yesterday she seemed to have a pretty bad day, and so the AD went down and tried to talk with her. Resident 162 had been asking about going home and had gotten upset she was not allowed to leave. The AD presented her with several options of activities to do in her room, but she refused everything and made self-harm statements like, "well if I have to live like this, I'll just kill myself!" Then she forgot she even said something like that. The safety sitters were good to have to help keep her from falling but could also help make sure she did not actually try to harm herself. The AD indicated Resident 162 was not super happy about the sitter either though, she didn't like them in her room, she'd say she didn't need one because, "I'm an adult person!" On 4/11/23 at 2:23 p.m., Resident 162 began to move around in her bed. The UCA Safety Sitter stood and entered her room (without knocking) as Resident 162 moved herself to a seated upright position on the edge of her bed. Resident 162 asked when she was going to be allowed to go home and UCA 18 indicated, "you have to stay in here," then assisted her to lay back and put her feet back in bed.			

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	On 4/11/23 at 2:30 p.m., Resident 162 stood up from bed with UCA 18's assistance. The bed alarm sounded, and Resident 162 smacked at her pillow and looked for the sound to turn it off. UCA 18 turned off the alarm and assisted Resident 162 to stand by her window and look outside. She asked repetitive questions about where they were, why she was there, and when she could go home. UCA 18 asked if Resident 162 was in any pain to which Resident 162 indicated she was having a little bit of pain, but she did not know why. UCA 18 indicated Resident 162 would need to sit back in bed, and she needed to turn her alarm back on so she could go let the nurse know about her pain. On 4/11/23 at 2:32 p.m., RN 10 entered Resident 162's room (without knocking). He asked Resident 162 what kind of pain she had, but Resident 162 indicated she was ok, and did not have any pain she just wanted to go home. RN 10 asked if she would like to take a walk about the unit, and Resident 162 indicated, "not really, I'd just feel like I was wandering around," but a few moments later she was agreeable and assisted to walk a lap around the unit, to the therapy gym where she sat down and completed some arm exercises. During an interview, on 4/11/23 at 2:43 p.m., UCA 18 indicated she worked in the Childbirth unit, so working with Resident 162 was a big difference. She did not have any experience working with people with dementia, and indicated it was challenging, but she did not mind, and Resident 162 was really sweet. She just asked the same questions over and over, so it's hard to think of answers sometimes. On 4/12/23 at 9:14 a.m., Resident 162 was observed in her bed with the HOB elevated as she ate breakfast. A Safety Sitter sat in the visitor			

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	chair beside her bed. Although Resident 162 was pleasant and polite, her answers to questions were not as animated as the previous day, and she indicated she felt, "ok, but not ready to take over the world yet." She turned to the Safety Sitter and asked, "do you know why I'm here?" The Safety Sitter explained, she had fallen and broken her hip, so she went to the hospital to have surgery, now she was here to recover. Resident 162 shrugged her shoulders and shook her head "no," then continued to eat. During an interview, on 4/12/23 at 9:16 a.m., the Safety Sitter indicated she was a RN who worked on the Medical Floor. RN 19 indicated she had some experience working with people who have dementia, but it was not her specialty. So far, Resident 162's main behavior was asking repetitive questions. During an interview, on 4/12/23 at 10:00 a.m., the Director of Nursing (DON) indicated Resident 162 had made progress in therapy but seemed to be coming to a plateau. She was stable from a skilled nursing perspective and with therapy coming to an end she would discharge soon, but not before the facility and family could ensure a safe discharge which could take some time. During her stay at EnMotion, it had become apparent her cognition had significantly declined and she would likely not return to her previous mental functioning, and this seemed hard for the family to accept. With her confusion, and increased anxiety, she kept trying to get up and walk around on her own, so the alarms were placed as a fall precaution. There were times when she became frustrated with the alarms so staff would turn it off and place a sitter with her instead. Her short-term memory was so compromised she did not remember getting upset about the alarms, except			

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the chair alarm, she was clearly getting agitated with it, so it was removed. The alarms should be on if a sitter was too far away or if her door was closed, but it did not need to be on if someone was with her.

During an interview, on 4/12/23 at 10:26 a.m., Resident 162's daughter indicated it seemed like her mother was a little bit more of a challenge for the staff than some of the other residents in the facility. When asked about the alarms on her bed and chair, she indicated, her mother hated them. In the couple of weeks, she was able to stay and visit with her mother in the facility, she observed her to get very mad and aggressive with the alarms. She would say things like, "oh I wish that thing would stop!" She understood it was there to help remind her mother not to get up without assistance, but it did not do any good because she would immediately forget. Her mother was not very happy with the sitters in her room either. Since she was so confused, she often thought she was at home, so she would be confused about why those strangers were in her house. Although the staff had been very willing and available to talk about her mother's condition, especially in conversation/determinations about whether this was still acute delirium or symptoms of her Alzheimer's, it just didn't seem like they were equipped to handle her confusion and behaviors.

On 4/11/23 at 10:00 a.m., Resident 162's medical record was comprehensively reviewed.

She admitted to the facility on 3/28/23 following surgery to repair a broken hip.

She had current diagnoses which included but were not limited to; left displaced femoral neck fracture (hip fracture), acute delirium, and

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	Alzheimer's disease (a progressive and incurable brain disorder that slowly destroys memory and thinking skills). She had a care plan, initiated on 3/29/23, which indicated Resident 162 had an altercation in behavior described in a timeline format of her behaviors as follows: 3/28 impulsive and consistently jumping out of bed, bed alarm placed for safety. 3/28 physical towards others, threatening behavior, pushing. 3/29 physical towards others, threatening behavior, pushing. 3/30 found in hallway by room twice, reported by RN to MD, reoriented to room/unit. 4/1 wandering. 4/2 required a sitter for overnight due to confusion. 4/5 occasionally standing up without asking for assistance. 4/6 agitation throughout day, redirection provided each time. 4/7 patient had no signs/symptoms of fear or anxiety related to use of chair alarm. Patient continued to move freely with use of bed/chair alarm. Patient able to shut off bed/chair alarm. Patient up and down most of shift. Patient repetitively confused and wanting to go home. Patient in recliner at this time with family at bedside. 4/8 supervision due to noncompliant with bed/chair alarms and was not able to use her call light for assistance. Patient attempted to get out of bed per self and not use her walker. 4/8 patient continued to turn off chair and bed alarm. Patient noncompliant with asking for assistance with transfers. Patient had become increasingly confused over the day per her normal. Patient up ambulating around room with			

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	caregiver packing her things stating it was time to go home. Caregiver tried to redirect and reassure but patient agitated and walking around without walker regardless of education provided. 4/10 noncompliance with bed alarm, had 1:1 sitter at all times for supervision. 4/11 constant 1:1 supervision due to noncompliance with bed alarm and call light. Interventions for this plan of care included, but were not limited to, plan activities of interest with the resident as she enjoyed arts/crafts, puzzles, using her tablet, being with family, working in her yard, and reading the newspaper. She had another care plan, initiated on 3/31/23, which indicated Resident 162 had altered mental status due to her diagnosis of Alzheimer's Disease. Interventions for this plan of care included, but were not limited to, provide individualized sensory stimulation (but did not specify/detail what kind of sensory stimulation, how to provide, when to provide, or what to provide). Resident 162 had a third care plan, initiated on 3/30/23, which indicated she had cognitive loss due to dementia. The goal for this plan of care indicated "resident will return to previous cognitive status," (an unrealistic goal considering dementia was degenerative, progressive, and incurable). Interventions for this plan of care included, but were not limited to, using reality orientation as needed, (reality orientation was an attempt to provide real-time factual information which was often difficult or impossible for people with short-term memory loss or mid-stage dementia to remember or even understand much of the information).			

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	A care plan, initiated 3/20/23, indicated Resident 162 had communication deficient related to her Alzheimer's/dementia complicated by acute delirium during her hospital stay. She was confused and had significant short term memory loss. A care plan, revised 4/10/23, indicated Resident 162 had impaired moods and described, "4/10 note from MD: [Resident 162] has exhibited increased anger and agitation today. She told the nursing staff earlier today that she wanted to kill herself. Her daughter was contacted by phone. She informed us that her mother has made these comments in the past but never acted on them. They usually occur when she becomes angry or upset...Plan: discussed the situation with the daytime and nighttime nursing staff. I do not feel that [Resident 162] is at risk of harm to herself. We will continue to have a sitter with her day and night. Her door remains open. The room was surveyed looking for anything that would be potentially harmful. Will check urinalysis with reflex and culture. Continue Seroquel [an antipsychotic medication] to 50 mg [milligrams] at bedtime. If symptoms persist, may consider a twice daily dose. Provide trazadone 50 mg as needed to achieve sleep. Prolonged duration of confusion would suggest that [Resident 162] is not experiencing acute delirium but instead is exhibiting symptoms of chronic dementia...." A care plan, initiated 3/30/23, indicated Resident 162 was at risk for falls due to her impaired cognition/dementia, poor safety awareness, impulsivity, pain, and balance deficits. Chair/bed alarms were used to promote patient safety. The care plan lacked revision to include her agitation towards the alarms, when to use them and when to turn them off.			

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	A physician's progress note, dated 3/30/23, indicated the MD made a visit at the request of nursing staff. "she remains confused. She had not slept the last 2 nights. She has been getting out of bed on her own and setting off the bed alarm. She was found in the hallway by her room twice. She has been restless. I evaluated her this afternoon. Her daughter was at the bedside. [Resident 162] remains confused. She is disoriented to place. I asked her about her hip, and she seems surprised to hear that she had a recent hip fracture. She denies pain...." At that time, the MD gave new orders to increase her Seroquel to 50 mg and prescribed 50 mg of trazadone as needed to achieve sleep. An Interdisciplinary Team (IDT) progress note, dated 4/3/23 at 3:00 p.m., indicated "seems to have increased anxiety. Asking repeatedly where are my sisters. Does not recall having a fall or surgery...." A nursing progress note, dated 4/4/23 at 11:47 p.m., indicated the alarm to Resident 162's bed sounded throughout the shift as the resident attempted to transfer without assistance. During one episode, she was found to be entirely out of bed on her feet when alarm sounded. She was at the end of the bed as she attempted to disarm the alarm, and the bed alarm sensitivity was increased. A nursing progress note, dated 4/5/23 at 2:09 p.m., indicated around 10:00 a.m., the resident started to get anxious and was fixated on thinking she was going to go get in her car and go home. She was reminded she was there for rehab and her leg was still healing. Resident 162 quickly forgot information which was given to her and got frustrated because she didn't understand why she			

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	was there. She was encouraged to color, work on a puzzle, or play on her computer but she was not easily redirected. She would do well for a little while if she could talk to family but then became frustrated again because she wanted to be with them. Staff had either been in her room or just outside of the room to ensure her safety because the chair alarm was causing some slight anxiety earlier in the day. A nursing progress note, dated 4/6/23 at 3:51 p.m., indicated Resident 162's chair alarm sounded, then was quiet. Staff looked up to find Resident 162 walking by herself with no walker and no gait belt. As staff entered the room, she became agitated and stated she was ready to go home. Resident 162 was assisted to the bathroom, then put back to bed. Within a few minutes, the bed alarm was heard, and the resident was noted as she stood at the side of the bed. She became agitated and anxious with staff and stated she wanted to go home. She was reassured and assisted back to bed. Again, within a few minutes the bed alarm sounded, and Resident 162 was anxious and agitated sitting on the side of the bed putting her shoes on. She stated she just needed to go home and attempted to persuade staff to take her home. She was not easily redirected and stated the staff were going to keep her here and she was going to die there as she began striking the bed. A nursing progress note, dated 4/6/23 at 6:19 p.m., indicated Resident 162 continued to be increasingly confused in the evenings. She got out of bed repetitively and expressed frustration about knowing she was confused and knew she was confused and kept forgetting things. She continued to think staff stole her car and purse. Staff continued to try and reassure her and redirect but most of the time was unsuccessful.			

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	A nursing progress note, dated 4/8/23 at 4:18 p.m., indicated Resident 162 continued to turn off the chair and bed alarms and was noncompliant with asking for assistance with transfers. She became increasingly confused over the day and was in her room packing her things as she stated it was time to go home. Caregiver tried to redirect and reassure her, but she still continued to be agitated and walked around without her walker regardless of education provided. A nursing progress note, dated 4/10/23 at 4:08 p.m., indicated Resident 162 verbalized an intent to hurt herself. She stated she was very frustrated with having to be in a facility and related to her dementia she did not remember why she was there. She told the sitter staff better not leave anything in her room she could hurt herself with because she would. Resident 162 was already placed on 1:1 with a sitter prior to this incident related to her impulsiveness and dementia. The MD and family were notified. MD would be in later that evening to evaluate her, and the family member contacted indicated the resident had a history of making such statements out of frustration but with no intent to actually hurt herself. On 4/12/23 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Dementia- Clinical Protocol," revised 11/2018. The policy indicated "...Treatment and Management: for individuals with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life...nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-Service will be conducted at least annually thereafter...the facility will strive to optimize familiarity through			

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	consistent staff-resident assignments...the IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes and other relevant factors...." 3.1-37(a)			
F 0812 SS=D 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. Based on observation, interview and record review, the facility failed to ensure food was properly stored, labeled, and dated, to prevent the potential for contamination, failed to ensure bulk canned goods were screened for dented dents,	F 0812	**F812 Food Procurement, Storage/Prepare/Serve-Sanitary** I. Steps taken to ensure foods are properly stored,	04/13/2023

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	and failed to ensure food storage floors were maintained under generally clean conditions for 1 of 1 observation. Findings include: On 4/10/23 at 10:23 a.m., an initial kitchen tour was conducted with the Kitchen Director (KD). The food storage areas were observed. In the dry storage area, there was an open, unlabeled plastic bag with a flour-based mixture. The KD indicated it was a breading mix used for chicken which should have been closed and put back in its box. There were metal racks of bulk canned goods which were stocked with ready to pull items, however 2 cans of pizza sauce and 2 cans of preserved peaches were observed to be dented, (dented cans create the potential for botulism which is a deadly form of food poisoning that attacks the nervous system). The KD indicated kitchen staff should not put dented cans on the storage rack. Cans should be inspected as they are unloaded form the delivery truck and dented cans are returned. In the walk-in refrigerator, a commercial looped-end mop head was observed left on the floor with small debris items entangled and around the strands. There were 2 bulk storage plastic bins, one contained whole mushrooms and the other contained cut mushrooms. Nether tote had an identifying label or dates for use. In the walk-in freezer there were several items found unlabeled and undated: a. a plastic bag of pre-prepared hamburger patties,		labeled and dated a. Review NUT050 Policy Infection Control- Food Storage (Policy uploaded into Gateway) b. In-serviced and re-educated staff on Policy NUT050 to ensure all foods are labeled and dated per policy specifications. Re-education evidence documented on Policy NUT050 Acknowledgement form (form uploaded into Gateway) c. Instituted Daily Pre-service Checklist which is inclusive of ensuring dry storage areas and cooler food items are labeled and dated d. Broadened use Daily Pre-service Checklist (form uploaded into Gateway) e. Nutrition and Dietetics Director instituted a new process for the Team Leaders to monitor label and dating compliance daily f. Team Leaders will round in the department daily and utilize the Daily Pre-service Checklist to check and document compliance with appropriate food storage, labeling and dating. g. If there is any food product found improperly stored or not labeled/dated appropriately will be discarded immediately. h. Team leaders will then coach/re-educate staff or complete progressive disciplinary action if appropriate. i. Citation monitoring will be presented and discussed in	

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	which was also left open to air. b. a bulk storage plastic bin of what appeared to be green beans. c. an open to air bag of pre-prepared breaded pork tenderloins. Additionally, in the back of the walk-in freezer, there was a spilled white substance, which was dried and crusty and was observed to have splashed into other surrounding storage containers. The KD indicated it appeared to be milk, and staff should have cleaned up the spill immediately. On 4/10/23 at 11:39 a.m., the KD provided a copy of current facility policy titled, "Nutrition & Dietetics Infection Control- Food Storage," revised 12/2021. The policy indicated, " ... all bulk stored food or food items that aren't packages individually in food prep and storage areas are to be covered and labeled with identification, date prepared or opened date, and use by date ... proper storage of all food items should be ensured at time of delivery ... all foods/containers will be dated and labeled with contents and covered. The date used is the date the item is prepared/sliced or panned ...." On 4/10/23 at 11:39 a.m., the KD provided a copy of current facility policy titled, "Kitchen/Central Sterile Floor Maintenance," revised 11/2022. The policy indicated, " ...dust mop & run floor scrubber, wet mop where floor scrubber won't go includes cold storage rooms ...." On 4/10/23 at 11:39 a.m., the KD provided a copy of current facility policy titled, "Nutrition & Dietetics Infection Control- Food Storage," revised 8/2021. The policy indicated, " ... at time of receiving and storing of foods, cans and packages		department meetings and enMotion Recovery Care QAPI meetings throughout 2023. II. Steps taken to ensure bulk canned goods are screened for dents a. Dented cans found were discarded immediately during survey b. Review NUT049 Policy Infection Control- Food Preparation (Policy uploaded into Gateway) c. Revised NUT049 Policy to included dented cans “At time of receiving and storing of foods, cans and packages are inspected for damages. Any broken packages or dented cans or packages of food with an abnormal odor or appearance are returned to the vendor or destroyed.” Policy change was made on 4/13/23. d. In-serviced storeroom clerks on revised Policy NUT049 to ensure any dented cans are disposed of per policy. Re-education evidence documented on Policy NUT049 Acknowledgement form (form uploaded into Gateway) e. Instituted Daily Pre-service Checklist which is inclusive of ensuring there are no dented cans in dry storage areas. f. Broadened use Daily Pre-service Checklist (form uploaded into Gateway) g. Nutrition and Dietetics Director instituted a new process	

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	are inspected for damage. Any broken packages or swollen cans of food with an abnormal odor or appearance and returned to vendor or destroyed ..." 3.1-21(i)(3)		and educated the Team Leaders to monitor dry storage areas for dented cans compliance daily. h. Team Leaders will round in the department daily and utilize the Daily Pre-service Checklist to check and document compliance with bulk storage areas being free of any dented cans. i. If there is any food product found with a dented can, they will be discarded immediately. j. Team leaders will then coach/re-educate storeroom clerks or complete progressive disciplinary action when appropriate. k. Citation monitoring will be presented and discussed in department meetings and enMotion Recovery Care QAPI meetings throughout 2023. III. Steps taken to ensure food storage floors are maintained under generally clean conditions a. Nutrition and Dietetics Chef, Team Leader and Director toured the kitchen immediately day of survey, and had all food storage floors cleaned appropriately. b. In-serviced Team Leaders to do a daily walkthrough to assure cleanliness of the kitchen, dry storage, walk in cooler and freezer area floors are clean. c. Instituted Daily Pre-service Checklist which is inclusive of ensuring floors are clean and	

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			well-maintained (form uploaded into Gateway). d. In-serviced Team Leaders to do a daily walkthrough to assure cleanliness of the kitchen, dry storage, walk in cooler and freezer area floors are clean. e. Team Leaders will round in the department daily on AM and PM shift and utilize the Daily Pre-service Checklist to ensure food storage floors are clean and well-maintained. f. If there are any floors which need to be cleaned, they will be immediately by Team Leader or Housekeeper. g. Team leaders will then coach/re-educate storeroom clerks or complete progressive disciplinary action when appropriate. h. Citation monitoring will be presented and discussed in department meetings and enMotion Recovery Care QAPI meetings throughout 2023.	