STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155039	A. BUILDING 00 B. WING	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PERU SKILLED NURSING FACILITY, THE	317 BLAIR PIKE PERU, IN 46970

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 21, 22, 23, and 24, 2024 Facility number: 000014 Provider number: 155039 AIM number: 100288670 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 5 Medicaid: 14 Other: 15 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 8/5/2024	F 0000	**August 16, 2024** **Indiana State Department of Health** **Attn: Brenda Buroker, Director of Long Term Care** **2 North Meridian Street** **Indianapolis, In 46204** **RE: Survey Event ID EU6O11** **Dear Ms. Buroker,** **Please accept the enclosed plan of correction as a credible allegation of compliance to the deficiencies cited during our Recertification and State Licensure Survey conducted on July 24th, 2024 at Water's of Peru. Our latest date of compliance will be August 23, 2024.** **Hopefully you will find that our**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra L Coppernoll	Administrator	08/16/2024

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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			remedies are sufficient. Waters of Peru is respectfully requesting paper compliance. **If after reviewing our plan of correction, you have questions or require further information, please do not hesitate to call me at your convenience at 765-473-4426** **Sincerely,** **Debra Coppernoll, HFA** **Administrator**	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to provide written bed hold information to the resident and/or patient representative upon transfer to a hospital for 1 of 3 residents reviewed for hospitalization (Resident 5).	F 0625	**F-625 Notice of Bed hold Policy Before/Upon Transfer** **It is the policy of this facility to provide the resident or resident**	08/23/2024

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	Findings include: The record for Resident 5 was reviewed on 7/21/24 at 2:12 PM. Diagnoses included but were not limited to: disorder of central nervous system, diabetes mellitus, violent behavior, insomnia, psychotic disorder with delusions, anxiety disorder, and major depressive disorder. A Quarterly MDS (Minimum Data Set) Assessment, dated 4/17/2024, indicated a BIMS (Brief Interview for Mental Status) score of 6, severe cognitive impairment. A Progress Note, dated 7/15/2024 at 9:55 P.M., indicated the resident was sent to the emergency room for evaluation for abdominal distention and hyperactive bowel sounds. Nursing staff documented the bed hold policy was sent with the emergency medicine technician (EMT) staff. A Progress Note indicated the resident returned to facility on 7/20/2024. The clinical record did not contain documentation of written notification to the patient representative of the facility bed hold policy. During an interview, on 7/24/2024 at 10:47 A.M., the DON (Director of Nursing) indicated the facility had never mailed the bed hold policy to the family and have just notified family or patient representative by phone when the patient is cognitively impaired. She indicated all residents and families are given a copy of the bed hold policy at time of admission. During an interview, on 7/24/2024, at 2:14 P.M., the DON indicated that nurses should send the bed hold notice to the family by mail or email the		**representative with a written notice of the duration of the bed hold policy.** **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Resident #5 was affected by this deficient practice. The bed hold policy was mailed the resident representative on 8/5/2024 **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who are transferred out to the hospital could be affected by this deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-serviced nursing staff on the “Bed Hold Policy” on 8/21/2024. Additionally,	

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	policy. On 7/24/2024 at 2:12 P.M., the DON provided a document titled "The Waters Bed Hold Policy", and indicated it was the policy currently being used by the facility. The policy indicated "...facility to provide Resident, Resident's family member, and/or the Resident's legal representative...in written form and/or by a telephone conversation prior to transfer..." 3.1-12(a)(25) 3.1-12(a)(26)		any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** MDS Coordinator/Designee will complete the QA tool titled Notice of Bed Hold Policy (Attachment A). This tool will be completed daily (M-F) auditing residents that go out to the hospital 4 weeks, then weekly for 4 weeks, then monthly for 4 months.. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** All systemic changes will be completed by 8/23/2024	

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F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing Based on record review and interview, the facility failed to complete the resident Care Area Assessment in a timely manner for 1 of 13 residents reviewed for comprehensive assessments. (Resident 30) Finding includes: A record review of Resident 30 was conducted on 7/22/2024 at 11:09 A.M. Diagnoses included, but were not limited to: dementia, history of malignant neoplasm of the bladder, and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 7/2/2024, indicated Resident 30 was cognitively intact, was frequently incontinent of bladder and bowel, required substantial/maximal assistance for transfer and toileting hygiene, had minimal difficulty with hearing, and had broken or loose-fitting denture/partial and obvious or likely cavity or broken natural teeth. The MDS assessment triggered Care Area Assessments (CAA) (identification of problems, strengths and preferences) to be further evaluated and potentially care planned for urinary incontinence, dental care, activities of daily living (ADL) abilities, and communication. The CAA area for ADL's indicated this area was an actual problem/need. Resident 30 had triggered related to ADL's and transfers. Resident 30 was able to participate in ADL's requiring staff assistance up to partial/substantial assist to complete his ADL's. Resident 30 was receiving	F 0636	**F-636 -Comprehensive Assessments and Timing** It is the policy of this facility to complete comprehensive care plans for residents within 14 days. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Resident #30's comprehensive care plans were completed on July 23, 2024 by the MDS Coordinator. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The MDS Coordinator/Designee completed an audit of all residents Comprehensive/Annual MDS for completion of CAA and Care Plans on August 21, 2024. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; .	08/23/2024

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	therapy to help with his strengthening and endurance. The facility will continue to assist residents with ADL's, monitor for changes, and notify the physician as necessary. The facility will proceed to care planning. ADL abilities will be addressed in the care plan to slow or minimize decline, avoid complications, and minimize risks. The CAA area for urinary incontinence indicated and actual problem/need. Resident 30 had triggered for urinary incontinence related to Resident 30 required substantial/max assistance with toileting. Resident 30 was unable to resist voiding at times, requiring staff assistance with cleansing, and changing if incontinent episodes occurred. The facility will continue to assist Resident 30 with ADL's, monitor for changes, and notify the physician as necessary. The facility will proceed to care planning. ADL abilities will be addressed in the care plan to slow or minimize decline, avoid complications, and minimize risks. The CAA area for dental care indicated a potential problem/need. Resident 30 triggered due to having a partial plate, and noted broken natural teeth. The facility will monitor Resident 30 for any further issues and complaints. The facility will continue to monitor Resident 30 for any problems and notify the physician as needed. Dental care will be addressed in the care plan to slow or minimize decline, avoid complications, and maintain current level of functioning. The CAA area for communication indicated an actual problem/need. Resident 30 triggered due to being hard of hearing with minimal difficulty, he wears hearing aids, and had demonstrated no issue with the use of his hearing aids. The facility will continue to address any problems, notify the physician as needed, and proceed to care plan.		The Regional MDS Coordinator in-serviced the MDS Nurse on completion on comprehensive care plans related to Care Area Assessment. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** MDS Coordinator/Designee will complete the QA tool Titled **Comprehensive Assessments and Timing** (Attachment A). This tool will be completed weekly X 4 weeks, then monthly times 5 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. however, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency**	

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	Communication will be addressed in the care plan to slow or minimize decline, avoid complications, and maintain current level of functioning. During an interview on 7/23/2024 at 3:14 P.M., the MDS Coordinator indicated the comprehensive care plan should be completed within 14 days of the assessment reference date, and Resident 30's comprehensive care plan was not completed. On 7/24/2024 at 8:44 A.M., the MDS Coordinator indicated that Resident 30 was admitted to the facility on 6/28/2024. The completion of the MDS assessment was on 7/2/2024, and the CAA has 7 days from that date to be completed, and the comprehensive care plan had 14 days from that date to be completed. She indicated all comprehensive care plans should be completed by the 21st day of admission. A policy was provided, on 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy was from the Resident Assessment Instrument Manual, dated October 2023. The manual indicated, " ...The CAA[s] completion date must be no later than 14 days [of the admission date]. The care plan completion date must be not later than the 7 days after the CAA[s] completion date ...." 3.1-31(e)		**will be completed.** All systemic changes will be complete on 8/23/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure a comprehensive person centered plan of care was created for a resident with behaviors (Resident 5) and for a resident receiving hospice care (Resident 24) for 2 of 17 residents reviewed for comprehensive care plans.	F 0656	**F-656 – Develop/Implement Comprehensive Care Plan** It is the policy of this facility to ensure a comprehensive person centered plan of care is created for	08/23/2024

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	Findings include: 1. The record for Resident 5 was reviewed on 7/22/2024 at 8:46 A.M. Diagnoses included but were not limited to disorder of central nervous system, diabetes mellitus, violent behavior, insomnia, psychotic disorder with delusions, anxiety disorder, and major depressive disorder. Resident 5's current medications included Risperidone (anti-psychotic) 0.25 mg (milligram) 1 tablet by mouth at bedtime every Sunday for psychotic disorder and Risperidone 0.25 mg give 1 tablet by mouth two times a day six days a week for psychotic disorder. A current Care Plan, dated 5/7/2024, indicated the resident had agitation and physical behaviors demonstrated as throwing legs over the bed, posturing in the wheelchair/bed, cursing, hitting, pinching, and grabbing staff. Interventions included but were not limited to: administer psych medication as ordered, monitor medication side effects at least daily on psychoactive administration record, notify physician as needed, monitor quarterly for medication GDR (Gradual Dose Reduction) for psychoactive medication through pharmacy consultant and psychiatric services, and social services (SS) to visit as needed. Resident 5's clinical record lacked a person-centered Care Plan for behaviors. During an interview, on 7/24/2024 at 10:33 A.M., the Social Service Director indicated the interventions should have been individualized around the preferences of each resident. She indicated Resident 5 enjoys watching baseball,		residents with behaviors and receiving hospice care. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The MDS Nurse/Designee completed a person-centered care for resident 5 related to behaviors on August 21, 2024. The MDS Nurse/Designee completed a hospice care plan for resident 24 on August 21, 2024. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The MDS Nurse/Designee completed an audit for residents receiving hospice service and care plan completed if needed on August 21, 2024. The MDS Nurse/Designee completed an audit of residents with behaviors and updated the care plan with person centered interventions on August 21, 2024. **what measures will be put into place and what systemic changes will be made**	

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	old movies, and IU, and indicated the Care Plans for Resident 5 were not person-centered.2. A record review of Resident 24 was completed on 7/22/2024 at 8:33 A.M. Diagnoses included, but were not limited to: fracture of the humerus, wedge compression fracture of thoracic vertebra, and anxiety disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 6/1/2024, indicated Resident 24 was receiving hospice services. A Nurse's Note, dated 5/31/2024 at 10:33 A.M., indicated that the hospice company was at the facility to conduct a face-to-face evaluation, and that Resident 24 met the criteria for hospice services. A Physician's Order, dated 6/3/2024, indicated Resident 24 was admitted to hospice service on 6/1/2024 due to heart failure, COPD (chronic obstructive pulmonary disease), and acute respiratory failure related to terminal prognosis. A Care Plan could not be located in the medical record for hospice care. During an interview, on 7/24/2024 at 8:36 A.M., the MDS Coordinator indicated that Resident 24 should have a care plan for hospice care. During an interview with the MDS coordinator she indicated that the resident should have a hospice care plan that included contact information and coordination of care with the hospice company. A policy was provided on, 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy titled, "Baseline Care Plan Assessment/Comprehensive Care Plans", indicated, " ...The Comprehensive Care Plan will further expand on the resident's		**to ensure that the deficient practice does not recur**; The DON/Designee in-service the MDS nurse and Social Services or person-centered interventions for care plans related to behaviors and hospice care plans. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Social Service/Designee will complete the QA tool titled (Attachment A) Develop/Implement Comprehensive Care Plan. Social Service will audit 10 random residents a week for 4 weeks, then 5 random resident weekly x 4 weeks, then 5 random residents a monthly X 5 months related to person centered interventions for behaviors and hospice care plans.. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any	

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	risks, goals and interventions using the "Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs ...." 3.1-35(b)(1)		needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** 8/23/2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review an interview, the facility failed to revise and updat care plans for activities, residing on the memory care unit, an eye infection, a pressure ulcer, for 1 of 17 residents whose care plans were reviewed (Resident 18) Finding include: The record for Resident 18 was reviewed on 7/22/2024 at 3:07 P.M. Diagnoses included but were not limited to dementia, intellectual disabilities, Down syndrome, depression and congestive heart failure. An Annual MDS (Minimum Data Set) Assessment, dated 5/7/2024, indicated the resident activity preferences were books, magazines, newspapers, listen to music, being around animals. A current Care Plan, dated 1/18/2024 indicated, ACTIVITIES: Although the resident was considered cognitively impaired, is still capable of making decisions about activity involvement and	F 0657	**F-657 Care Plan timing and Revision** **It is the policy of this facility to ensure care plans are revised and updated for residents.** **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The MDS Nurse/Designee updated and revies care plans for resident 18 on August 21, 2024. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	08/23/2024

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	prefer to not attend some group activities. She stays busy watching TV, relaxing, coloring & communicating with staff & occasionally looking at magazines. Know Resident has times where she prefers to stay in her room or stay in the common area of the memory care unit ,color and watch what is going on around her. Interventions included, but were not limited to. She occasionally enjoys listening to music in the common area of the Boulevard (locked unit). A Care Plan, dated 10/21/2021, indicated: MEMORY CARE: The resident resides on the Memory Care unit. I benefit from the programming on this unit. Although it is a locked unit, she is able to come off the unit for special activities I enjoy with staff/family as desired. Secured Unit. Physician has certified resident is appropriate for this unit and programming. Specialized programming provided. The resident does not reside on the locked unit and does not receive specialized programming. A current Care Plan, dated 5/27/2024, indicated the resident had an eye infection and was non compliant with isolation and does not understand the rationale for it. The resident gets agitated and refuses to stay in her room even after multiple attempts from staff to try to make me understand why she needed to be in isolation. The record lacked any documentation of an eye infection at this time. A Care Plan, dated 5/8/2024, indicated the resident had developed an actual pressure injury. The record lacked any documentation of Resident 18 having a pressure injury at this time.		All the residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applied to all residents. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-service nursing staff and MDS nurse on the policy “Comprehensive Care Plans” on August 21, 2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Care Plan/IDT Team/Designee will complete the QA tool titled (Attachment A) Care Plan timing and Revision. Care Plan/IDT Team/Designee will audit of 10 random residents a week for 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random residents monthly X 5 months for activities, infections, and pressure ulcers. If the facility is within 95% compliance at the end of the 6	

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	During an observation, on 7/23/2024 at 2:18 P.M., of Resident 18's buttocks and thighs were free from pressure injuries. During an interview, on 7/23/2024 at 9:10 A.M., the Director of Nursing indicated the care plans were not updated and should have been revised. During an interview, on 7/23/2024 at 11:44 A.M., the Activity Director indicated the resident care plans were not updated and should have been. On 7/23/2024 at 1:27 P.M., the Social Service Director provided the policy titled,"Baseline Care Plan Assessment/Comprehensive Care Plans", undated, and indicated the policy was the one currently used by the facility. The policy indicated."...9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues...." 3-1.35(d)(2)(B)		months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** 8/23/2024	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review the facility failed to implement an activities program that incorporated the resident's interest and hobbies for 1 of 3 resident reviewed for activities. (Resident 18) Finding includes: During an interview, on 7/21/2024 at 10:51 A.M.,	F 0679	**F-679 – Activities Meet Interest/Needs Each Resident** It is the policy of this facility to implement activity programs that incorporate the residents interests and hobbies. **what corrective action(s) will be accomplished for those residents found to have been**	08/23/2024

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	155039	A. BUILDING 00 B. WING	07/24/2024

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	Resident 18's family indicated the resident used to like music and TV. During an observation, on 7/21/2024 at 1:44 P.M., Resident 18 was lying in bed with the television on, but unable to see it. The television was positioned above and at the back of her head. During an interview, on 7/22/2024 at 10:47 A.M.,CNA 3 indicated it depended on the resident if she wanted to or not to get out of bed. She indicated we try to encourage her. During an observation, on 7/22/2024 at 3:03 P.M., Resident 18 remained in bed with the bed sheet covering her face. The record for Resident 18 was reviewed on 7/22/2024 at 3:07 P.M. Diagnoses included but were not limited to dementia, intellectual disabilities, Down syndrome, depression, and congestive heart failure. An Annual MDS (Minimum Data Set) Assessment, dated 5/7/2024, indicated the resident had adequate hearing. The activity preferences were documented as books, magazines, newspapers, listen to music, and being around animals. During an observation, on 7/23/2024 at 8:37 A.M., Resident 18 was in bed with a sheet over her face. A current Care Plan, dated 1/18/2024 indicated: ACTIVITIES: The resident is considered cognitively impaired, and still capable of making decisions about activity involvement and prefer to not attend some group activities. She would like her preferences not to attend activities be honored by staff. She stays busy watching TV,		**affected by the deficient practice**; The Activity Director/Designee updated the care plan for television preferences for resident 18's on August 21, 2024. The DON/Designee re-arranged resident 18's room to enable resident to seen television on August 21, 2024. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All the residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applied to all residents. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The Administrator/Designee in-services staff on activity preferences on resident care plan and ensuring television is visible to resident on August 21, 2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicted.	

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	relaxing, coloring & communicating with staff & occasionally looking at magazines. Interventions included, but were not limited to: Through past history & staff interview it has been determined that religion is somewhat important to resident. Religious programs are on her TV program list. Staff offer to turn on for her. She occasionally enjoys listening to music in the common area of the Boulevard. Through past history and staff interview it has been determined that resident's favorite activities are: coloring, counting crayons, watching some TV and watching what is going on around her when she is in the common area. A pink care has been placed in the resident's room to assist staff in resident preferences for (TV shows, music, of other activities) resident might enjoy while in room. During an observation, on 7/23/2024 at 8:54 A.M., the residents room lacked a pink card for television preferences and the television was positioned where the resident could not see it. During an observation, on 7/23/2024 at 11:23 A.M., Resident 18 was in bed with coloring book and crayons in her hands. The television was on, but was placed above her bed to the back of her head where she could not see it. During an interview, on 7/23/2024 at 11:44 A.M., the Activity Director indicated the resident should be able to watch TV, but her bed was is in the wrong position and she should have had the pink list in her room. She indicated the resident did not attend the religious service on Sunday. On 7/23/2024 at 1:27 P.M., the Social Service Director provided the policy titled,"Activities Program", undated, and indicated the policy was the one currently used by the facility. The policy		**how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Activity Director/Designee will complete the QA tool titled (Attachment A) Activities Meet Interest/Needs Each Resident. Activity Director will audit of 10 random rooms a week for 4 weeks, then 5 random rooms X 4 weeks, then 5 random resident rooms monthly x 4 months for placement of television and activities per residents preference in place. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** 8/23/2024	

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	indicated"...It is the policy of this facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents. 6. Facility will provide activities that are appropriate for residents related to their interests, culture and background...." 3.1-33(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on record review and interview, the facility failed to properly use a mechanical lift for 1 of 1 resident reviewed for a facility reported incident, which resulted in a laceration to the scalp. (Resident 9) Finding includes: A record review of Resident 9 was completed on 7/23/2024 at 2:03 P.M. Diagnoses included, but were not limited to: paraplegia, obesity, and muscle weakness. A Quarterly MDS assessment, dated 6/11/2024, indicated Resident 9 was cognitively intact, and was dependent for transfers. A Nurse's Note, dated 6/22/2024 at 5:48 P.M., indicated that while transferring Resident 9 to his wheelchair with the Hoyer lift, the Hoyer lift tipped over onto the top of his head causing a 3-centimeter laceration. There was a moderate amount of blood initially, but stopped bleeding when pressure was applied. Neurological checks were within normal limits, but Resident 9 indicated after 10 minutes of the incident he was not feeling	F 0689	**-689 – Free of Accident Hazards/Supervision/Devices** It is the policy of this facility to ensure proper use of the mechanical lift by staff. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Resident 9 was assessed by the nurse on June 22, 2024 and sent to ER to evaluation and treatment. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents that require the use of a mechanical lift have the potential	08/23/2024

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	right, and complained of neck and head pain. Resident 9 was sent to the emergency room for further evaluation. On 6/22/2024 at 7:10 P.M., Resident 9 arrived back from the emergency room with steri-strips covering the sutures to the frontal skull. He complained of a minor to moderate headache. A Care Plan, dated 1/31/2021, and revised on 4/20/2023, indicated Resident 9 was a total assist for transfers with a mechanical lift. A facility reported incident was sent to the Indiana Department of Health, on 6/23/2024. The report indicated that CNA 12 and CNA 10 were transferring resident 9 with a Hoyer lift (mechanical lift) from his bed to the wheelchair. The Hoyer lift fell over as Resident 9 was being placed in the wheelchair making contact to his head. Resident 9 was immediately disconnected from the Hoyer lift, and an assessment was completed. Resident 9 sustained a 3-centimeter laceration to the top of his head. Resident 9 was transported to the local hospital. During an interview, on 7/23/2024 at 1:24 P.M., CNA 10 indicated that she and CNA 13 were getting Resident 9 up for supper. She indicated CNA 12 was using the Hoyer lift, and she was assisting. She indicated CNA 12 put the Hoyer lift legs in between the front wheels and back wheels of the wheelchair, and that the legs were not extended or locked. She indicated the Hoyer lift tipped over and hit Resident 9's head. She indicated she assisted in pulling the Hoyer lift off Resident 9's head. A review of CNA 12 and CNA 10 employee files indicated CNA 12 had completed the competency		to be affected by the cited practice, therefore, this plan of correction applies to resident requiring use of the mechanical lift for transfers. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-serviced nursing staff on the polit "Mechanical Lift Transfers/Usage" on August 21, 2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Staff Development/Designee will complete the QA tool titled (Attachment A) Free of Accident Hazards/Supervision/Devices. Staff Development will audit of 10 random staff members week for 4 weeks, then 5 random staff members monthly X 4 weeks, and then 5 random staff members for 4 months for proper use of the mechanical lift, this will include random shifts. If the facility is	

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	checklist for the use of the Hoyer lift on 10/1/2019, and CNA 10 had completed the competency on 4/19/2024. An Annual Skills Checklist was provided by the Executive Director that was completed on 3/20/2024-3/21/2024. CNA 12 completed the annual training which included use of the Hoyer lift. A policy was provided, on 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy titled, "Guidelines for Mechanical Lift Transfer/Usage", indicated, " ...About the Mechanical Lift ...16. Position the lift around the resident's bed/chair/surface. Base legs are usually more stable in the fully open position ...Using the Mechanical Lift ...32. The mechanical lift should be moved so that the extended legs slide under the bed [for bed transfers]. As stated prior, the mechanical lift legs are able to open and close to accommodate wheelchair transfers. 33. Slide the legs under the bed until the swivel bar hook of the lift is directly over the resident's abdomen. The legs are widened using the shift handle located on the back. Widening the legs is essential in order to get a stable base under the mechanical lift. 34. Apply the wheel lock so it does not move once the mechanical lift is in position ...." 3.1-45(a)(1)		within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed** 8/23/2024	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance 2. During an observation, on 7/21/2024 at 1:43 P.M., Resident 18 was observed with dry/cracked lips and her tongue had a coating. The residents water pitcher was not in reach of the resident.	F 0692	**F-692 Nutritional/Hydration Status Maintenance** It is the policy of this facility to provide interventions to prevent	08/23/2024

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	During an observation, on 7/21/2024 at 2:21 P.M., the resident tried to move the bed side table with the water pitcher on it but was unable to move it. The record for Resident 18 was reviewed on 7/22/2024 at 3:07 P.M. Diagnoses included but were not limited to: dementia, intellectual disabilities, Down syndrome, chronic kidney disease stage 3, dysphagia and congestive heart failure. An Annual MDS (Minimum Data Set) Assessment, dated 5/7/2024, indicated the resident required supervision/touching assistance during for eating. A current care plan, dated 8/26/2022, indicated Late loss ADL (activities of daily living): the resident needs limited assist with eating/drinking, supervision up to extensive assistance with bed mobility due to diagnosis of dementia and Down Syndrome. Interventions included, but were not limited to: assist at meals with tray set-up and meals/eating as needed. During an observation, on 7/23/2024 at 8:36 A.M., the water pitcher was on the over the bed side table not within reach of the resident. During an observation, on 7/23/2024 at 9:38 A.M., Resident 18's water pitcher was on the over the bed side table not within reach of the resident. During an observation, on 7/23/2024 at 11:58 A.M., Resident 18 was observed in bed, leaning to the left with her lunch tray on the over the bedside table. The resident was trying to hold onto a glass of chocolate liquid. Resident 18 drank 1/2 of the chocolate liquid and placed it back on the tray. Resident 18 was observed with		significant weight loss and provide adequate fluids. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The DON/Designee assessed residents 24 and 18 on August 21, 2024, interventions to prevent weight loss implemented. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All the residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applied to all residents. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-serviced the dietitian/designee on the “SWAT” and “Weight” policy and implementing interventions to prevent weight loss on Aught 21, 2024. Additionally, any staff members that fails to comply with	

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	dry/cracked lips and a coating on her tongue. There were no staff around the residents room to assist with her meal. On 7/23/2024 at 12:05 P.M., the Social Service Director entered the residents room and started to assist with her lunch meal. The Social Service Director observed the chocolate liquid was spilled on the blanket and indicated she would change the linens and would try to feed the resident. During an interview, on 7/23/2024, at 12:06 P.M., the Social Service Director indicated the residents' lips were dry and cracked and her tongue had a coating on it and she should have more liquids. On 7/23/2024 at 3:40 P.M., the Director of Nursing provided the policy titled,"Clinical Nutrition Documentation", dated 4/2017, and indicated the policy was the one currently used by the facility. The policy indicated "... Residents will be provided with a sufficient fluid amount and consistency to maintain proper hydration status...." 3.1-46(a)(1) 3.1-46(b) Based on observation, record review, and interview, the facility failed to provide interventions to prevent significant weight loss for 1 of 3 residents reviewed for nutrition, and failed to provide adequate fluids for 1 of 2 residents reviewed for hydration. (Residents 24 & 18) Findings include: 1. During an observation on 7/21/2024 at 1:42 P.M., Resident 24 was observed to appear thin		the points of this in-service will be further educated and/or disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/Designee will complete the QA tool titled (Attachment A) Nutritional Assessment Recommendations. The DON/Designee will audit weights weekly x 6 months for interventions to prevent weight loss. The DON/Designee will audit 10 random residents receiving weight loss prevention interventions weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 5 random residents monthly x 4 months for compliance with interventions. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator	

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	and frail. A record review was completed on 7/22/2024 at 8:33 A.M. Diagnoses included, but were not limited to: fracture of the humerus, wedge compression fracture of thoracic vertebra, and anxiety disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 6/1/2024, indicated Resident 24's nutrition was not assessed. A review of resident 24's weights indicated: - 3/18/24 86.0 (admission weight) - 3/30/24 76.8 - 3/31/24 75.5 - 4/8/2024 76.1 - 5/6/2024 79.6 - 6/4/2024 78.1 Physicians' Orders indicated the following orders: - Ensure Clear two times a day for Supplement 3/21/2024-3/26/2024. - Regular diet 3/30/2024 - Admitted to hospice 3/30/2024-4/12/2024. - Ensure Clear two times a day for Supplement 4/3/2024-5/28/2024. - Admit to hospice on 6/1/2024. A Nurse's Note, dated 3/19/2024 at 2:11 P.M., indicated Resident 24's daughter informed the staff that Resident 24 had vomited after she had eaten. The daughter indicated that Resident 24 only had 1/3 of her stomach with multiple surgeries completed, vomiting happened at times after meals, and had a history of weight loss due to not being able to keep down. A Mini Nutritional Assessment, dated 3/20/2024 at 8:16 A.M., indicated Resident 24 was		weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** **8/23/2024**	

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	malnourished. A Nutritional Assessment, dated 3/20/2024 at 8:27 A.M., indicated Resident 24 was lactose intolerant, drank one vanilla Ensure a week, and inadequate oral intake even though she reported her appetite as good. Resident 24 indicated her physician wanted her to gain weight to a minimum of 100 pounds. Her body weight index indicated she was underweight. Interventions recommended included Ensure Clear three times a day, and providing lactose-free alternatives. A Nurse's Note, dated 3/22/2024 at 12:07 P.M., indicated to hold the Ensure Clear for 3 days due to awaiting delivery. A Nutritional Assessment, dated 4/3/2024 at 7:15 A.M., indicated 12.2 percent weight loss in approximately 2 weeks. She had been readmitted to the facility from her hospitalization related to a fall and newly found tracheal mass. Her body mass index was 15.8, indicating she was underweight. An Interdisciplinary Note, dated 4/17/2024 at 12:53 P.M., indicated Resident 24 was receiving Ensure Clear 237 milliliters twice daily, and consumed 51-75 percent of her meals and approximately 50 percent of her supplements for 7 days. Continues to receive hospice services with weight loss anticipated and unavoidable as disease processes progress. No new nutritional recommendations were placed. An Interdisciplinary Note, dated 4/17/2024 at 12:53 P.M., indicated Resident 24 was receiving Ensure Clear 237 milliliters twice daily, and consumed 51-75 percent of her meals and approximately 51-75 percent of her supplements for 7 days.			

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	Continues to receive hospice services with weight loss anticipated and unavoidable as disease processes progress. No new nutritional recommendations were placed. Resident 24 was discontinued from nutritional monitoring. A Nutritional Assessment, dated 4/24/2024 at 8:21 A.M., indicated a 11.6 percent weight loss in approximately 2 weeks. Resident 24 had good supplement intake on most days, and does not accept snacks. Her body mass index was 15.8, indicating underweight, but closer to her self-reported usual body weight of 78 pounds. Resident 24 to continue with Ensure Clear. A Nurse's Note, dated 5/28/2024 at 3:03 P.M., indicated Ensure Clear was discontinued due to resident refusals and stating the drink makes her sick to her stomach. A Care Plan, dated 3/19/2024, and revised on 7/14/2024, indicated Resident 24 was at nutritional risk. During an interview on 7/24/2024 at 9:03 A.M., the Dietary Manager indicated that interventions should have been put in place when Resident 24 was not on hospice services from 4/13/2024-5/31/2024, and more options to further increase weight should have been put in place. A policy was provided on 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy titled, "Weights", indicated, " ...Nursing will notify the dietician or designee of any significant weight changes. Significant weight changes is defined as 5% change x [times] 1 month, 7.5% change x 3 months, 10% changes x six months ...."			

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WATERS OF PERU SKILLED NURSING FACILITY, THE	317 BLAIR PIKE PERU, IN 46970

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to follow physician's orders for oxygen use, and store oxygen tubing appropriately for 1 of 2 residents reviewed for oxygen therapy. (Resident 24) Finding includes: During an observation on 7/21/2024 at 9:43 A.M. and 10:32 A.M., Resident 24 was observed sleeping in bed, and her wheelchair was outside the room with the nasal cannula draped over the wheelchair seat. On 7/21/2024 at 2:40 P.M., Resident 24 was observed to be connected to the oxygen concentrator via nasal cannula. The oxygen concentrator was not on, and Resident 24 was sleeping, and was pale. On 7/21/2024 at 2:44 P.M., LPN 13 was requested to check Resident 24's oxygen saturations. Resident 24's oxygen saturation was 84 percent. LPN 13 requested Resident 24 to take several deep breaths, and then noted the oxygen concentrator was not on. The oxygen concentrator was placed on, and within several minutes Resident 24's oxygen saturations were 93 percent. LPN 13 stated, "There you go. You are pinking up." During an interview on 7/21/2024 at 2:55 P.M., CNA 3 indicated Resident 24 was in bed upon her arrival to the shift at 1:00 P.M. During an interview on 7/21/2024 at 3:01 P.M., LPN 13 indicated she was responsible for the transition of oxygen. She indicated she was not	F 0695	**F-695 Respirator/Tracheostomy Care and Suctioning** It is the policy of this facility to follow physicians orders for oxygen se and to store oxygen tubing appropriately. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The DON/Designee assessed resident 24 on August 21, 2024 and no negative outcome related to the alleged deficient practice. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The DON/Designee completed an audit on August 21, 2024 receiving oxygen for tubing dates and stored appropriately and physician orders. **what measures will be put into place and what systemic changes will be made to ensure that the deficient**	08/23/2024

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	aware resident 24 was in bed, but thought she was in an activity due to asking the CNA's to keep her upright due to previous vomiting. LPN 13 indicated she was not aware of how resident 24 transitioned from the portable oxygen tank to the oxygen concentrator. A record review was completed on 7/22/2024 at 8:33 A.M. Diagnoses included, but were not limited to: chronic respiratory failure, COPD (chronic obstructive pulmonary disease), and anxiety disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 6/1/2024, indicated Resident 24 was cognitively intact, on hospice therapy. The assessment indicated oxygen was not in use. A Physician's Order, dated 3/30/2024, indicated oxygen at 3 liter per minute per nasal cannula continuously. A Nurse's Note, dated 7/21/2024 at 2:50 P.M., indicated a nurse from the State Department of Health asked for an oxygen saturation of Resident 24. LPN 13 was unaware that Resident 24 had been placed in bed related to verbalizing to staff that Resident 24 needed to remain upright until further notice due to vomiting. LPN 13 thought Resident 24 was in an activity, and had not observed Resident 24 return to the unit. The oxygen saturation was obtained and noted to be 84 percent with the nasal cannula in her nares. LPN 13 noted the oxygen concentrator to be off. LPN 13 turned on the oxygen concentrator, and instructed Resident 24 in breathing exercises to increase her oxygen saturation. Resident 24's oxygen saturations recovered to 93 percent on 3 liters of oxygen via nasal cannula, her cheeks pinked up, and was smiling. Resident 24 indicated,		**practice does not recur**; The DON/Designee in-services nursing staff on August 21, 2024 on the policy “Guidelines for Transporting and Storage of Oxygen”. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DON/Designee will complete the QA tool titled (Attachment A) F-Respiratory/Tracheostomy Care and Suctioning The DON/Designee will audit residents receiving oxygen 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months for proper storage of oxygen tubing and following physician orders for oxygen. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written	

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	"I feel better than I did earlier." A Care Plan, dated 3/19/2024, and revised on 3/25/2024, indicated Resident 24 had chronic respiratory disease with the potential for exacerbation related to COPD and chronic respiratory failure. An intervention, dated 3/19/2024, indicated to administer oxygen as ordered. During an observation on 7/23/2024 at 8:34 P.M., the nasal cannula was draped over the back of the wheelchair. During an interview, on 7/24/2024 at 8:38 A.M., CNA 8 indicated that nasal cannulas should be stored in a respiratory bag when not in use. A policy was provided, on 7/24/2024 at 1:25 P.M., by the Director of Nursing. The policy titled, "Guidelines for Transporting and Storage of Oxygen", indicated, " ...Note: Only staff who have been educated on Oxygen storage and Oxygen administration will manage and administer oxygen ...." 3.1-47(a)(6)		by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed.** 8/23/2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review the facility failed to ensure physician ordered snacks were provided for 1 of 1 pantry areas observed and failed to ensure staff did not thumb the eating surface of dinner plates when serving in 1 of 2 dining rooms observed. This had the potential to affect all 34 residents who reside in the facility and who receive food from the kitchen.	F 0812	**F-812 Food Procurement Store/Prepare/Serve-Sanitary** **It is the policy of this facility to ensure physician ordered snacks are provided to the residents and that staff does not touch the**	08/23/2024

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	Findings include: 1. A food storage area on the south hall was observed, on 7/23/2024 at 1:08 P.M. In the refrigerator was a tray with snacks for 6 residents that were dated 7/22/2024, and a hard boiled egg in the side door. During an interview, on 7/23/2024 at 1:14 P.M., the Social Service Director indicated the snacks should have been passed out last night and the hard boiled egg should have been in a container. On 7/23/2024 at 2:12 P.M., the Administrator provided the policy titled,"Clinical Nutrition Documentation", dated 4/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...The Food & Nutrition department will send snacks to the nursing stations between meals and at HS. The Food & Nutrition department will maintain a system of "snack list" for labeling and delivering snacks to those residents that receive scheduled snacks as part of their plan of care/preference...."2. During a dining observation on 7/21/2024 at 11:49 A.M. through 12:10 P.M., staff was observed removing bread from a sandwich bag with their bare hands for a resident, thumbing dinnerware for 3 residents, and cupping the top of the glassware for 2 residents. On 7/22/2024 at 11:40 A.M. through 11:58 A.M., staff was observed thumbing dinnerware for 6 residents, and cupping the top of glassware for 2 residents. During an interview on 7/24/2024 at 10:58 A.M., the Director of Nursing indicated that the thumb should not be over the edge of the dinnerware,		**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The DON/Designee disposed of the July 22, 2024 snacks and hard boiled eggs in the refrigerator on the south hall on 7/23/2024 The DON/Designee assessed all residents on August 21, 2024 and no negative outcome related to the cited deficient practice. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All the residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applied to all residents **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-service staff on the proper handling of dinnerware on August 21, 2024. The DO/Designee in-serviced nursing staff on the administering of physician ordered snacks	

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	and the glassware should not be cupped. A policy was provided, on 7/24/2024 at 2:08 P.M., by the Director of Nursing. The policy titled, "Handling Tableware", indicated, " ...7. All tableware will be handled appropriately so that the eating surface of the utensil/tableware is not contaminated ...." 3.1-21(2)		timely and proper storage of food items in the refrigerators on the resident hallways on August 21, 2024. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DON/Designee will audit the hallway refrigerators 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months for proper storage of food items, The DON/Designee will audit physician ordered snacks given to resident 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will observe 10 random meals services weekly x 4 weeks, then 5 random meals services weekly x 4 weeks, then 5 random meal services monthly x 4 months for proper handling of dinnerware by staff. If the facility is 95% compliant after six months the monitoring will stop. Any concerns will be addressed immediately and have a Quality Assurance and Quality improvement action plan	

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			completed. The action plan will be reviewed at the monthly QAPI meeting with changes made as appropriate. **by what date the systemic changes for each deficiency will be completed.** 8/23/2024	
F 0880 SS=D 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 staff changes gloves and completed hand hygiene when providing peri care for 1 of 1 resident reviewed for peri care. (Resident 14) Finding includes: On 7/22/2024 at 1:25 P.M., CNA 3 and CNA 7 was observed providing peri care to Resident 14. CNA 3 washed her hands and applied gloves. CNA 7 rolled the resident to the right side and pushed the brief under the resident. CNA 3 removed the brief from under the resident. CNA 3 used a soapy washcloth and wiped the residents left groin area, then with the same area of the washcloth,wiped the right groin area. CNA 3 moved the residents penis and wiped underneath it with the same area of the washcloth and then wiped towards the groin area. CNA 3 then dried the areas with a towel. CNA 7 turned the resident to his left side and CNA 3,with her dirty gloves applied a clean brief to the resident. CNA 3 removed the bed sheet and covers due to wetness. CNA 3 & CNA 7 applied clean linens to the bed. CNA 3 was observed to move the residents pillow, adjust his clothes and move his	F 0880	**F-880 Infection Prevention & Control** It is the policy of this facility to ensure staff changes gloves and complete hand hygiene when providing peri care. **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The DON/Designee assessed resident 14 and no negative outcome related to the cited deficient practice on August 21, 2014. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	08/23/2024

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	hands with the dirty gloves still on. During an interview, on 7/22/2024 at 1:57 P.M., CNA 3 indicated she did not remove her gloves and wash her hands and should have when she completes peri care for any resident. On 7/24/2024 at 1:30 P.M. the Social Service Director provided the policy titled, "Guidelines For Incontinence Care", undated and indicated the policy was the one currently used by the facility. The policy indicated"...5. Apply latex free non-sterile gloves...12. ...Use separate area of cloth for each stroke... 16. Remove and discard gloves. 17. Perform hand hygiene. 18. Apply clean linen or underpad, brief or other incontinent product(s) as needed...." 3.1-18(a)		All the residents that reside in the facility have to potential to be affected by the cited practice, therefore, this plan of correction applied to all residents. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The DON/Designee in-service nursing staff on hand hygiene and the policy “Guidelines for Incontinence Care” on August 21, 2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DON/Designee will observe 10 random staff members providing incontinence care for hand hygiene and glove changes weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 5 random staff members monthly x 4 months, these observation will include all shifts. If the facility is within 95%	

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			compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **by what date the systemic changes for each deficiency will be completed** 8/23/2024	