STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155419	A. BUILDING 00 B. WING	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT CRAWFORDSVILLE	817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 17, 20, 21, 22, and 23, 2024 Facility number: 000533 Provider number: 155419 AIM number: 100267230 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 0 Medicaid: 26 Other: 8 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 3, 2024.	F 0000		
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua	Jackson	06/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on interview and record review, the facility failed to ensure that personal funds were available on the weekends for 1 of 16 residents reviewed for personal funds (Resident 19). Finding includes: During an interview, on 5/17/24 at 11:36 a.m., Resident 19 indicated she was not able to get money on the weekends and hadn't been able to	F 0567	**Protection and management of Personal funds** **The resident has the right to manage his or her financial affairs.** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Money will be available for	08/21/2024

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	for a while. Resident 19's record was reviewed on 5/22/24 at 2:00 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/1/24, indicated the resident was cognitively intact. During an interview, on 5/22/24 at 2:30 p.m., the Business Office Manager (BOM) indicated the residents could obtain their money out of their personal funds Monday through Friday. She was not at the facility on the weekends and had not been employed by the facility for very long. She wasn't aware of the procedure for the weekends. During an interview, on 5/22/24 at 2:33 p.m., the Corporate Business Office Specialist indicated a money bag should be kept at the nurse's station so the residents could obtain the money on the weekends. She was not sure where it was kept exactly at this facility. She indicated they had not had consistent business office staff at the facility for a while. Staff and residents needed to be educated on the procedure for obtaining personal funds on the weekends. During an interview, on 5/22/24 at 2:39 p.m., Licensed Practical Nurse (LPN) 6 indicated she was not aware of any money bag being at the nurse's station on the weekends for the residents to have personal funds. During an interview, on 5/22/24 at 2:41 p.m., Registered Nurse 3 indicated there had not been a money bag or cash box at the facility for personal funds. She indicated the Director of Nursing had recently purchased a cash box that she thought was for personal funds, but they had not been educated on the process yet.		residents outside of business hours. Resident 19 has been informed of the ability to obtain money on the weekend. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. All residents will be notified of the availability of funds outside of business hours through signage posted in common areas. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The facility Administrator or designee will ensure money is available for residents outside of business hours. Money will be kept in the nursing cart with count sheet. BOM or designee will ensure all residents are aware of process to obtain monies outside of business hours Through signage posted in common areas. Nursing staff will be in-serviced on process of providing residents with funds on off hours. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Administrator, or designee, will complete the personal funds CQI tool. Weekly for one month	

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	On 3/22/24 at 3:01 p.m., the Regional Director of Clinical Services provided an undated document titled, "Resident Trust Overview," and indicated it was the policy currently used by the facility. The policy indicated, " ...Funds should be available to residents 24 hours a day and 7 days a week. A method for distributing funds after hours and on weekends must be established ...." 3.1-6(a)		and monthly for 6 months. Results of audits will be reported to the bimonthly QAPI committee meeting for further review. If 100% compliance has been achieved, an action plan will be completed. The Administrator is responsible for the implementation and monitoring of this plan. **Date of compliance:** 06/21/2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure dependent residents were shaved, for 2 of 16 residents reviewed for Activities of Daily Living (ADLs-activities related to personal care) (Residents 30 and 17). Findings include: 1. During the initial observation, on 5/17/24 at 2:17 p.m., Resident 30 was observed with long facial hair. At the same time, the resident indicated he had not been shaved for quite a while. The staff had told him the facility had run out of razors. His preference was to be shaved when he received his shower. He did not wish to shave himself because of his seizure disorder and his fear of having a seizure while shaving.	F 0677	**ADL Care Provided for Dependent Residents** **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 30 and resident 17 was provided ADL care per preference including shaving. All Residents ADL preferences were reviewed to ensure preferences are completed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to affected by the alleged deficient practice.	08/21/2024

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	During a random observation. on 5/20/24 at 11:18 a.m., The resident was observed sitting in the dining room waiting on his lunch meal to be served. The resident was observed to be unshaven. Resident 30's record was reviewed on 5/23/24 at 10:11 a.m. The profile indicated the resident's diagnoses included, but were not limited to, other sequalae of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and epilepsy, unspecified (brain condition that causes recurring seizures [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements such as twitching, stiffness, or limpness]). An admission Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/26/24, indicated the resident had moderate cognitive deficit, had no documented behaviors of rejection of care, and required partial to moderate assistance with bathing or showers. A care plan, dated 2/23/2024, indicated the resident required assistance with ADLs. Interventions included, but were not limited to, assist with bathing per resident preference and offer showers two times per week, with partial bath in between and assist with hygiene. A care plan, dated 2/23/2024, indicated the resident was at risk for bleeding related to use of an antiplatelet medication (medicines that stop blood cells from sticking together and forming a blood clot).		All residents to be interviewed for shower/bathing preferences/shaving by IDT, bathing preferences will be updated in the profile and plan of care. All residents' plans of care to be reviewed and reflective of preferences regarding bathing and shaving. **What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff to be educated regarding shower schedules and resident specific preferences including shaving. Nursing management will review shower sheets daily to ensure bathing preferences are being met and residents were properly shaved. Tuesday night overnight staff will audit supplies and turn into DNS or designee for supply to be replaced. Nursing management will review shower sheets daily to ensure bathing preferences are met and showers given per preference to include shaving preference. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold.	

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	A care plan, dated 2/23/2024, indicated the resident was at risk for bleeding due to the use of an anticoagulant medication (medication used to prevent and treat blood clots in blood vessels and the heart). A physician's order, dated 2/21/24, indicated to administer aspirin (antiplatelet medication), 81 milligrams (mg) chewable once a day. A physician's order, dated 2/21/24, indicated to administer Eliquis (apixaban-anticoagulant medication), tablet; 5 milligrams (mg) two times a day. Resident 30's May 2024 shower sheets indicated shaving was a part of the bathing and/or showering process. The shower sheets indicated the resident had not been shaved from 5/9/24 through 5/19/24. A shower sheet, dated 5/20/24, indicated the resident had been shaved on that date. 2. During an initial observation, on 5/17/24 at 2:18 p.m., Resident 17 was observed with long facial hair. At the same time, the resident indicated he had not been shaved for several days. The staff had told him the facility had run out of razors. He desired to be shaved regularly and did not want to have a beard. He was unable to shave himself and depended on the staff to do it for him when he received his shower or bed bath. During a random observation, on 5/20/24 at 11:22 a.m., the resident was observed in his bed watching TV. The resident's long facial hair was still observed. At the same time, the resident indicated the staff had been told that the facility had ordered razors, but they had not come in yet.		All nursing staff will be educated on notification of low supplies by ED/Designee. **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?** Bathing/Showers QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Results from QA tool will be reviewed by the QAPI committee. **Date of Compliance: 06/21/2024**	

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	During a random observation, on 5/22/24 at 12:20 p.m., the resident was observed to be clean shaven. At the same time, the resident indicated the facility had finally received some razors and he was shaved last evening. It had been 4-5 days since he had last been shaved. He again indicated that he wished to be shaved every time he gets his baths. Resident 17's record was reviewed on 5/22/24 at 1:56 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure (high blood pressure and damage to the heart caused by damage to the kidneys) and type 2 diabetes mellitus with diabetic chronic kidney disease (a decrease in kidney function that occurs in some people who have diabetes [uncontrolled blood sugar levels]). A significant change Minimum Data Set MDS assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 6/15/23, indicated the resident had no cognitive deficit and required total assistance with bathing and extensive assistance with personal hygiene. A quarterly MDS, dated 2/13/24, indicated the resident had no cognitive deficit and had no documented behaviors for rejection of care. A care plan, dated 9/2/2022, indicated the resident required assistance with ADLs. Interventions included, but were not limited to, assist with bathing per resident preference and offer showers two times per week, with partial bath in between and assist with hygiene.			

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	A care plan, dated 2/23/2024, indicated the resident was at risk for bleeding related to use of an antiplatelet medication (medicines that stop blood cells from sticking together and forming a blood clot). A physician's order, dated 5/10/24, indicated to administer aspirin (antiplatelet medication), 81 milligrams (mg) chewable once a day. Resident 17's May 2024 shower sheets indicated shaving was a part of the bathing and/or showering process. The shower sheets indicated the resident had not been shaved from 5/16/24 to 5/21/24. A shower sheet, dated 5/22/24, indicated the resident had been shaved on that date. During an interview, on 5/22/24 at 2:46 p.m., the Regional Director of Clinical Services (RDCS) indicated that it often took the facility several days to receive their supply order. She had been made aware that the facility had only 1 box of razors. She was unsure as to why the residents had not been shaved. It was possible that the facility could have gone to pick up some razors at a local store. During an interview, on 5/23/24 at 10:02 a.m., Certified Nursing Assistant (CNA) 10 indicated she was aware that there had been at least one day when the facility did not have any razors. It had been reported to the nurses so that some could be ordered. During an interview, on 5/23/24 at 10:05 a.m., the Administrator (ADM) indicated the facility had some issues with the ordering process. The Director of Nursing (DON) had taken on the process in hopes of getting the issues resolved. He had not been made aware that the facility was			

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	out of razors or of the residents not getting shaved. Someone could have gone to a local store to purchase razors to ensure the facility had them on hand for use. During an interview, on 5/23/24 at 10:19 a.m., the ADM indicated he was not able to locate a policy specific on razors or supplies being in stock. The expectation was that the facility would always have enough supplies on hand, to meet the needs of the residents. 3.1-38(a)(3)(D)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse was in the facility for 8 consecutive hours during a 24-hour period for 2 of 3 months of the first quarter of 2024 reviewed for sufficient staffing (10/23, 10/29, 12/3, 12/9, 12/10, 12/14, 12/16, 12/17, 12/23, 12/24, 12/25, and 12/30).	F 0727	**RN 8 Hrs/7 days a week. Full time DON** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility has obtained RN	08/21/2024

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	Findings include: A Payroll-Based Journal (PBJ) Staffing report, for the first quarter (October 1-December 31) of 2024, indicated the facility failed to have Registered Nurse (RN) coverage for 8 consecutive hours on 10/23, 10/29, 12/3, 12/9, 12/10, 12/14, 12/16, 12/17, 12/23, 12/24, 12/25, and 12/30. During an interview on 5/22/24 at 11:37 a.m., the Regional Director of Clinical Services (RDCS) indicated they had reviewed the PBJ and she could not verify if the information on the PBJ was correct and would pull staffing reports. She indicated the facility submitted the PBJ data to the home office who reviewed and submitted it for them. During an interview on 5/22/24 at 12:14 p.m., the RDCS provided staffing schedules and indicated they did not have RN coverage for 10/23, 10/29, 12/3, 12/9, 12/10, 12/14, 12/16, 12/17, 12/23, 12/24, 12/25, and 12/30. During a record review, on 5/22/24 at 12:15 p.m., the actual worked staffing schedules indicated there was no RN coverage for 10/23, 10/29, 12/3, 12/9, 12/10, 12/14, 12/16, 12/17, 12/23, 12/24, 12/25, and 12/30. During an interview on 5/22/24 at 2:01 p.m., the RDCS indicated the reason why there was not an RN on duty for 10/23, 10/29, 12/3, 12/9, 12/10, 12/14, 12/16, 12/17, 12/23, 12/24, 12/25, and 12/30 was because they did not have a Director of Nursing Services (DNS), they had a float DNS at that time, but they were not there on those days. During an interview on 5/22/24 at 2:05 p.m., the RDCS indicated the facility did not have a policy		coverage for 8 consecutive hours a day/ 7 days a week. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. If RN coverage is needed, the facility will contact staffing agencies and the in-company staffing group to obtain an RN. The Executive Director and Director of Nursing are continuing to recruit and hire RNs, full and part time. Current staff have been educated on proper procedures for RN staffing with the nursing in-service on 06/12/2024. **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**	

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	related to RN coverage. 3.1-17(b)(3)		**into place?** To ensure compliance the ED/DNS will review the staffing schedule showing RN coverage monthly for 6 months with the CQI Committee, after which the CQI team will re-evaluate the continued need for review. If RN coverage has not been achieved as required, an action plan will be developed, and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours. Administrator is responsible for development and implementation of plan. Date of compliance: 06/21/2024	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly and the facility failed to ensure expired medications were disposed of for 2 of 2 medication carts reviewed for medication storage (Residents 22, 11, and 8). Findings include: 1. On 5/22/24 at 10:19 a.m., the front hall medication cart contained an undated and opened bottle of eye drop solution. The eye drops solution bottle contained a label that indicated it was for Resident 22. During an interview, on 5/22/24 at 10:20 a.m., Qualified Medication Aide (QMA) 9 indicated eye drops were good for 28 days once opened and should have an open date on the bottle when opened by staff. Resident 22's record was reviewed on 5/22/24 at 10:48 a.m. A physician order, dated 5/17/24, indicated to administer Refresh Optive Advanced (relieves dry, burning, and irritated eyes) 0.5-1-0.5%, 2 drops in each eye twice a day. 2. On 5/22/24 at 10:25 a.m., the back hall medication cart contained an undated and opened insulin pen. The insulin pen contained a label that indicated it was for Resident 11.	F 0761	**It is the policy of this facility that all medications and biologicals are stored without cohorting.** **What corrective action will be done by the facility?** The medication cart was audited on 5/23/2024 for proper labeling and storage of medications and supplies. All Insulins and eye drops will be dated upon day of opening and discarded after 28 days. An in-service will be held on 6/13/2024 to educate nursing staff on the importance of proper labeling, storage and this implemented process. Eye drops for resident 22 were discarded. Insulin pen for resident 11 and 8 were discarded. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected. The medication cart was audited by the DON or designee. Any issues with storage or labeling will be immediately addressed and corrected. **What measures will be put into**	08/21/2024

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	155419	A. BUILDING 00 B. WING	05/23/2024

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	Resident 11's record was reviewed on 5/22/24 at 11:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy (a complication of diabetes mellitus that occurs when high blood sugar damages the peripheral nervous system). A physician order, dated 3/25/24, indicated to administer Fiasp (insulin medication) FlexTouch 100 unit/ml (milliliter) 3ml by injecting 7 units subcutaneous (under the skin) three times a day. 3. On 5/22/24 at 10:27 a.m., the back hall medication cart contained an open insulin pen with an open date of 1/9/24. The insulin pen contained a label that indicated it was for Resident 8. During an interview, on 5/22/24 at 10:27 a.m., Licensed Practical Nurse (LPN) 6 indicated she thought insulin pens were good for 60 days once opened but she was not sure and would have to check the policy. During an interview, on 5/22/24 at 10:29 a.m., Regional Director of Clinical Services indicated insulin pens were good for 28 days once opened. Resident 8's record was reviewed on 5/22/24 at 11:10 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus without complications (a chronic condition that affects the way the body processes blood sugar). A physician order indicated to administer Novolog (insulin medication) FlexPen 100unit/ml (3ml) by injecting per sliding scale subcutaneously three times a day at 8:00 a.m.,		**place to ensure this practice does not recur?** The DON or designee will audit the treatment cart weekly. Results of the audits will be taken to the morning clinical meeting and discussed with the IDT. An in-service will be held on 6/13/2024 to educate nursing staff on the importance of proper labeling, storage and this implemented process by the DNS. **How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or designee will complete the Medication Storage CQI audit tool weekly for 4 weeks and monthly for 6 months. The DON or designee will bring the results of the audits to the bimonthly QAA meeting for review by the CQI Committee. If 100% compliance is not achieved at that time, an action plan will be developed. The DON is responsible for the development and implementation of the plan. Date of Compliance: 06/21/24	

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	12:00 p.m., and 5:00 p.m. On 5/22/24 at 10:31 a.m., the Regional Director of Clinical Services, provided a document as a current facility policy titled, "LTC Facility's Pharmacy Services and Procedures Manual," revised date of 7/21/22. The policy indicated, " ...5.3 If a multi dose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days ...5.4 When an ophthalmic solution or suspension has a manufactures' shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container ...." On 5/22/24 at 10:52 a.m., the Regional Director of Clinical Services, provided an undated document as a currently facility policy, titled, "Storage Recommendations for Injectable Diabetes Mediations." The policy indicated, " ...Fiasp cartridge or pen ...expiration date at room temperature was 28 days ...Novolog cartridge or pen ...expiration date at room temperature was 28 days ...." 3.1-25(j)			
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.			

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	(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 dining meal service was completed in a sanitary manner, for 1 of 2 dining service observations. Findings include: During the initial dining meal service observation, on 5/17/24 at 12:36 p.m., Registered Nurse (RN) 3 was observed assisting Resident 9 to cut her sandwich. The nurse was observed to hold a portion of the sandwich with her ungloved left index finger while cutting the sandwich. On 05/17/24 at 12:37 p.m., Certified Nursing Assistant (CNA) 4 was observed assisting Resident 24 with cutting her sandwich. The CNA was observed to push down on the resident's sandwich with her ungloved hand as she cut the sandwich for the resident. During an interview, on 5/22/24 at 2:50 p.m., the Regional Director of Clinical Services (RDCS) indicated it was not appropriate for staff to touch resident food items with ungloved hands. The facility would follow the Indiana retail food guidelines.	F 0812	It is the intent of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 9 and Resident 24 were provided with new meal trays. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that need assistance with cutting food have the potential to be affected. All nursing staff will be in-serviced on serving meals in dining room and cut residents food. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	08/21/2024

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	Section 410 IAC 7-24-171 of the Indiana Department of Health Retail Food Establishment Sanitation Requirements, effective November 13, 2004, indicated, "Preventing contamination from hands...Sec. 171 (c) Food employees shall minimize bare hand...contact with exposed food...." 3.1-21(i)(3)		In service to nursing staff on cutting residents food when serving meal tray. DNS/Designee will conduct rounds during meal service to ensure food is provided in a sanitary manner. **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?** QA tool for meal observation to be completed by DNS/designee weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee. If 90% threshold is not achieved, an action plan will be developed to ensure compliance DON will be responsible for the development and implementation of plan. Date of compliance: 06/21/2024	