STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155342	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MOUNT VERNON NURSING AND REHABILITATION	1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620

(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 and Investigation of Complaint IN00405306. This visit was in conjunction with Complaint IN00408247. Complaint IN00405306 -No deficiencies related to allegations are cited. Complaint IN00408247- Federal/State deficiencies related to the allegations are cited at F921. Survey dates: May 8, 9, 10, 11, 12, 15, 2023 Facility number: 000234 Provider number: 155342 AIM number: 100273490 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 6 Medicaid: 28 Other: 25 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 25, 2023.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian Bailey	Executive Director	06/05/2023

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

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interviews, and record review, the facility failed to provide supervision to prevent multiple falls. Supervision and effective interventions were not in place to prevent continued falls for 1 of 5 residents (Resident 52) reviewed for accidents. Findings include: During an interview on 5/8/23 at 9:30 A.M. with RN 1, she indicated that Resident 52 hollers out and becomes combative with staff. Resident was not aware of safety and tries to get out of bed on her own. During observation on 5/8/23 at 11:45 A.M., Resident 52 was observed in a high-back wheelchair at the table in the dining room on the locked unit. Resident called out sporadically "help me! help me"! On 5/9/23 at 1:52 P.M. Resident 52's clinical records were reviewed. Diagnoses included, but were not limited to: metabolic encephalopathy, type 2 diabetes, COPD (chronic obstructive pulmonary disease), dementia. Significant Change Minimum Data Set (MDS) Assessment dated 5/9/23 indicated resident had severe cognitive impairment. Resident was unable to respond correctly to any of the Brief Inventory of Mental Status (BIMS) questions, and required limited assist of 2 for bed mobility, extensive	F 0689	The fall avoidance plan of care for resident 52 will be reviewed and updated appropriately by the interdisciplinary care plan team (IDT). Following a second review of 5/10/2023 fall for resident 52, the activity level was changed per physician order to up with supervision with assist to standard wheelchair and replaced the previous physician order of activity level: up ad lib with assist to standard wheelchair. Subsequently, the intervention of up with supervision when up in wheelchair was added to resident 52's fall avoidance plan of care. It was determined that all residents have the potential to be affected by the alleged deficient practice. To address this potential, each resident's most recent fall will be reviewed to verify there is a corresponding intervention/fall prevention step. If there is not, an intervention based on root cause and intervention history will be developed by IDT. Nursing staff will be trained regarding timely fall intervention development and implementation and this training will become part of new hire training.	06/15/2023

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	assist of 2 for transfers and toileting, supervision and assistance of 1 for eating, and total dependence for bathing. Current Physician orders include, but were not limited to: 2/26/23, activity level: up ad lib with assist to standard wheelchair. 4/21/23 Physical therapy to treat 3 x/week for 4 weeks...as indicated to allow for improved and safety with mobility tasks; 2/27/23 low bed for safety; 2/28/23 head of bed elevated to alleviate shortness of breath; 4/15/23 Positioning/Devices Wanderguard for dementia and other behavioral disturbances, check once a day for function Care plan included, but was not limited to: Resident is at risk for falls due to: weakness, dementia, history of falls, advanced age, lack of understanding of one's physical and cognitive limitations, requires assist with mobility, new environment, high risk medication use, altered awareness of immediate physical environment, impulsive, urgency/frequency incontinence, unsteady gait. Most recently updated 4/27/23. Interventions included, but were not limited to, 1. Resident to be directed away from crowded common areas unless being directly supervised. Updated 4/24/23 2. fall mat at bedside Updated 2/28/23 3. low bed. Updated 2/27/23. 4. Keep pathways free of clutter. Updated 2/27/23. 5. Non-skid footwear Updated 2/27/23 6. Call light in reach Updated 2/27/23 Resident has fallen 11 times since her admission of 2/26/23. Falls were:		To assure ongoing compliance, fall Continuous Quality Improvement (CQI) tool will be completed by DNS/designee weekly times 4 weeks and then monthly times 6 months to ensure compliance. If 95% compliance is not achieved, an action plan will be developed to ensure compliance.	

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	Fall #1 On 2/27/23 at 8:05 A.M., resident was found sitting beside her bed on her buttocks with her back and head leaning against the bed; had been toileted at 5:25 A.M. Resident unable to communicate how fall happened due to advanced dementia. Bed in lowest position, No new orders. Gripper socks and clothing on, non-skid strips in front of bed. Resident had two skin tears to left forearm. Vital signs within normal limits. Neurochecks performed. Physician, resident representative, and Director of Nursing (DON) notified of fall and injury. No new orders. Care plan reviewed and updated interventions. Fall #2 On 3/1/23 at 7:28 A.M., resident was observed to slide off the side of her bed, sitting on buttocks in upright position with back leaning against the bed, on fall mat. No injury. Range of motion performed, no difficulty noted to upper or lower extremities. Vital signs within normal limits and neurochecks continued. Physician, resident representative, DON and nurse practitioner (NP) notified. No new orders. Care plan reviewed. No new interventions added to care plan. Fall #3 On 3/13/23 at 9:13 P.M., resident was found lying on right side on the floor mat beside her bed. Bed in lowest position, gripper socks on; resident had been restless that evening. No injury. Physician, resident representative and DON notified. Event report indicated new orders were received but no new orders noted in orders. No new interventions added to Care plan. Fall #4 On 3/14/23 at 11:01 P.M., resident was found lying on left side on bedside mat, with head against the			

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	wall, with laceration to right posterior head. Pressure dressing and wrap applied to control bleeding. Physician notified and ordered transfer to emergency room (ER) for evaluation. New orders obtained. Resident's daughter notified. No new interventions added to care plan. Fall #5 On 4/17/23 at 6:40 P.M., resident was observed walking in the TV lounge and attempted to sit on the sofa and missed the cushion, landing on her buttocks on the floor in front of the couch. No injuries noted. Vital signs within normal limits. Resident assisted off floor by two staff and gait belt applied; staff assisted her back to bed. Physician and daughter notified. No new orders. No new interventions added to Care plan. Fall #6 On 4/18/23 at 5:21 P.M., resident was found lying supine with legs extended behind the nurses' desk, fully clothed without gripper socks on feet. Resident unable to say how the fall happened. No injury noted. Vital signs within normal limits, neurochecks completed. Physician and representative notified. No new orders. No new interventions were added to care plan. Fall #7 On 4/19/23 at 7:35 A.M., resident was found sitting on the floor on buttocks with back against the bed and legs extended out in front of her, fully clothed with no footwear on. No injuries noted. Viral signs within normal limits. Neurochecks initiated. Physician and representative notified. No new orders. No new interventions added to care plan. Fall #8 On 4/22/23 at 11:49 A.M., resident was observed			

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	walking on carpeted area in the TV lounge and tripped over another resident's feet, landing on the floor on her left side. Received two skin tears to left elbow and left forearm. Cleansed tears with normal saline and applied dressing. Resident assisted back to wheelchair and taken to nurses station. Vital signs within normal limits, Range of motion performed to upper and lower extremities with no difficulty. Physician and representative notified. No new orders. No new interventions added to care plan. Fall #9 On 4/26/23 at 7:45 A.M., resident was found lying in supine position on the floor next to bed in room 138, another resident's room, her legs extended out in front of her with head resting on leg of bedside table. No injuries noted. Resident was fully clothed with no gripper socks. Vital signs within normal limits. Range of motion to all extremities within normal limits. Physician and representative notified. No new orders. No new interventions were added to care plan. Fall #10 During an observation of unit on 5/10/23 at 2:20 P.M., the nursing staff was observed at the nurse's station, a noise was heard, the staff did not respond to the noise. Observed the resident's wheelchair was rocking back and forth as the resident had just fallen on the floor in the carpeted area of the TV lounge. Resident was lying on her right side, crying. There were 3 or 4 other residents in the TV lounge watching a movie. No staff were in the lounge at the time. The nurse at the desk was alerted to the resident on the floor and staff came to her aid. No Wanderguard/position change alarm was observed or heard at that time.			

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	Review of the 5/11/23 at 3:00 P.M., the fall event report for the 5/10/23 fall, indicated the resident was found lying on her right side on the floor in front of her wheelchair in the TV lounge, fully clothed without gripper socks on. Resident received skin tear to right hand and right shin. Vital signs within normal limits, range of motion to all extremities within normal limits. Physician and representative notified. No new orders. Care plan reviewed. New interventions were added. Fall #11 On 5/14/23 at 4:50 P.M., a progress note was entered into the chart that indicated the resident was found lying on her left side on the floor. Range of motion for all extremities with no complaint of pain or discomfort. Resident had two hematomas on left forehead and three skin tears on left forearm. Two staff assisted resident up to wheelchair and placed resident in bed to continue a full skin assessment. No further injuries noted. The on-call NP, DON, and representative were notified. Vital signs and neuro checks started per facility policy. There was no documentation in the progress notes regarding whether the resident was sent to the ER for evaluation of the head injury, or whether new orders were received or the care plan reviewed. The event report was not available. On 5/12/23 at 12:30 P.M. the facility policy was received from the Administrator and reviewed at that time. The last revision date was 8/2022. The facility fall policy indicated residents residing within the facility must receive adequate supervision and/or assistance to prevent injury-related falls. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and			

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	provide immediate interventions. 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interviews, and record review, the facility failed to ensure that 1 resident who needed respiratory care, did not receive the prescribed amount of oxygen and 2 residents' equipment was not labeled or maintained for 2 of 2 residents (Resident 1 and Resident 43) reviewed for respiratory care. Findings include: 1. During an interview with Resident 1 on 5/8/23 at 9:40 A.M., she said she wears her oxygen when she sleeps. Oxygen was on at 2 liters per minute (lpm) per nasal cannula (nc). Filter on the oxygen concentrator was covered with white lint. On 5/9/23 at 10:00 A.M., observed resident asleep in bed with oxygen on at 2 lpm per nc. Filter on concentrator is covered with white lint. During an interview on 5/11/23 at 9:12 A.M. with RN 1, she indicated a respiratory care company manages their oxygen concentrators. The	F 0695	Nursing will consult Resident 1's attending physician and obtain/clarify order so that Resident 1's oxygen delivery rate and oxygen order are in agreement. The oxygen tubing and concentrator filters were changed for resident 1 and 43. The exterior of concentrators for Residents 1 and 43 were cleaned. It was determined that all residents using supplemental oxygen have the potential to be affected by the alleged deficient practice. To address this potential, training on oxygen tubing changing and dating, oxygen contractor filter change frequencies, and cleaning of concentrator exterior will occur for all nursing and this training will become part of new hire training. Training and subsequent	06/15/2023

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	company is supposed to change the filters and maintain the machines. On 5/11/23 at 9:19 A.M., observed resident's oxygen concentrator while resident was out of the room; the filter was covered with white lint. During an interview with the DON on 5/11/23 at 9:20 A.M., she indicated the respiratory care company comes to the facility monthly and the last time they were here was 5/9/23. On 5/15/23 at 9:15 A.M., observed Resident 1's oxygen concentrator and found the filter was cleaned. Resident was resting in bed with oxygen on at 2 lpm per nc. On 5/9/23 at 11:23 A.M., Resident 1's clinical records were reviewed. Diagnoses included, but were not limited to: COPD (chronic obstructive pulmonary disease), type 2 diabetes, and dementia. Most recent quarterly MDS Assessment dated 3/3/23 indicated resident has severe cognitive impairment and requires supervision and assist of 1 for bed mobility, transfers, and toileting, setup and assist of 1 for eating, physical help in part of bathing. Current physician orders included, but were not limited to: oxygen at 1 lpm per nc continuous at bedtime; change oxygen tubing, humidity and set-up bag, clean concentrator and filter, once a week on Sunday. Care plan included, but was not limited to: Resident is at risk for ineffective tissue perfusion related to COPD, diabetes, hyperlipidemia, dementia, gout, insomnia, vitamin D deficiency,		monitoring will be the responsibility of DNS/designee. All residents on oxygen had their tubing changed, their concentrator filters changed, and the exterior of their concentrator cleaned. All residents receiving oxygen were reviewed to ensure physician order was being followed. Nurse training will be done to ensure that all nurses understand it is the physician order that determines the rate of oxygen flow, and this training will become part of new hire training. DNS/designee will monitor physician orders related to oxygen, oxygen tubing changing and dating, oxygen contractor filters, and cleaning of oxygen concentrators. This will occur during daily clinical meetings and rounds. Non-compliance will be addressed in a timely and appropriate manner. To assure ongoing compliance, Oxygen CQI form will be completed weekly times 4 weeks and then monthly for 6 months. If 95% compliance is not achieved, an action plan will be developed to ensure compliance.	

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	emphysema, edema, anxiety. Lasix daily and wears oxygen at 1 lpm per nc at bedtime. Interventions included, but were not limited to: observe for and document pallor, cyanosis, dizziness, syncope, shortness of breath, bounding/thready pulse, headache, variations in blood pressure, abnormal lung sounds, abnormal oxygen saturation; meds as ordered, observe for and document signs and symptoms of change in mental status, disorientation, increased confusion, anxiety. Notify MD. 2. On 5/9/23 at 8:37 A.M., oxygen tubing was observed in Resident 43's room that was on the floor and unlabelled. There was also a humidifier bottle that was unlabelled. The nebulizer tubing was unlabelled. On 5/11/23 at 2:54 P.M., oxygen tubing and concentrator was observed in Resident 43's room unlabelled. On 5/10 at 2:12 P.M., the clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's disease with late onset and COPD (chronic obstructive pulmonary disease), unspecified. A quarterly MDS (Minimum Data Set) dated 4/30/23 indicated the resident was severely cognitively impaired. The resident needs extensive assistance with all activities of daily living. Current physician orders included, but not limited to: Change nebulizer tubing set, once a day on Sunday. A Treatment Administration Record (TAR) dated 5/1/23 to 5/12/23 indicated the tubing was changed on 5/7/23. The start date of 1/23/23 and a			

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	discontinuing date of 5/9/23. The Medication Administration Record (MAR) lacked the above. The care plan intervention date 11/30/22 indicated nebulizers treatments are as ordered. During an interview on 5/11/23 at 3:04 P.M., RN 1 indicated the tubing changes appear on the MAR on the night shift and they will change the tubing on Sundays. During an interview on 5/12/23 at 2:08 P.M., the Clinical Support Supervisor indicated the facility lacked a written policy for respiratory care such as changing oxygen tubing, but the policy would be to follow the MD (Medical Doctor) orders On 5/12/23 at 12:30 from the Administrator provided the current policy, it was reviewed at that time. . The facility policy was noted dated or have a revision date on the policy. The facility oxygen policy and procedures for concentrators indicated that the respiratory care company's technicians would clean the gross particle filter weekly. They would also check the internal bacteria filter and dispose of it if dirty and replace it with a new filter. The technician must replace the filter each year. The technician must fill out the PM care attached to the unit with the date, filter changes or cleaning performed, oxygen purity level, lpm verification and technician's initials. 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	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 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 with open dates for 1 of 3 medication carts observed. (Plaza Unit Cart) Finding includes: During an observation on 5/10/23 at 8:37 a.m., of the Plaza Unit medication cart, the following medications were observed to be open and undated: sulfacetamide sodium drops 10% ; amt : 1 drop; ophthalmic (eye)	F 0761	The medications observed to opened and undated were replaced. It was determined that all residents are at risk for the alleged deficient practice. To address this potential, all resident medications will be reviewed and verified for a date open being recorded on opened primary medication containers whose medication has a shortened expiration date once opened. In instances of such a container being open with no open	06/15/2023

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	insulin lispro insulin pen; 100 unit/ml (milliliter); amt; per sliding scale; subcutaneous hyoscyamine sulfate (anticholinergics/antispasmodics) drops; 0.125 mg/ml (milligram, milliliter); oral refresh P.M. (white petrolatum-mineral oil) ointment; 57.3- 42.5% ophthalmic (eye) On 5/10/23 at 8:46 a.m., RN 1 indicated if the seal is not broken on a medication it is not dated, when the seal is broken it should be dated, insulin is good for 28 days after it is open, if it is in the medication cart, even if not open, a date it should be applied. On 5/15/23 at 11:30 a.m., the Administrator provided the current LTC facility pharmacy services and procedures policy with a revision date of 7/21/22. The policy included, but was not limited to, ...facility staff should record the date opened on the primary medication container(vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened. Facility staff may record the calculated expiration date based on date opened on the primary medication container. 3.1-25(j)		date, the medication will be replaced. To prevent recurrence, all nurses and Qualified Medication Aides (QMAs) will receive training on Labeling/Storing Drugs and Biologicals and this training will become part of new hire training. In addition, medication carts will be placed on a scheduled Compliance Check by DNS/designee to ensure meds are labeled and stored appropriately. Med Labeling QAPI tool will be completed by DNS/designee weekly times 4 weeks and monthly times 6 months. If 95% compliance is not achieved, an action plan will be developed.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	155342	A. BUILDING 00 B. WING	05/15/2023

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

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for 2 of 4 observations of personal care. Hand hygiene was not done and gloves not changed. (Resident 12, Resident 53). Findings include: 1. On 5/11/23 at 9:39 a.m., CNA 1 and CNA 2 were observed giving Resident 12 a shower. CNA 1 and CNA 2 entered the shower room pushing Resident 12 on a shower bed and donned gloves. No hand hygiene was observed before donning gloves. CNA 1 was observed to take off gloves, leave the shower room to obtain supplies, enter the shower	F 0880	Nursing staff are performing proper hand hygiene techniques with glove changes per policy. Residents 12 and 53 have had no adverse effects. Skills validations were completed for C N A 1 and QMA 3 It was determined that all residents have the potential to be affected by the alleged deficient practice. Refresher training regarding hand hygiene will be completed for all nursing staff and this training will become part of new hire training. Skills validations for Nursing Staff	06/15/2023

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	room and don gloves. No hand hygiene was observed before donning gloves. After the shower, CNA 1 was observed to obtain a denture cup, hand to Resident 12 to put his dentures in, clean the dentures at the sink, hand the dentures back to Resident 12 with gloved hands, pull the shower bed to the doorway, doff gloves and push Resident 12 down the hallway to his room. No hand hygiene was observed after doffing gloves. On 5/12/23 at 10:02 a.m., CNA 1 indicated hands should be washed before gloves are put on, if touch something change gloves, hand sanitizer is used every time before gloves are put on or after taking off. 2. During an observation on 5/9/23 at 9:23 A.M., QMA 3 provided care to Resident 53, who was in isolation for clostridium difficile. QMA 3 donned Personal Protective Equipment (PPE) and gloves, entered the room, and provided medications to the resident. Before leaving the room, she removed her PPE and gloves, disposed of them in a plastic bag, removed them from the resident's room and took them to the trash room, then used hand sanitizer instead of soap and water for hand hygiene. Resident 53's diagnoses included, but were not limited to: clostridium difficile, dementia. On 5/12/23 at 10:50 a.m., the Administrator provided the current hand hygiene policy with a revision date of 12/20/21. The policy included, but was not limited to, purpose of policy: To provide a standardized approach to hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees ...Indication for hand-rubbing but not limited to: before having direct contact with a		hand hygiene will be completed for all nursing staff and these validations will become part of new hire training. To prevent recurrence, nursing staff will be trained by DNS/designee on appropriate infection control procedures with hand hygiene when changing gloves and this training will become part of new hire training. Daily rounding by DNS/designee will include ensuring that nursing staff are utilizing appropriate hand hygiene techniques with glove changes. Hand Hygiene/Glove Change CQI tool will be completed weekly times 4 weeks then monthly times 6 months by DNS/designee. If 95% compliance is not achieved, an action plan will be developed.	

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	resident and/or equipment, before and after removing glove (except Culinary Department staff). 3.1-18(l)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 5 residents reviewed for environment. Findings include: During an observation on 5/8/23 at 8:45 A.M., the mirror in bathroom of room 120 was hanging forward from the wall, with a broken bracket on the right side and the left side of the mirror leaning on the paper towel dispenser. The air conditioning unit had a black mold-like substance underneath it and on the left side of it. Two residents were assigned to Room 120 and shared the bathroom. During an interview on 5/10/23 at 10:15 A.M. with housekeeper 5, she indicated that if the housekeepers saw anything in resident rooms that required maintenance, they would fill out a work order for the maintenance staff to fix it. During an interview on 5/11/23 at 1:05 P.M. with housekeeper 7, she indicated that if the housekeepers saw anything in resident rooms that required maintenance, they would either fill out a work order or just tell the maintenance staff.	F 0921	The identified mirror was repaired and the identified PTAC unit was replaced. It was determined that all residents are at risk for the alleged deficient practice. To address this potential, all bathroom mirrors will be checked for repair needs and addressed by Maintenance. The PTAC units were checked for cleanliness by Maintenance. All PTAC units were cleaned as needed. To prevent recurrence, there will be training for Maintenance regarding preventive maintenance schedules and training for Housekeeping and Maintenance regarding repair requests. This training will become part of new hire training. PTAC cleaning schedule will continue. Daily rounds by Maintenance and Housekeeping will include that hanging mirrors are secure and PTAC outward cleanliness. To assure ongoing compliance Maintenance CQI tool will be	06/15/2023

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	During an interview on 5/12/23 at 10:20 A.M. with maintenance supervisor, he indicated he does not keep the work orders after he completes them, but throws them away. During an interview on 5/12/23 at 9:48 AM with the resident in room 120, she indicated the tilted mirror in the bathroom is intentional for short people. She is wheelchair-bound and could not see into the mirror otherwise. During an interview on 5/12/23 at 10:30 AM with the maintenance supervisor, the mirror in room 120 is a specific mirror for people in wheelchairs. He observed the mirror and found the bracket on the right was missing a bolt. He said he'd fix it right away. This Federal tag relates to complaint IN00408247. 3.1-19(e)		completed weekly times 4 weeks then monthly times 6 months to ensure compliance. If 95% compliance is not achieved, an action plan will be developed.	