STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00445576 Complaint IN00445576 - No deficiencies related to the allegations are cited. Survey dates: October 16, 17, 18, 21, & 22, 2024 Facility number: 000175 Provider number: 155275 AIM number: 10027440 Census Bed Type: SNF/NF:59 Total:59 Census Payor Type: Medicare: 4 Medicaid: 47 Other: 8 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2024.	F 0000	F000 Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 11-22-2024. Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, interview, and record review, the facility failed to ensure physician consultation was provided before treatment alterations occurred to modify medications prior to administration for 1 of 1 residents reviewed for	F 0580	**Tag 580Care Plans** **It is the policy of this facility to ensure the physician is consulted prior to alterations in treatment prior to modifying**	11/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Seibel	HFA	11/15/2024

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	crushed medications received. (Resident 47) Finding includes: On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 6/7/24. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety. The most recent Significant change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, and was completely dependent on staff for transfers. A progress note, dated 10/17/24 at 12:32 P.M., indicated Resident 47 had been given her medications in a crushed form. The clinical record, including physician orders, progress notes, care plan, and assessments, lacked an order for medications to be crushed prior to administration or physician notification indicating resident need for medications to be crushed for administration. During a random observation on 10/22/24 at 9:01 A.M., LPN (Licensed Practical Nurse) 16 placed four tablets and opened one capsule of medication into a medication cup, crushed the medications together, and mixed the crushed medications in chocolate pudding. LPN 16 took the medication and pudding mixture to Resident 47 and spooned the medications into Resident 47's mouth. During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing indicated she was unable to		**medications.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **The DON/Designee assessed resident 47 on 10-22-2024, and no negative outcome related to the cited practice.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** The DON/Designee completed an audit for residents requiring medications requiring to be crushed prior to administration and notified the MD and obtained orders to crush medications on 11-13-2024. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not reoccur:** **The DON/Designee in-serviced the nursing staff on obtaining a physician order for residents that require medications to be crushed. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** **Audits will be brought to QAPI for review. Audits will be brought to QAPI monthly for review and the QAPI team will determine when it is**	

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	find a physician order or evaluation related to crushing Resident 47's medications. On 10/22/24 at 11:01 A.M., the Director of Nursing provided a policy titled "Medication Administration", dated 2/2017, that indicated "Review the resident's Medication Administration Record (MAR). Read each order entirely. Remove the medication from the drawer. If there is any discrepancy between the MAR and the label, check physician orders before administering medication. Crush medications only after checking with the 'Crush List' reference. Refer to medication reference text for administration when when added to any substance i.e., applesauce, juice, milk, etc.". 3.1-5(a)(3)		**appropriate to stop audits. The DON/Designee will audit 10 random medication observations for residents having medications crushed, verify physician notification and order obtained weekly x 4 weeks, then 5 random medication observations weekly x 4 weeks, then 3 random medication observations monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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. DOC: 11-22-2024**	
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 ensure residents' MDS (Minimum Data Set) Assessment's were completed within 14 days of admission for 1 resident reviewed for accidents and 1 resident reviewed for advanced directives. (Resident 259 and Resident 261) Findings included:	F 0636	**Tag# 636 MDS /Admission assessment. It is the policy of this facility to ensure residents MDS Assessments are completed within 14 days after admission. What corrective actions will be**	11/22/2024

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	1. On 10/17/24 at 1:43 P.M., Resident 261's clinical record was reviewed. The resident's Admission MDS dated 10/9/24 indicated it was in progress and was not complete. Resident 261 was admitted on 10/2/24. 2. On 10/21/24 at 10:00 A.M., Resident 259's clinical record was reviewed. The resident's Admission MDS dated 10/4/24, indicated it was in progress and was not complete. On 10/22/24 at 9:45 A.M., the DON (Director of Nursing) indicated it was expected that an Admission MDS be completed within 14 days after admission to facility, and the facility followed the RAI (Resident Assessment Instrument) manual guidelines for comprehensive assessments. 3.1-31(d)(1)		**accomplished for those residents found to be affected by the deficient practice:** **The MDS Nurse/Designee submitted the MDS for resident 261 on 10-22-2024 and resident 259 on 10-22-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **The MDS nurse/designee completed a 90 day look back for new admissions on 11-13-2024 for submission on admission MDS within 14 days of admission.** . **What measures will be put in place and what systemic changes will be made to ensure that deficient practice:** **The ADM/Designee completed an in-service with the MDS Nurse on completing new admission MDS's within 14 days of admission.** **Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined.** **How the corrective actions will be monitored to ensure the deficient practices will not recur: Audit results will be brought to QAPI for review until QAPI deems it no longer**	

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			necessary to continue. **The DON/Designee will audit new admissions and re-admissions for submission on admission MDS within 14 days of admission x 6 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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.** **DOC: 11-22-2024**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, record review, and interview, the facility failed to ensure the MDS (Minimum Data Set) Assessments were completed accurately for 1 of 2 residents reviewed for falls, 1 of 2 residents for nutrition, 1 of 5 residents reviewed for unnecessary medications. (Resident 50, Resident 30) Findings include	F 0641	**Tag# 641 MDS accuracy** **It is the policy of this facility to ensure the MDS Assessments are accurately coded to chair alarms, weight loss and unnecessary medications** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:**	11/22/2024

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	1. On 10/16/24 at 11:44 A.M., Resident 50 was observed sitting in a chair in the activities room with a chair alarm attached to the resident's clothing. On 10/18/24 at 1:25 P.M., Resident 50 was observed sitting in a chair in the activities room with a chair alarm. On 10/21/24 at 9:55 P.M., Resident 50 was observed sitting in a chair in the activities without a chair alarm. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS Assessment dated 9/24/24, indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded for the quarterly assessment for a chair alarm or significant weight loss. Current physicians order included, but were not limited to: General diet, Regular texture, Thin Liquids consistency, fortified foods with meals as available dated 2/27/24. There were no orders for chair alarms or Dycem devices. The current fall risk care plan lacked interventions for a chair alarm and a Dycem device. The current care plan lacked a intervention for fortified foods with each meal.		**The MDS Nurse/Designee completed submitted a modified MDS for Resident 50 to accurately code the chair alarm and significant weight loss on 11-11-2024 and on Resident 30 for accurately coding resident for not receiving an antiplatelet medication on 10-22-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **The MDS Nurse completed an audit for residents with chair alarms, significant loss and modified the MDS Assessment as needed. The MDS Nurse completed an audit of MDS Assessments that were completed for residents coded for antiplatelets and verify resident receiving medication on 11-13-2024.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **The Regional MDS Nurse completed an in-service with the MDS nurse on acute coding on 11-13-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as needed.**	

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	An IDT (Interdisciplinary Team) note dated 9/9/2024 at 12:02 P.M., indicated a recommendation to access chair for need of adding Dycem or other devices. During an interview on 10/21/24 at 10:35 A.M., the MDS (Minimum Data Assessment) Coordinator indicated the chair alarm should have been in the MDS Assessment. During an interview on 10/21/24 at 3:15 P.M., the DON (Director of Nursing) indicated it was the policy of the facility to use the RAI (Resident Assessment Instrument) as a guide for the MDS Assessment.2. On 10/17/24 at 12:54 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and hypertension. The most recent Annual MDS (Minimum Data Set) assessment, dated 10/2/24, indicated Resident 30 was cognitively intact, required partial assistance from staff for toileting, bathing, and transfers, and was receiving antipsychotic, antianxiety, anticoagulant, antiplatelet, and hypoglycemic medications during the 7-day lookback period. Physician orders for September 2024 and October 2024 lacked an antiplatelet medication. During an interview on 10/22/24 at 8:52 A.M., the MDS Coordinator indicated the antiplatelet medication marked as received by Resident 30 on the Annual MDS assessment, dated 10/2/24, was marked in error and Resident 30 had not received an antiplatelet medication.		**How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The DON/Designee will audit MDS Assessments for accurate coding for residents with chair alarms and significant weight loss and verify residents coded for antiplatelets are receiving the medication weekly x 6 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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.** **DOC: 11-22-2024**	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop care plans for 1 of 1 residents reviewed for communication. A care plan was not developed for residents with English as a second language. (Resident 50) Findings include: 1. On 10/17/24 at 9:01 A.M., during a random observation in Resident 50's room there was no Spanish communication board available in room to meet the resident's needs if asked. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS Assessment dated 9/24/24, indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded this assessment for a chair alarm or significant weight loss. The clinical record lacked an order for the use of communication devices. The clinical record lacked a care plan to concerning the resident's communication needs. On 10/21/24 at 10:04 A.M., the communication board was observed under a stack of papers on the resident's dresser and readily available. On 10/21/24 at 2:22 P.M., the resident was observed using her wheelchair in the activities	F 0656	Tag # F656 Care plan development It is the policy of this facility to develop a communication care plan for residents with English as a second language. 1) What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice; The DON/Designee updated Resident 50's communication care plan on 11-14-2024. The DON/Designee created a communication board for Resident 50 on 11-14-2024. 2) How other resident's having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken; The DON/Designee completed an audit for residents that use English as a second language on 11-14-2024, a care plan and communication board were implemented as needed. 3) what measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; Upon The DON/Designee in-serviced staff on developing a communication care plan and use of a communication board for residents that use English as a	11/22/2024

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	room trying to talk with a CNA (Certified Nurse Aide) in Spanish. The CNA indicated that she could not understand the resident and made no effort to communicate with the resident because she was preoccupied passing ice water. During an interview on 10/21/24 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated there should be a care plan for communication since the resident spoke Spanish as a first language. On 10/22/24 at 12:56 P.M., the DON (Director of Nursing) provided a current, non-date policy "Communication in the Predominant Language." The policy indicated " the resident has the right to a dignified existence...and communication with and access to persons and with services with the facility. The resident has the right to be full informed in a language that he or she understand of his/her health status..." On 10/21/24 at 3:15 P.M., the DON provided a current policy "Baseline Care Plan Assessment/ Comprehensive Care Plan" revised 3/23/21. The policy indicated"...the comprehensive care plan will further expand on the resident's medical, nursing, physical functioning... needs. These needs will be based on observation, record review, interviews, ... and thorough assessments...the comprehensive care plan shall include any specialized services..." 3.1-35(b)(1) 3.1-35(d)(2)(A)		second language on 11-14-2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4) how corrective action(s) will be monitored to ensure the deficient practice will not recur: Audits will be brought to QAPI for review. The DON/Designee will audit care plans and communication boards for current residents, new admissions and re-admissions 5 times a week x 4 weeks, then 3 times a week x 4 weeks , then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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. 5) DOC 11-22-2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview the facility,	F 0657	Tag # F657 Care Plan Timing	11/22/2024

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	failed to ensure that documentation of interventions were not revised for 1 of 2 residents reviewed for falls and revise a residents care plan after they returned to facility from a hospital admission with a urinary tract infection and sepsis for 1 of 1 resident reviewed for urinary tract infections. (Resident 36, Resident 50). Findings include: 1. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS (Minimum Data Set) Assessment dated 9/24/24, indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded in assessment for a chair alarm or significant weight loss. There were no orders for chair alarms or Dycem devices. The current fall risk care plan lacked interventions for a chair alarm and a Dycem device. During an interview on 10/21/24 at 10:12 A.M., the ADON (Assistant Director of Nursing) indicated care plans need to be updated with each fall and there should be an intervention for the Dycem and chair alarms.2. On 10/21/24 at 11:54 A.M., Resident 36's clinical record was reviewed. The diagnoses included Sepsis and End Stage Renal Disease (ESRD). The most recent Quarterly MDS Assessment, on 10/4/24, indicated Resident 36 was cognitively intact, had complex medical conditions included,		and Revision It is the policy of this facility to ensure care plans are updated with a new fall intervention after a fall and when a resident returns from the hospital with a new diagnosis. 1) What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice; The DON/Designee reviewed and updated resident 50's fall care plan and at risk for weight loss care plan on 10-24-2024 and resident 36's care plan for urinary tract infection and sepsis on 10-25-2024. 2) How other resident's having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken; All residents of the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. 3) what measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; Upon The DON/Designee in-serviced the MDS Nurse and nursing staff on revising and updating care plans after a resident falls or returns from the hospital on 11-15-2024. Additionally, any staff that fails to comply with the points of this	

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	but not limited to, sepsis and end stage renal disease. Resident 36's clinical record lacked an updated care plan to reflect their recent hospitalization for sepsis with a Urinary Tract Infection. On 10/22/24 at 9:45 A.M., the DON (Director of Nursing) indicated that a resident's care plan should have been updated after a hospitalization. On 10/21/24 at 3:15 P.M., the DON provided a current policy "Baseline Care Plan Assessment/ Comprehensive Care Plan" revised 3/23/21. The policy indicated"...the comprehensive care plan will be reviewed and updated every quarter at a minimum. The facility may need to be review the care plans more often based on changes in the resident's conditions and/or newly developed health/psychological-social issues..." 3.1-35(a)		in-service will be further educated and/or disciplined as indicated. 4) how corrective action(s) will be monitored to ensure the deficient practice will not recur: Audits will be brought to QAPI for review. The DON/Designee will audit care plans after falls for updated interventions and re-admissions with new diagnosis 5 times a week x 4 weeks, then 3 times a week x 4 weeks , then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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. 5) DOC 11-22-2024	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on interview and record review, the facility failed to ensure practitioner's diagnostic practices met professional standard of care for 1 of 1 resident diagnosed with scizoaffective disorder and bipolar disorder after admission. (Resident 47) Finding includes:	F 0658	Tag # F658 Services Provided Meet Professional Standards It is the policy of this facility to ensure practitioners diagnostic practices meet professional standards. 1) What corrective action(s) will be	11/22/2024

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(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
	On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 6/7/24. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety. The most recent Significant change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, was completely dependent on staff for transfers, and received antipsychotic, antianxiety, and antidepressant medications during the 7-day lookback period. Current physician orders included, but were not limited to: Depakote sprinkles (antiepileptic medication) oral capsule delayed release 125 MG, Give one capsule by mouth three times a day, Start date 6/8/24 risperidone (atypical antipsychotic medication) oral tablet 1 MG, Give one tablet by mouth two times a day for, Start date 6/8/2024 Alprazolam (antianxiety medication) tablet 0.5 MG, Give one tablet by mouth two times a day, Start date 6/13/2024 Escitalopram oxalate (antidepressant medication) oral tablet 10 MG, Give one tablet by mouth one time a day, Start date 6/8/2024 Hydroxyzine HCl (antihistamine medication) 25 MG, Give one tablet every eight hours as needed, Start date 6/12/24 The clinical record lacked a care plan related to behavioral disturbances requiring antipsychotic		accomplished for those resident's found to have been affected by the deficient practice; The DON/Designee notified the practitioner on 11-11-2024 and clarified and removed diagnosis of schizoaffective disorder. 2) How other resident's having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken; The DON/Designee completed an audit of residents receiving antipsychotic medications to verify diagnosis added after admissions have a physician evaluation related to the new diagnosis on 11-20-2024. The DON/Designee completed and audit for residents receiving psychoactive medications for orders to monitor side effects and care plan related to behaviors on 11-14-2024. 3) what measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; Upon The DON/Designee in-serviced the physician on completing an evaluation when adding a new psych diagnosis on 11-21-2024. The DON/Designee educated nursing staff to implement order to monitor side effects of psychoactive medications and to monitor every shift on 11-19-2024. Additionally, any staff that fails to	

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	155275	A. BUILDING 00 B. WING	10/22/2024

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	medication use or monitoring for side effects of antipsychotic medications. A pharmacy medication review, dated 7/13/24, indicated Resident 47 was receiving risperdone 1 mg twice a day for dementia with behaviors. The physician selected to change the diagnosis associated with the medication from dementia with behaviors to schizoaffective disorder. A pharmacy medication review, dated 7/13/24, indicated Resident 47 was receiving Depakote 125 mg three times a day for dementia. The physician selected to change the diagnosis associated with the medication from dementia with behaviors to bipolar disorder. During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing indicated she was unable to find a physician evaluation related to Resident 47's diagnosis of schizoaffective disorder or bipolar disorder. On 10/21/24 at 1:30 P.M., a policy related to services provided meeting professional standards was requested and unable to be provided. 3.1-35(g)(1)		comply with the points of this in-service will be further educated and/or disciplined as indicated. 4) how corrective action(s) will be monitored to ensure the deficient practice will not recur: Audits will be brought to QAPI for review. The DON/Designee will audit pharmacy recommendations monthly for evaluations when adding new psych diagnoses x 6 months. The DON/Designee will audit 10 random resident receiving psychoactive medications for side effect monitoring and care plan weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will 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. 5) DOC 11-22-2024	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on clinical record review and interview, the facility failed to ensure care consistent with	F 0686	**Tag# F686 Treatment/Services to Prevent/Heal Pressure Ulcer**	11/22/2024

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	professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16) Finding includes: On 10/17/24 at 12:08 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/19/24, indicated Resident 16 was cognitively intact, required partial assistance from staff for toileting and bathing, and was completely dependent on staff for transfers. Current physician orders included, but were not limited to: Sacral wound: Cleanse and pat dry, apply skin prep, and cover with bordered gauze every day shift, Start date 10/12/24. Left heel: cleanse with wound cleanser, apply skin prep to peri wound, apply collagen to wound bed, and cover with silver alginate. Secure with abdominal pad and rolled gauze every day shift, Start date 9/14/24. Use wedge or pillow to alleviate pressure off of wound to sacrum- document any non-compliance every shift, Start date 9/6/24 Off loading device to left foot every shift when in bed, Start date 9/11/23 Apply skin prep to left heel every shift for prevent		**It is the policy and intent of the facility to ensure that prevent pressure ulcers from progressing by administering the treatment as ordered.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **DON/Designee assessed Resident 16 no negative outcome by the alleged deficient practice on 10-24-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **DON/Designee completed an audit for residents with pressure ulcer to treatment orders and interventions ordered in place on 11-20-2024. Any concerns were immediately addressed.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **DON/Designee in-serviced nursing staff on completing treatments as ordered and interventions in place as ordered and in-serviced QMA's on Scope of Practice that includes not completing treatment as ordered on 11-19-2024. Additionally, any**	

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	skin break down, Start date 8/16/24 Care plan: Wound is present on sacral region- Pressure ulcer stage 3, Start date 4/25/24. Interventions: air mattress on bed, 9/17/24; treatment as ordered, 4/25/24. Wound is present on left heel- Pressure ulcer stage 3, Start date 9/15/23. Interventions: air mattress on bed, 9/17/24; treatment as ordered, 2/7/24. (Stage three pressure ulcer is defined as a full-thickness tissue loss that extends through the skin into deeper tissue and fat.) Wound evaluations dated 8/29/24 through 10/17/24 indicated the following weekly measurements: Stage three left heel wound: 10/17: 2.6 cm x 3 cm x 0.1 cm 10/10: 2.5 cm x 3.1 cm x 0.1 cm 10/3: 2.6 cm x 3.2 cm x 0.1 cm 9/26: 2.6 cm x 3.2 cm x .1 cm 9/19: 3.1 cm x 4.1 cm x .1 cm 9/12: 1.6 cm x 1.2 cm x .1 cm 9/5: 1.4 cm x 1 cm x .1 cm 8/29: 1 cm x 0.5 x 0.1 cm Stage three sacral wound: 10/17: 4.4 cm x 7.1 cm 10/10: 4.5 cm x 8.2 cm 10/3: 0.2 cm x 0.2 cm 9/26: 0.8 cm x 1.4 cm x 0.2 cm 9/19: 2 cm x 1.5 cm x 0.2 cm 9/12: 1.9 cm x 1.2 cm x 0.2 cm 9/6: 2.5 cm x 2 cm x .1 cm 8/29: 2 cm x 2 cm x 0.1 cm		**staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The DON/Designee will audit completion of treatment orders by nurse and interventions in place as ordered on 10 random residents weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is 95% compliance at the end of 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 QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **DOC: 11-22-2024**	

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	On the following dates treatment administration was documented by a QMA on the electronic medication administration record during the last 60 day period: Stage three left heel wound: 9/12/24 9/20/24 9/23/24 9/27/24 10/2/24 10/3/24 10/17/24 10/21/24 Stage three sacral wound: 9/12/24 9/13/24 9/20/24 9/27/24 10/2/24 10/3/24 10/17/24 10/21/24 On the following dates treatment administration was not documented as completed during the last 60 days: Stage three left heel wound: 9/1/24 9/13/24 10/13/24 10/16/24 10/18/24 Stage three sacral wound: 10/11/24 10/16/24 The clinical record, including electronic administration record and progress notes, did not			

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	indicate any refusal of wound treatment during the last 60 days. A laboratory wound culture, resulted on 9/16/24, indicated Resident 16's stage three pressure ulcer left heel wound was positive for the organism methicillin resistant staphylococcus aureus. A nurse practitioner skin and wound note, dated 10/10/24, indicated staff had obtained a pressure reduction air flow mattress since last seen, on 10/3/24, due to long standing wound. Unfortunately, the air pressure mattress developed issues, so (resident) was placed back on a regular mattress. At today's visit the wound size worsened in size and shape. During an interview on 10/22/24 at 11:11 A.M., the Assistant Director of Nursing indicated a QMA (Qualified Medication Aide) should never administer treatments. On 10/22/24 at 9:58 A.M., the Director of Nursing provided a document titled "Qualified Medication Aide Scope of Practice" that indicated "The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all. The following tasks shall not be included in the QMA scope of practice: Administer a treatment that involves advanced skin conditions, including stage two, three, and four decubitus ulcers." On 10/22/24 at 9:58 A.M., a policy related to treatment and staging of wounds was requested and was not provided. 3.1-40(a)(2)			

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to ensure diet recommendations were followed in 1 of 3 residents reviewed for nutrition. (Resident 34) Findings include: On 10/17/24 at 1:11 P.M., Resident 34's clinical record was reviewed. Diagnoses included, but were not limited to, gastro-esophageal reflux disease, schizoaffective disorder, and dementia. The current Quarterly MDS (Minimum Data Set) Assessment dated 9/19/24 indicated Resident 50 was moderated cognitively impaired. The resident needed partial assistance to for toileting and dressing. The resident was noted for significant weight loss during the assessment period. Physician orders included, but were not limited, General diet, regular texture, and thin liquid consistency dated 4/12/24. Weekly weight records as follows: 10/2/2024 1:06 P.M. 124.5 Lbs. (Pounds) 9/25/2024 10:35 A.M. 126.5 Lbs. 9/16/2024 9:25 A.M. 121.5 Lbs. 9/9/2024 10:49 A.M. 122.0 Lbs. 9/2/2024 9:34 A.M. 128.0 Lbs. 8/23/2024 7:22 A.M. 124.5 Lbs. 8/1/2024 10:12 A.M. 128.5 Lbs. 7/29/2024 3:08 P.M. 130.0 Lbs. 7/22/2024 12:20 P.M. 128.5 Lbs. 7/15/2024 10:20 A.M. 129.5 Lbs. 7/8/2024 9:37 A.M. 130.0 Lbs. 7/3/2024 11:07 A.M. 131.0 Lbs. 7/1/2024 11:19 A.M. 130.0 Lbs.	F 0692	**Tag# F692 Nutrition/Hydration Status Maintenance** **It is the policy of the facility to ensure that dietary recommendations are being followed.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident 34 diet order was updated on 11/13/24 to reflect the dietary recommendations.** **The DON/Designee assessed Resident 34 no negative outcome by the alleged deficient practice.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **DON/Designee completed a 90 day look back audit to ensure all dietary recommendations are being followed through with on 11/19/2024.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **DON/Designee in-serviced nursing and dietary staff on following dietary recommendations on 11/19/24.**	11/22/2024

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	6/26/2024 1:14 P.M. 131.5 Lbs. 6/10/2024 9:08 A.M. 129.0 Lbs. 6/5/2024 10:25 A.M. 135.0 Lbs. 5/27/2024 10:31 A.M. 134.0 Lbs. 5/20/2024 1:18 P.M. 133.0 Lbs. 5/13/2024 10:02 A.M. 134.0 Lbs. 5/6/2024 10:00 A.M. 134.5 Lbs. 5/1/2024 2:09 P.M. 137.0 Lbs. 4/29/2024 1:20 P.M. 149.0 Lbs. 4/22/2024 12:31 P.M. 145.8 Lbs. 4/17/2024 10:53 A.M. 146.5 Lbs. The weight loss calculator indicated the resident had a 15.1% weight loss in 6 months A Nutrition at Risk Review (NAR) dated 5/8/24, at 2:40 P.M., recommended fortified food with breakfast to help prevent further weight loss. A NAR dated 5/22/24, at 3:24 P.M., recommended fortified food with meals to help prevent further weight loss. A NAR dated 5/29/24, at 3:15 P.M., recommended fortified food with meals to help discourage further weight loss. A NAR dated 6/12/24, at 2:41 P.M., recommended fortified food with meals to help discourage any further weight loss. A NAR dated 6/21/24, at 4:15 P.M., recommended fortified food with meals to help discourage any further weight loss the diet indicated it was general, regular, thin fluids, fortified foods with meals. The record lacked an order for change of of diet. A NAR dated 10/17/24, at 9:43 A.M., indicated the resident had a weight warning when the resident		**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 actions will be monitored to ensure the deficient practices will not recur:** **The DON/Designee will audit dietary recommendations weekly x 6 months. If the facility is 95% compliance at the end of 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 QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **DOC: 11-22-2024**	

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	was at 126.5 pounds, had a weight change in 6 months of 15.01 pounds over 6 months, and the diet was general, regular, with thin liquids. The record lacked an order for fortified foods with meals. The current care plan for nutritional risk indicates the resident is at risk related to BMI (Body Mass Index) > (greater than) 25, with a diagnosis of depression and dementia. Interventions included, but were not limited to, serve diet as ordered and offer substitutions if resident consumes < (less than) 50 % (Percent) of meal dated 9/15/23. During an interview on 10/18/24 at 9:13 A.M., the DON (Director of Nursing) indicated the resident should be on supplements if there is significant weight loss. During an interview on 10/18/24 at 9:17 A.M., the Diet Manager indicated he had talked with the dietitian about the resident's weight loss and were suggesting using fortified shakes, boost, etc. and change had not been done yet. On 10/21/24 at 3:12 P.M., the DON provided a current, non-dated policy "SWAT Program/ Skin and Weight Assessment Team." The policy indicated "... it is the policy of the facility to assess the nutritional status of each resident...the program is designed to aggressively review and address those residents exhibiting significant weight changes. these residents will be monitored ...involving all disciplines to best cater to the improvement of the resident nutritional status..." 3.1-46(2)			
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act			

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Bldg. 00	On Based on record review and interview, the facility failed to ensure a pharmacy recommendation was followed for 1 of 5 residents reviewed for unnecessary medications (Resident 47). Finding includes: On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 6/7/24. Diagnoses included, but were not limited to, dementia and cognitive communication deficit. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, and was completely dependent on staff for transfers. Physician orders included, but were not limited to: Omeprazole (proton pump inhibitor (PPI) medication) 40 MG capsule delayed release, give one capsule by mouth one time a day. Start date 6/8/24 The clinical record lacked a care plan related to the use of a proton pump inhibitor (PPI) medication. A pharmacy recommendation, dated 9/14/24, indicated a pharmacy recommendation to reduce or hold Resident 47's omeprazole medication for two weeks and if no GI symptoms occur, discontinue the medication. The eMAR (electronic medication administration record) indicated omeprazole 40 MG was held for 14 days and started again. The clinical record, including orders, care plans, assessments, and progress notes, lacked documentation if any GI	F 0756	**Tag# F 756** **It is the intent of this facility to ensure pharmacy recommendations are followed and care plans are in place for each medication.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident 47 was assessed with no negative effects were identified and Omeprazole was discontinued and care plan updated on 11-8-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **DON/Designee completed a 90 day look back of pharmacy recommendations and verified care plans in place and physician notified of any concerns on 11-20-2024.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **DON/Designee in-serviced staff on following through on the pharmacy recommendations and care plans in place on 11/19/24. Additionally, any staff that fails to comply with the points of this in-service will be**	11/22/2024

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	symptoms occurred during the 14 day hold period and rationale for Resident 47 continuing the medication. On 10/22/24 at 9:58 A.M., the Director of Nursing provided an undated policy titled "Pharmacy Recommendations" the stated "It is the policy of the facility to monitor medication by pharmacy regimen review conducted monthly or more often if indicated. The objective being to ensure that the residents are receiving medications that are effective and safe. The pharmacy consultant will contact the DON and or the physician and the concern will be addressed and resolved per physician orders/direction. This will be documented." 3.1-25(b)(2)		**further educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The DON/Designee will audit pharmacy recommendations for completion and care plans monthly x 6 months. If the facility is 95% compliance at the end of 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 QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **DOC: 11-22-2024**	
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician's orders and professional standard for 4 of 4 residents observed during medication pass. (Resident 10, Resident 39, Resident 42, Resident 30) Five medication errors were observed during 31 opportunities for error in medication	F 0759	**Tag# F759 Free of Medication Error Rates 5 Percent or More** **It is the policy of this facility to ensure it is free of medication error rate of less than 5%.** **What corrective actions will be accomplished for those residents found to be affected**	11/22/2024

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	administration. This resulted in a 16.13 error rate. Findings include: 1. During a medication administration on 10/18/24 at 8:02 A.M., RN 6 prepared the following medications for Resident 10: one tablet of certirizine 10 mg, one tablet of desvenlafaxine 100 mg, one tablet of famotidine 10 mg, one tablet of furosemide 40 mg, one tablet of meloxicam 7.5 mg, one tablet of Nuedexta 20-10mg, one tablet of vitamin D3 5000 units, one tablet of asenapine 5mg, and mixed a packet of polyethylene glycol in 8oz of water. RN 6 took the medications to Resident 10; Resident 10 took all of the medications orally and drank the polyethylene gylcol mixed in water. RN 6 then went to the EDK and removed a tablet of metoprolol 25mg, placed the pill in a medication cup, and gave the medication to Resident 10. On 10/18/24 at 9:45 A.M., Resident 10's clinical record was reviewed. Physician orders included, but were not limited to: asenapine 5mg take medication sublingually. During the medication administration, asenapine 5mg was not given to Resident 10 sublingually. 2. During the medication administration on 10/18/24 at 8:22 A.M., RN 6 prepared the following medications for Resident 39: one tablet of metformin 500mg, one soft gel of docusate sodium 100mg, one tablet of escitalopram 10 mg, one tablet of Farxiga 5 mg, one tablet of levetiracetam 1000mg, one tablet of metoprolol 25 mg, two tablets of quetiapine 25mg, attached a needle to the Admelog insulin pen and turned the dial to 10 units. RN 6 entered Resident 39's room and handed Resident 39 the cup of		**by the deficient practice: Resident 10, 39, 42, 30 was assessed by DON on 10/20/24 and no negative effects related to alleged deficient practice. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. The DON/Designee in-serviced the nursing staff and QMA's on Medication Administration policy on 11/19/24. 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 actions will be monitored to ensure the deficient practices will not recur: DON/Designee will complete 10 random medication observations weekly x 4 weeks, then 5 random medication observation x 4weeks. If the facility is within 95% compliant**	

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	155275	A. BUILDING 00 B. WING	10/22/2024

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	medications, then administered 10 units of Admelog insulin in Resident 39's right lower abdomen. During the medication administration, RN 6 did not prime the insulin pen needle prior to administration. Resident 39's clinical record was reviewed on 10/18/24 at 10:00 A.M. 3. During the medication administration on 10/18/24 at 8:40 A.M., RN 7 prepared the following insulin for Resident 42: Lantus insulin pen 70 units and lispro insulin pen 50 units. RN 7 primed each insulin pen with two units with the cap on, then set the dial to 70 units for Lantus insulin pen and 50 units to insulin lispro pen. RN 7 then administered 70 units of Lantus insulin in the resident's left lower abdomen and 50 units insulin lispro in the resident's left upper abdomen. During the medication administration, RN 7 did not prime the insulin pen needle properly prior to administration. Resident 42's clinical record was reviewed on 10/18/24 at 2:27 P.M. 4. During the medication administration on 10/18/24 at 8:52 A.M., RN 7 prepared the following medications for Resident 30: one tablet of Eliquis 5 mg, two tablets of Tylenol 235 mg, one tablet of folic acid 1mg, one tablet of lansoprazole 15mg, one tablet of vitamin D3 5000 units, one tablet of levothyroxine 50mcg, one tablet of lisinopril 20 mg, one tablet of loratadine 10 mg, a multivitamin tablet, and one tablet of olanzapine 5 mg. RN 7 took the cup of medications to Resident 30 and Resident 30 took the		**after 6 months, the monitoring will 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.** **DOC: 11-22-2024**	

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	medications orally. On 10/18/24 at 9:55 A.M., Resident 30's clinical record was reviewed. Current physician orders included, but were not limited to: olanzapine 2.5mg give 2.5mg by mouth one time a day, Start date 10/1/24. During an interview on 10/18/24 at 10:07 A.M., RN 7 opened the medication cart and pulled the medication card for olanzapine and confirmed the instructions on the card indicated give 5mg twice a day. RN 7 indicated there were not 2.5 mg tablets available and Resident 30 had been given the incorrect dose during the medication pass. On 10/22/24 at 11:01 A.M., the Director of Nursing provided a policy titled "Medication Administration", dated 2/2017, that indicated "Review the resident's Medication Administration Record (MAR). Read each order entirely. Remove the medication from the drawer. If there is any discrepancy between the MAR and the label, check physician orders before administering medication." On 10/22/24 at 11:01 A.M., the Director of Nursing provided an insulin injection instruction leaflet that stated "Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly, removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if			

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	insulin comes out of the needle. You may have to perform the safety test several times before insulin is seen." 3.1-48(c)(1)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were properly dated and labeled, failed to keep medications refrigerated until opening, and failed to destroy expired medications for 2 of 2 medication carts observed. (100 hall west medication cart and 200 hall east medication cart) Findings include: 1. During an observation on 10/16/24 at 9:03 A.M., the 200 hall east medication cart contained the following items: Humalog insulin pen - opened; lacked opened on or expiration date Lantus insulin pen- opened; lacked opened on or expiration date, pen needle attached and not capped Latanoprost eye drops- expiration date 10/13/24 Lantus insulin pen - expiration date 9/23/24 Humalog insulin pen- lacked identification tag or resident name - expiration date 10/14/24 insulin aspart pen- name rubbed off of identification tag two insulin lispro pens - seal is unopened, tag on insulin states "refrigerate until opening" opened bottle of Pro-Stat (liquid protein)- lacked label or opened date 2. During an observation on 10/16/24 at 9:25 A.M., the 100 hall west medication cart contained	F 0761	**Tag# F761 Label/Store Drugs and Biologicals** **It is the policy of this facility to ensure insulins and Pro-Stat are labeled with open and discard dates, discard expired medications and medications are refrigerated as indicated.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **No residents were identified for the alleged cited practice.** **The DON/designee immediately removed the undated insulins, expired medications and medications were re-ordered 11-23-2024 .** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **The DON/Designee audited medication carts for undated medications and expired medications on 11/15/24.** **Medications were re-ordered as needed.** **What measures will be put in**	11/22/2024

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	the following items: Humalog insulin pen- expiration date 9/11/24 insulin lispro pen- expiration 9/11/24 Basaglar insulin pen- opened; lacked opened on or expiration date two novolog insulin pens - opened; lacked opened on or expiration date Lantus insulin pen- opened; lacked opened on or expiration date Two novolog insulin pens - seal is unopened, tag on insulin states "refrigerate until opening" Ozempic (antidiabetic medication) injection- unopened, tag on injection box states "refrigerate until opening" two Basaglar insulin pens - opened; lacked opened on or expiration date Bottle of opened Pro-Stat (liquid protein)- lacked label or opened date During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing stated the facility was aware of the injections in the medication carts not being refrigerated properly due to pharmacy delivering the injections without ice packs. On 10/21/24 at 3:31 P.M., the Director of Nursing provided a policy titled "Medication Storage in the Facility", dated 6/2012, that stated "Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. Medications requiring "refrigeration" or temperature between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists."		**place and what systemic changes will be made to ensure that deficient practice does not recur.** **The DON/Designee in-serviced nursing staff on dating insulin and disposing of insulin by the discard date, placing medications in the refrigerator and ensuring all medication is labeled properly on 11/19/24. Additionally, any staff that fails to comply with the points of this in-service will be furthered educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **DON/Designee will complete an audit of insulin pens, vials, and bottles for expiration dates, properly labeled and refrigerate as indicated 5 times a week x 4 weeks, then 3 times a week x 4weeks, then once a week x 4 months. If the facility is within 95% compliant after 6 months, the monitoring will be stopped. Results of the 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**	

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	3.1-25(j) 3.1-25(m) 3.1-25(o)		**monitored by the Administrator weekly until resolved.** **DOC: 11-22-2024**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (200-hall) Finding includes: On 10/16/24 at 10:13 A.M., Resident 52 indicated the food was cold. On 10/16/24 at 10:38 A.M., Resident 31 indicated the food was cold. On 10/16/24 at 12:14 P.M., Resident 15 indicated the food tasted bad and was cold. On 10/17/24 at 10:45 A.M., Resident 42 indicated the food tasted bad and was cold. On 10/21/24 at 12:22 P.M., a test tray was obtained. Food temperatures for that meal were: BBQ chicken 102.9 F (Fahrenheit) Roasted potatoes 109.7 F Yellow squash 107.9 F At that time, the food tasted cold. On 10/21/24 at 12:31 P.M., the Dietary Manager expected food to be about 148 F when served. He indicated he was aware cold food was an issue and hoped to get new insulated holders and carts to help.	F 0804	**Tag# F804 Nutritive Value/Appear, Palatable/Prefer Temp** **It is the intent of this facility to ensure food temperature are within range and served at the appropriate temperatures.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Residents 52, 31, 15, 42 were assessed and not negatively affected related to the alleged deficient practice on 10-23-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **All residents who reside in the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility.** **What measures will be put in place and what systemic**	11/22/2024

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	On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated current Food Temperatures policy that indicated "Best efforts will be made to present hot foods hot and cold foods cold at point of service ...". 3.1-21(a)(2)		**changes will be made to ensure that deficient practice does not recur.** **The Dietary Manager/Designee in-serviced dietary staff on monitoring food temperature on 11/19/24. Additionally, any staff member that fails to comply with the points of this in- service will be further educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The Dietary Manager/Designe will monitor food temperatures for proper temperature daily for a random meal service services 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week for 4 weeks, then once a month x 3 months. If the facility is 95% compliance at the end of 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 QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.**	

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			DOC: 11-22-2024	
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation, interview, and record review, the facility failed to ensure food was correctly prepared for 4 of 4 residents who received puree altered diets. Finding includes: On 10/17/24 at 10:01 A.M., Cook 5 was observed preparing 4 servings of pureed beef and cheddar sandwiches. Cook 5 added the following ingredients to the blender and blended in between each item: 8 slices of pre-cooked roast beef 1-ounce (oz) scoop of mayonnaise 1-oz scoop of mayonnaise 1-oz scoop of mayonnaise 4 hamburger buns torn up 2 1-oz scoops of mayonnaise 2 1-oz scoops of mayonnaise 4 slices of cheese torn up 2 1-oz scoops of mayonnaise At that time, Cook 5 indicated the food did not look right and it would probably taste like straight mayonnaise. She indicated she usually would add broth to help with the consistency, but the recipe did not call for it. That was a new recipe and she had never made it before. Cook 5 added 4 more 1-oz scoops of mayonnaise. (Total mayonnaise added was 13-oz.) Cook 5 went to the reach-in refrigerator and obtained milk. The best by date on the milk was 10/16/24. She added a quarter cup of milk to the blender and blended to pudding consistency.	F 0805	**Tag# F804 Nutritive Value/Appear, Palatable/Prefer Temp** **It is the intent of this facility to ensure food temperature are within range and served at the appropriate temperatures.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Residents 52, 31, 15, 42 were assessed and not negatively affected related to the alleged deficient practice on 10-23-2024.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **All residents who reside in the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.**	11/22/2024

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	On 10/21/24 at 9:37 A.M., the Dietary Manager provided the recipe for the Beef and Cheddar Sandwich that was prepared by Cook 5 on 10/17/24. The ingredients for one serving included: 2-oz shaved roast beef 1 slice cheese 1 bun The puree preparation instructions indicated to place in food processor and process to a smooth pudding like consistency. Add mayo, a little at a time, as needed to achieve smooth consistency. No serving size was identified per serving. On 10/21/24 at 2:32 P.M., the Dietary Manager indicated the menu and recipes were new to the facility. He indicated 13 oz of mayonnaise was a lot of mayonnaise and he would have advised Cook 5 to use milk to help achieve the appropriate consistency. At that time, he indicated expired food was thrown out daily and he didn't realize the milk in the refrigerator was expired. On 10/22/24 at 11:00 A.M., the Dietary Manager provided an undated current Characteristics and Procedures for Consistency Modified Foods policy that indicated "Properly prepared pureed food has the following characteristics...it is soft (pudding like consistency) ... Successfully pureeing food depends on using the right process as well as the right equipment. If you cannot puree an item to meet the above characteristics with the processing equipment that you have, contact your manager or dietician to determine an appropriate substitute". On 10/22/24 at 11:00 A.M., the Dietary Manager provided a current Pureed Food Preparation		**The Dietary Manager/Designee in-serviced dietary staff on monitoring food temperature on 11/19/24. Additionally, any staff member that fails to comply with the points of this in- service will be further educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The Dietary Manager/Designee will monitor food temperatures for proper temperature daily for a random meal service services 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week for 4 weeks, then once a month x 3 months. If the facility is 95% compliance at the end of 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 QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.** **DOC: 11-22-2024**	

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	policy, dated 10/25/23, that indicated "Milk, broth, soup, gravy, juice, and margarine will be used to thin the pureed food ... The flavor of pureed foods will be checked as these items must have the same flavor as original regular menu item". On 10/22/24 at 11:21 A.M., the Director of Nursing (DON) provided a current First In First Out (FIFO) policy, dated 4/2017, that indicated "Stock must be used before the expiration date. Items not used by the expiration date will be discarded". 3.1-21(a)(3)			
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 food was prepared under sanitary conditions during 3 of 3 kitchen observations and 1 of 1 dining observations. Staff did not wear hairnets, and gloves were not changed before touching food items. (Dietary Manager, Cook 5, Cook 14, Activities Department Staff) Findings include: 1. During a lunchtime dining observation on 10/16/24 at 12:00 P.M., Activities Department staff were observed assembling and serving hot dogs for lunch in the dining room. Residents placed orders and staff assembled buns, hot dogs, condiments, and chili in the dining room. Staff did not change gloves in between touching the hot dog buns and touching condiment bottles. Staff were not wearing hairnets while assembling food. 2. On 10/16/24 at 9:12 A.M., the Dietary Manager was observed in the kitchen without a beard net.	F 0812	**Tag# F812 Food Procurement, Store/Prepare/Serve-Sanitary** **It is the intent of this facility to ensure food is prepared under sanitary conditions with hairnets and gloves to be worn properly.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Residents were assessed and not negatively affected related to alleged deficient practice on 10-23-2024, by the DON/Designee.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **All residents who reside in the facility have the potential to be**	11/22/2024

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	Cook 5 and Cook 14 were observed in the kitchen wearing a hairnet that did not cover all of their hair. 3. On 10/17/24 at 10:01 A.M., the Dietary Manager was observed in the kitchen without a beard net. Cook 5 was observed in the kitchen wearing a hairnet that did not cover all of her hair. 4. On 10/21/24 at 11:30 A.M., Cook 5 was observed taking temperatures of lunch foods on the steam table. Cook 5 was wearing gloves. She touched her face, the refrigerator, a cart, the hot plate heater, the oven, a cooking tray, and a hot pad. Without changing gloves, Cook 5 reached in a bread bag and retrieved a bun, opened the bun, and prepared a chicken sandwich. Cook 5 was observed wearing a hairnet that did not cover all of her hair. At that time, the Dietary Manager was observed in the kitchen without a beard net. On 10/21/24 at 2:32 P.M., the Dietary Manager indicated hairnets were worn when handling food. All hair should be covered while wearing a hairnet including facial hair. At that time, he indicated gloves should be changed after touching nonfood items and before touching food, and Cook 5 should have changed gloves before touching the bun. On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated Glove Use policy that indicated "Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled or when interruptions occur in the operation ... Gloves are just like hands. They get soiled.		**affected by this alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **The Dietary Manager/Designee in-serviced dietary and activity staff on the proper use of hairnets and gloves on 11/15/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **The Dietary Manager/Designee will complete validation of hairnet and glove usage on 6 random staff members weekly x 4 weeks, then 3 random staff members weekly x 4 weeks, then 2 random staff member monthly x 3 months. If the facility is within 95% compliance at the end of 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been**	

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	155275	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

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	Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: ... During food preparation, as often as necessary...to prevent cross contamination when changing tasks". On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated current Hair Restraints/Jewelry/Nail Polish policy that indicated "Hairnet, hat or hair restraint will be worn at all times in the kitchen". On 10/22/24 at 12:56 P.M., the Administrator provided a current Employee Health and Personal Hygiene policy, dated 9/17/23, that indicated "Hair restraints will be worn at all times. Beards should be well-trimmed and covered with an appropriate hair restraint". 3.1-21(i)(2) 3.1-21(i)(3)		**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.** **DOC: 11-22-2024**	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 4 of 5 residents reviewed for insulin, 5 of 5 reviewed for late medications and 1 of 2 residents reviewed for wound care. Insulin documentation and wound treatments were not documented by the staff that provided the service, medications were documented correctly when administered one hour and 45 minutes late. (Resident 53, Resident 15, Resident 42, Resident 16, Resident 259, Resident 17, Resident 22) Findings include: 1. On 10/17/24 at 12:37 P.M., Resident 53's clinical	F 0842	**Tag# 842 Resident Records-Identifiable Informtion** **It is the policy of this facility for the Medication Administration Records to accurately reflect the administration of insulin and wound treat to be documented by the nurse administering.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **The DON/Designee assessed Resident 53, 16, 15, 42, 259, 17,**	11/22/2024

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	record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Admission Minimum Data Set (MDS) Assessment, dated 8/20/24, indicated Resident 53 was cognitively intact and received insulin. Physician orders included, but were not limited to: Insulin lispro (a fast-acting insulin) 100 units/milliliter (mL) - Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; 401+ = 7units subcutaneously before meals for diabetes mellitus, dated 8/14/24 The Medication Administration Record (MAR) from 8/7/24 to 10/17/24 indicated Qualified Medication Aide (QMA) 10 administered insulin lispro to Resident 53 on the following dates: 8/24/24 at 7:02 A.M. 8/24/24 at 5:24 P.M. 9/7/24 at 12:48 P.M. 9/9/24 at 5:28 P.M. 9/24/24 at 10:20 A.M. 9/30/24 at 10:04 A.M. Medication Administration progress notes from QMA 10 indicated the insulin was given by the nurse on duty on those days. The progress notes did not specify which nurse on duty gave the insulin. The clinical record lacked documentation from the nurse that administered the insulin on those days.2. On 10/17/24 at 12:08 P.M., Resident 16's clinical record was reviewed. Resident 16 was admitted on 2/13/19. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes mellitus.		**22 on 10/22/24 and no negative outcome related to the cited practice.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: All residents who receive insulin and wound treatments have the potential to be impacted by this deficient practice, therefore, this plan of correction applies to all residents that reside in the facility.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **DON/Designee will in-service nursing staff on the policy "Medication Administration", signing off medications and treatments timely and for nurses to sign off medications that the QMA is unable to administer by 11/20/24. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:**	

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	The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/19/24, indicated Resident 16 was cognitively intact, required partial assistance from staff for toileting and bathing, and was completely dependent on staff for transfers. Current physician orders included, but were not limited to: Basaglar (insulin medication) Inject 10 unit subcutaneously every morning and at bedtime for diabetes, Start date 4/9/24 On the following dates subcutaneous insulin administration was documented by QMA 10 on the electronic medication administration record during the last 30 day period: 9/20/24 8:00 A.M. 9/27/24 8:00 A.M. 10/2/24 8:00 A.M. 10/3/24 8:00 A.M. 10/16/24 8:00 A.M. 10/17/24 8:00 A.M. 10/21/24 8:00 A.M. On 10/22/24 at 9:58 A.M., the Director of Nursing provided a document titled "Qualified Medication Aide Scope of Practice" that indicated "The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all. The following tasks shall not be included in the QMA scope of practice: Administering medication by the injection route, including the following: Subcutaneous route."3. On 10/17/24 at 2:03 P.M., Resident 15's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) Assessment, on 10/27/24, indicated that the resident was cognitively intact, had diagnoses that included but was not limited to diabetes		**DON/Designee will audit insulin and wound treatment administration for 10 random residents a week x 4 weeks for documentation in the EMR, then 5 random residents a week for 4 weeks, then 3 random residents a monthly x 2 months. ="" span="">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.** **DOC: 11-22-2024**	

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	mellitus, and received insulin. Current orders included: Humalog KwikPen (short-acting insulin) dated 11/2/23. Resident 15's MAR (Medication Administration Record) for October 2024 indicated that the following doses of Humalog (insulin) for the resident were administered by QMA (Qualified Medication Aide) 10: 10/2/24 8 A.M. and 12 P.M. 10/3/24 8 A.M. and 12 P.M. 10/16/24 8 A.M. and 12 P.M. 10/17/24 8 A.M. and 12 P.M. QMA 10 was not qualified to administer insulin. On 10/18/24 at 11:30 A.M., Resident 15's MAR (Medication Administration Record) was reviewed. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24 4. On 10/18/24 at 2:27 P.M., Resident 42's clinical record was reviewed. The most recent State Optional MDS , dated 8/9/24, indicated the resident was cognitively intact and had diagnoses that included but was not limited to diabetes mellitus and received insulin. Current orders included: Insulin Lispro Injection Solution 50 units before meals, dated 6/28/24. Insulin Lispro Injection Solution, inject as per sliding scale before meals and bedtime, dated 6/28/24.			

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	Resident 42's MAR (Medication Administration Record) for October 2024 indicated that the following doses of Insulin Lispro injections for the resident were administered by QMA (Qualified Medication Aide) 10: 10/3/24 11 A.M. insulin Lispro 50 units 10/3/24 11 A.M. insulin Lispro sliding scale QMA 10 was not qualified to administer insulin. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. 5. On 10/16/24 at 3:50 P.M., Resident 259's clinical record was reviewed. The resident was recently admitted and did not have a completed MDS. Resident 259 had diagnoses that included but was not limited to zoster (shingles). Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. 6. On 10/18/24 at 2:30 P.M.., Resident 17's clinical record was reviewed. The most recent Quarterly MDS dated 9/16/24, indicated the resident was cognitively intact, had diagnoses that included but was not limited to cerebrovascular accident, and was receiving opioid medications. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. 7. On 10/18/24 at 2:20 P.M., Resident 22's clinical record was reviewed. The most recent Quarterly MDS dated 7/16/24, indicated the resident was cognitively intact, had diagnoses that included but was not limited to coronary artery disease,			

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	and was receiving an opioid medication. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. On 10/18/24 at 2:40 P.M., RN (Registered Nurse) 7 indicated that she did not stay over her scheduled shift to give Resident 15, Resident 17, Resident 42, Resident 259, and Resident 22's medications and the nurse scheduled to relieve her had called in, the nurse working night shift gave Residents' 8 P.M. medications late but had not charted they were given. On 10/21/24 at 9:40 A.M., the Administrator indicated that RN 7 gave some of the scheduled medications and RN 22 gave the rest, also that RN 22 fixed their documentation to reflect that they had given these medications. On 10/21/24 at 10:00 A.M., controlled drug receipt/record/disposition forms were reviewed for Residents 15, 17, 42, 259, and 22. These indicated that the residents received their medications scheduled for 10/15/24 at 8:00 P.M., at 8:00 P.M. on 10/15/24 with the signature of RN 22. DON (Director of Nursing) indicated on 10/21/24, at 10:20 A.M., RN 22 clocked in for their shift on 10/15/24 at about 9 or 9:30 P.M. An official time stamp from RN 22's time card on 10/15/24, indicated they clocked in for their shift at 9:45 P.M. On 10/21/24 at 2:20 P.M., the Director of Nursing (DON) indicated that QMAs did not give insulin. A nurse would give the insulin for the QMA and the QMA could mark it done for the nurse who gave the insulin. At that time, the DON indicated			

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	that insulin is the only medication in the facility that one staff could give and another staff could sign off on giving. On 10/21/24 at 3:12 P.M., the DON provided a current Guidelines for Nursing Documentation, dated 5/17/23, that indicated "be definite in what you record ... If you did not write it down, you did not do it. If you did not do it, you were negligent. ...should you need to document something out of time do it properly and in an orderly manner by first documenting when you are making the last note, then detailing the actual time the event occurred. Never be deceptive and 'back-date' or fake that you are writing at an earlier time." 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to implement infection prevention measures by following physician orders for enhanced barrier precautions for 1 of 1 residents observed for wound care. (Resident 6) Finding includes: On 10/17/24 at 10:40 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, seizures and bipolar disorder. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/16/24, indicated Resident 6 was severely cognitively impaired and required partial assistance from staff for eating, bathing, toileting, and transfers.	F 0880	**Tag# F880 Infection Prevention and Control** **It is the policy of this facility to ensure that enhanced barrier precautions are followed.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident 6 was assessed and not negatively affected related to alleged deficient practice by the DON/Designee on 10-24-2024.** **How other residents having the potential to be affected by the same deficient practices will**	11/22/2024

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	Current physician orders included, but were not limited to: Enhanced Barrier Precautions, start date 9/16/24 Left calf abrasion: Cleanse with wound cleanser, apply collagen and secure with rolled gauze due to fragile skin. No tape on skin every day shift, Start date 9/28/24. During an observation of wound care on 10/21/24 at 9:11 A.M., LPN (Licensed Practical Nurse)12 entered Resident 6's room. Resident 6's door had a sign that indicated enhanced barrier precautions. LPN 12 washed her hands, put gloves on, and began opening wound care supplies on a bedside table. LPN 12 sprayed wound cleanser on gauze and cleaned Resident 6's wound bed on her left calf. LPN 12 applied collagen to the wound, applied rolled gauze around the left lower extremity, secured the gauze with tape, removed her gloves, and used a marker to write the date on the tape. LPN 12 gathered the wound supplies, threw the trash away, and washed her hands. LPN 12 did not wear a gown while providing wound care. During an interview on 10/22/24 at 8:52 A.M., the MDS coordinator indicated Resident 6 had wounds that required enhanced barrier precautions. On 10/21/24 at 3:31 P.M., the Director of Nursing provided a policy titled "Enhanced Barrier Precautions", dated 12/19/22, that indicated Enhanced Barrier Precautions (EBP) are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs (multi-drug resistant organisms) in the form of blood or body		**be identified and what corrective action will be taken: All residents who reside in the facility have the potential to be affected by this alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur.** **The DON/Designee in-serviced the nursing staff on 11/19/24 related to facility policy and protocol on enhanced barrier precautions. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **DON/Designee will complete validation of enhanced barrier precautions are in place on 10 random staff member weekly x 4weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members weekly x 4 weeks then 3 random staff members monthly x 3 months will be completed on. If the facility is within 95%**	

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	fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of MRDO or a colonized MRDO." 3.1-18(b)		**compliance at the end of 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.** **DOC: 11-22-2024**	