STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155617	A. BUILDING 00 B. WING	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 7, 8, 9, 10, and 13, 2025. Facility number: 000524 Provider number: 155617 AIM number: 100267090 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 5 Medicaid: 26 Other: 8 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 23, 2025.	F 0000	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 February 14, 2025. The Waters of Chesterfield is respectfully requesting paper compliance for all deficiencies in the Plan of Correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to develop and provide a menu to encourage intake and promote dignity for residents who received a pureed diet for 3 of 3 residents who received pureed diets. (Residents 1, 16, and 7) Findings include: A current Facility menu, item and portion size	F 0550	***It is the policy of the facility to develop and provide a menu to encourage intake and promote dignity for resident's that receive a pureed diet.*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***Residents 1, 7 and 16's were***	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eileen Thomas	Administrator	02/06/2025

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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	guide (spread sheets) for lunch on Thursday 1/9/25 indicated the following meals were menued to be served: Regular Diet: BBQ chicken wings, herb roasted potatoes, broccoli florets, chilled peaches, and a dinner roll. The "Pureed Diet" was menued to receive all of the above items in pureed form. During a lunch meal observation on 1/9/25 from 12:00 p.m. to 12:36 p.m., the following food items were served: Regular diet trays were served breaded chicken nuggets/boneless chicken wings with a side of BBQ sauce, steamed broccoli florets, roasted herbed potatoes, and pudding as a substitute for peaches. During an interview on 1/9/25 at 12:25 p.m., the Acting Dietary Manager (ADM) indicated pudding was a substitute for peaches due to availability. Residents 1, 16, and 7 were served pureed grilled chicken, mashed potatoes, and a pureed vegetable blend. During an interview on 1/9/25 at 12:30 p.m., the ADM indicated he hadn't followed the recipes and menus because he didn't have the time. Review of portion size guide and food type menus (spread sheets) for the week of 1/5/25 to 1/12/25 identified the following concerns regarding lack of variety and/or the failure to serve residents with pureed diets the same meal as other residents, when possible, as follows: a. 4 of 7 days had a menu for pureed diets to		***assessed by the DON and no negative outcome related to the alleged deficient practice.*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All residents that receive puree diet had the potential to be affected, therefore this plan of correction applies to all residents that reside in the facility.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The Administrator inserviced the dietary department on following menus for altered diet texture on 2.6.2025. Employees who fail to comply with education and inservice training will be further educated per facility policy.*** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***The Administrator or designee will audit 10 random meal services a week for four weeks for pureed diets, then 5 random meal services weekly for four weeks, then 3 random meal services monthly for four months. Results of the***	

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	receive pureed buttered carrots: 1/5/25 lunch, 1/9/25 dinner, 1/10/25 lunch, and 1/11/25 dinner. On 1/5/25 the pureed buttered carrots were served as salad when the regular diet was Caesar salad. On 1/9/25 the pureed buttered carrots were served as a vegetable when the regular diet was mixed vegetables. On 1/10/25 the pureed buttered carrots were served as a vegetable when the regular diet was peas and carrots. On 1/11/25 the pureed buttered carrots were served when the regular diet was mixed vegetables. b. Pureed pork was menued to be served for both lunch and dinner on 1/10/25. On 1/10/25 lunch all diet types were menued to receive roast pork. On 1/10/25 dinner, regular diets were to receive Kielbasa when pureed diets were menued for pureed pork, resulting in the same meat being served twice in day. c. Apple sauce with cinnamon was menued to be served for pureed diets for both lunch and dinner on 1/8/25. On 1/8/25 at lunch, the regular diet was apple crisp and the pureed diet was apple sauce. On 1/8/8/25 at dinner, all diet types were menued to receive apple sauce. d. Pureed ranch pasta salad was menued to be served for pureed diets two days in a row 1/6/25 and 1/7/25. e. Vegetable juice was menued to be served 3 of 7 days of the week: 1/5/25 dinner, 1/8/25 dinner, and 1/12/25 dinner On 1/5/25 at dinner, vegetable juice was served as a salad to pureed diets when regular diets were		***monitoring will be reviewed monthly at the QAPI meeting. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	

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	served Cole slaw. On 1/8/25 at dinner, regular diets were served house garden salad and pureed diets were menued to be served vegetable juice. On 1/12/25 at dinner, pureed diets were menued to receive vegetable juice when regular diets were served tossed salad. f. Mashed potatoes were menued to be served 4 meals during the week: 1/6/25 lunch, 1/9/25 dinner, 1/11/25 breakfast and dinner. On 1/6/25 at lunch all diet types were menued to receive mashed potatoes. On 1/9/25 at dinner, pureed diets were menued to receive mashed potatoes when regular diets were served potato chips. On 1/11/25 at breakfast, pureed diets were menued to receive mashed potatoes when regular diets were menued to receive hash brown potatoes. On 1/11/25 at dinner, all diets were menued to receive mashed potatoes. This resulted in those residents who received pureed diets being menued to receive mashed potatoes two times in one day. Resident 1's clinical record was reviewed on 1/10/25 at 10:14 a.m. Current diagnoses included TIAs (Transient Ischemic Attack), dysphasia, major depressive disorder, and delusional disorder. The resident had a current physician's order for a pureed diet. The diet order originated 12/29/2024. An 11/12/24, annual, MDS indicated the resident was severely cognitively impaired. The resident had a current, 11/13/24, care plan problem/need regarding being at nutritional risk. Resident 16's clinical record was reviewed on			

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	1/10/25 at 10:16 a.m. Current diagnoses included diabetes mellitus, hypertension, and dysphasia. The resident had a current physician's order for a pureed diet. This order originated 11/25/2024. An 11/15/24, quarterly, MDS indicated the resident was severely cognitively impaired. The resident had a 11/6/2024, care plan problem/need regarding nutritional risk. Resident 7's clinical record was reviewed on 1/10/25 at 10:19 a.m. Current diagnoses included congestive heart failure, chronic kidney disease, and gastro-esophageal reflux disease. The resident had a current physician's order for a pureed diet. The order originated 9/19/2023. A 12/26/24, quarterly, MDS indicated the resident was severely cognitively impaired. The resident had a current,10/6/2024, care plan problem/need regarding nutritional risk. A current, 1/7/25, facility policy titled, "Resident Rights," provided by the Administrator following the entrance conference on 1/7/25, indicated: "...The resident has the right to a dignified existence, self-determination... A facility must protect and promote the right of each resident...." A current, 4/5/24, facility policy titled "Menus," provided by the Administrator on 1/9/25 ay 3:15 p.m., indicated "...Menus shall provide a variety of foods and indicate standard portions at each meal. Menus shall be varied for the same day of consecutive weeks...." 3.1-3(a)			

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F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on record review and interview, the facility failed to provide the appropriate 48-hour notification of Medicare A Non-coverage for 2 of 2 residents reviewed for Beneficiary Notifications. (Residents 37 & 38) Findings include: On 1/8/25 at 1:23 p.m., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed for Residents 37 and 38, and indicated the following: 1. Resident 37 was admitted to Medicare Part A Skilled Services on 7/24/24. The last covered day of Part A services was 9/10/24. The Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and SNF Notice of Medicare Non-Coverage (NONMC) were reviewed with the resident's representative and signed on 9/10/24. A 9/9/24, "Detailed Explanation of Non-coverage" form indicated Resident 37 had reached the maximized functional potential for physical and speech therapy. 2. Resident 38 was admitted to Medicare Part A Skilled Services on 8/13/24. The last covered day of Part A services was 9/11/24. The SNF ABN and SNF NONMC were reviewed with the resident's representative and signed on 9/10/24. A 9/10/24,"Detailed Explanation of Non-coverage" form indicated Resident 38 had reached the maximized functional potential for physical, occupational, and speech therapy.	F 0582	***It is the policy of the facility to provide 48 hour notification of Medicare Non-Coverage (NOMNC).*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***Residents 37 & 38 no longer reside in the facility.*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All residents that reside in the facility and receive Medicare services have the potential to be affected by the alleged deficient practice. Social Services or a designee completed a 30 day look back on 1.31.2025 to verify residents discharging from Medicare services were provided with a NOMNC prior to discharge, in a timely manner.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The Administrator has inserviced the IDT on providing NOMNC's to residents who are receiving Medicare services and are discharging from Medicare services. Employees who fail to***	02/14/2025

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	During an interview, on 1/10/25 at 9:34 a.m., LPN 3 indicated she was the Social Service Director at the time. The process for when a resident was discharged from any therapy service was for the therapy department to notify the Social Service department of the last day of covered services. She indicated there were times when she was not given the full two days advanced notice before services ended. The resident representatives needed to review and sign the NOMNC and ABN forms and this was sometimes difficult to complete. She aimed to complete this on the same day as she was notified by therapy. During an interview, on 1/13/24 at 10:35 a.m., Speech Therapist (SLP) 4 indicated the therapy discharge forms were filled out a week in advance and provided to the Social Services (SS) and Minimum Data Set (MDS) departments. SLP 4 indicated the facility had a weekly Medicare A meeting where the residents on caseload were discussed and any upcoming discharges were reviewed. The SS and MDS departments attended these meetings. An undated, current facility policy, titled, "Advanced Beneficiary Notices", provided by the Administrator on 1/13/25 at 10:51 a.m., indicated the following: "...It is the policy of the facility to follow the Medicare requirements for issuing Advanced Beneficiary Notices and Notices of Non-coverage of services as defined in the Medicare Claim Processing manual, Chapter 30... The SFN ABN must be issued "Prior" to receiving the non-covered care... The Notice/Form will be completed per the CMS guidelines by a facility designee...The Center of Medicare and Medicaid Services (CMS) require a Notice of Medicare Non-coverage (NONMC) Notice to be issues to		***comply with education and inservice training will be further educated per facility policy.*** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***Social Services or a designee will complete the NOMNC audit tool 5 days a week for four weeks, then 3 days a week for two months, then weekly for three months. Results of the monitoring will be reviewed monthly at the QAPI meeting. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	

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	Medicare Beneficiaries who are receiving Services from the skilled nursing facility to inform them that their Medicare covered services are ending...The NOMNC will be issues to the Traditional Medicare A Beneficiaries or the authorized representative, 2 days prior to the Medicare coverage ending when the Beneficiary has days remaining...." 3.1-4(f)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to notify the physician as ordered for changes in daily weights for 1 of 1 resident reviewed for weight loss/gain. (Resident 5) Finding includes: Resident 5's record was reviewed on 1/9/25 at 2:24 p.m. Diagnoses included heart failure, hypertension, and unspecified edema. Physician's orders included, but were not limited to, a. Monitor 1600 millimeter (mL) fluid restriction daily, 360 mL per meal. The order was dated 11/21/24. b. Take daily weight and notify the physician for an increase of 3 pounds (lbs) in 24 hours or an increase of 5 lbs in 7 days. The order was dated 11/22/24. c. Give one torsemide (a diuretic) 40 milligrams (mg) tablet twice daily for edema. The order was dated 11/29/24.	F 0684	***It is the policy of the facility to notify the MD/NP as ordered for changes in daily weights.*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***The DON notified the MD/NP of changes in Resident #5's weight on 1.19.2025 and new order received to discontinue parameters.*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All residents with daily weight orders that include to notify the MD/NP of weight gain have the potential to be affected by the alleged deficient practice. The DON or designee completed a 30 day look back on 1.31.2025 related to daily weight orders to confirm physician orders were***	02/14/2025

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	Review of the resident's documented weights, included, but were not limited to, the following: a. On 12/24/24, the resident's weight was 362.6 pounds. On 12/23/24, the resident's weight was 353.0 pounds. This was an increase of 9.6 pounds in 24 hours. The record lacked a physician notification regarding weight gain. b. On 12/27/24, the resident's weight was 362.0 pounds. On 12/26/24, the resident's weight was 347.2 pounds. This was an increase of 14.8 pounds. The record lacked a physician notification regarding weight gain. c. On 12/31/24, the resident's weight was 360.6 pounds. On 12/30/24, the resident's weight was 354.0 pounds. This was an increase of 6.6 pounds. The record lacked a physician notification regarding weight gain. A care plan, dated 9/20/24, related to congestive heart failure risks and complications included, but was not limited to, the following interventions: Fluid restriction as ordered, medications as ordered, and monitor for signs and symptoms of an exacerbation. During an interview, on 1/13/24 at 11:17 a.m., LPN 5 indicated the weights and physician notifications were documented in the electronic medical record. During an interview, on 1/13/24 at 11:54 a.m., the DON indicated the weights were documented in the vitals section of the electronic medical record. This resident was being seen weekly by the Nurse Practitioner (NP) since she was aware of his weight fluctuations. She indicated she was not able to locate documentation indicating the		***followed. No other residents were identified.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The DON or designee completed education to licensed nursing staff on 1.24.2025 related to following physician orders, obtaining daily weight and notifying MD/NP of weight gain and ensuring documentation of notification. Employees who fail to comply with education and inservice training will be further educated per facility policy.*** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***The DON or designee will complete daily weight and MD/NP notifications audit five days a week for four weeks, then weekly for four weeks, then monthly for four months. The audits will be reviewed monthly during the QAPI Committee meeting. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	

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	physician or NP were notified of weight gain as ordered. A current facility policy, dated 6/18/23, titled, "Guidelines for physician orders-(following physician orders), provided by the Administrator on 1/13/25 at 1:32 p.m., indicated the following: "...4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received...." 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure insulin (a medication to treat diabetes mellitus) vials were dated when opened and disposed of when expired for 1 of 2 carts reviewed for medication storage. (200 hall cart) Finding includes: During a medication storage observation of the 200 hall cart, accompanied by RN 6 on 1/10/25 at 10:22 a.m., the following was observed: One open vial of Lantus (long-acting) insulin, dated 12/10/24; the vial contained approximately 40 units. One open vial of Lantus (long-acting) insulin, undated; the vial contained approximately 260 units. One open vial of Novolog (rapid-acting) insulin, undated; the vial contained approximately 200 units. During an interview at the time of the observation,	F 0761	***It is the policy of the facility to ensure that insulin is dated with date opened and destroyed when expired.*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***The DON discarded the open insulin that were not dated and insulin that was expired on 1.10.2025.*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All residents that have orders for insulin have the potential to be affected by the alleged deficient practice. The DON and Consultant Pharmacist completed an audit of all***	02/14/2025

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	RN 6 indicated insulin was good for 28 days and the insulin dated 12/10/24 was expired and should no longer be used. The undated insulin pens had one or more doses used and should have been dated when opened. During an interview, on 1/10/25 at 11:37 a.m., the DON indicated insulin pens should be dated when opened and discarded when expired. The expiration date for insulin is 28 days after it's been opened. A current facility policy, dated 8/10/23, provided by the DON on 1/10/25 at 11:37 a.m., indicated the following: "...3. Upon opening for the first time, the insulin pen will have a date sticker applied. This will be done by the nurse. The date will reflect the date the seal was broken for use...6. Insulin pens will be considered expired after 28 days and up to 45 days depending on the manufacturer's instructions---after they are opened, no matter the amount of insulin remaining in the pen...." 3.1-25(j) 3.1-25(k)		***medication carts on 1.21.2025 to verify all open insulin have dates for opening and are not expired. No concerns were noted.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The DON or designee in-serviced all licensed nursing staff on 1.24.2025 related to properly dating insulin with dates upon opening and destroying insulin according manufacture guidelines. The*** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***Medication carts audits will be completed five days per week for four weeks, then three days per week for four weeks, then weekly for four months. The QAPI committee will review the audits monthly. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	
F 0812 SS=F 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	F 0812	***It is the policy of the facility to ensure all food is prepared and***	02/14/2025

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WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

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	prepared and served under safe and sanitary conditions. This deficient practice had the potential to impact 39 of 39 facility residents. Finding include: During a lunch meal service observation on 1/9/25 from 12:00 p.m. to 12:40 p.m. the following concerns regarding food handling, food distribution, hand washing, glove use, and prevention of cross contamination were made: The Acting Dietary Manager (ADM) was wearing gloves on both hands. He began meal services, touching meal tickets, meal trays, bowls, counter tops, lids, utensils, napkin wrapped silverware, and the food contact surface of plates with his gloved hands. He picked up cooked chicken nuggets/boneless chicken wings with his contaminated gloves and placed the chicken on meal plates. At 12:04 p.m., he left the kitchen through the rear door by the refrigerators and freezers. He touched the door handle with his gloved hands. He returned carrying dinner rolls in bags. With his soiled gloved hands, he touched the bag of the dinner rolls. He tore the bread bag open. He placed 5 dinner rolls on trays. With the same soiled gloves he returned to the process of touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates with his gloved hands. He then picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. At 12:10 p.m., he left the serving area. Wearing the same contaminated gloves, he touched		***served in a safe and sanitary manner.*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***All residents residing at the facility on 1.9.2025 had the potential to be affected. The Nursing Managers completed assessments on all residents and no adverse effects occurred related the deficient practice.*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All residents residing at the facility had the potential to be affected, however no adverse effects occurred, this plan of correction applies to all residents residing in the facility.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The Administrator inserviced dietary employees on 2.6.2025 on safe and sanitary food preparation, handling and service, hand washing, and wearing and changing gloves. Employees who fail to comply with education and inservice training will be further educated per facility policy.*** how the corrective action(s)	

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	counter tops, cabinet fronts, cabinet handles, the refrigerator, obtained a bag of broccoli, and obtained a steam table pan. With the same contaminated gloved hands, he opened the broccoli and placed the broccoli in the steam table pan. He touched the broccoli with his soiled gloved hands and rearranged the broccoli in the pan. He knocked a small black triangular object from the table and retrieved it from the floor using his contaminated gloved hands. He then used his soiled gloves to open the steamer and place the broccoli inside. After placing the broccoli in the steamer, he returned to the steam table again touching items with his contaminated gloved hands. He returned to touching, meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates with his gloved hands. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. He began to occasionally pick up roasted potatoes with his soiled gloves and place them on the meal tray as well. At 12:15 p.m., he left the serving area once again, he checked potatoes in the oven. He touched the potatoes with his contaminated gloved hands as if checking for tenderness. He then returned to the steam table area. With his soiled gloved hands, he returned to touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. Occasionally, he pick up roasted potatoes with his soiled gloves and placed them on the meal tray as well.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***The dietary manager or designee will complete observation audits of the food preparation, service and handling, hand washing, and wearing and changing gloves five days per week for four weeks, then three days per week for four weeks, then weekly for four months. The audits will be reviewed monthly by the QAPI committee. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	

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	At 12:17 p.m., he left the food service area, he went to the oven and food prep area in the kitchen. He placed a new pan of broccoli on the steam table. He took a pan to the dish room. He used the spray hose at the three compartment sink to spray down the pan. He stuck his contaminated gloved hands in a sink of sudsy water. He removed his gloves and threw them away. He then pulled gloves from his pocket or apron and placed them on his now bare hands. He did not wash his hands prior to putting on the new pair of gloves. He returned to the steam table and began serving with the newly applied gloves. He returned to using the same process of serving as he had previously. He touched meal trays, meal tickets, bowls, food service contact surfaces of plates, napkin wrapped silverware, chicken nuggets, rolls, and roasted potatoes. At 12:19 p.m., he broke apart large pieces of broccoli using his contaminated gloves and placed the broccoli on meal plates. At 12:20 p.m., he drank from his water bottle while wearing his contaminated gloves. He then wiped his mouth on the back of his gloved hand and returned to the steam table area. With his soiled gloved hands, he returned to touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. He also occasionally pick up roasted potatoes with his soiled gloves and place them on the meal tray as well. Periodically, he broke large broccoli with his contaminated gloved and placed the smaller pieces on meal trays.			

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	At 12:25 p.m., he brushed meal tickets off the counter onto the floor. He picked the meal tickets up from the floor using his contaminated gloved hands. Using his soiled gloved hands, he returned to serving meals touching food, dishes and utensils in the same manner he had been using since 12:00 p.m. At 12:27 p.m., with his soiled gloved hands, he took off his ball cap, smoothed the cap, and re-applied it. He returned to meal services using his contaminated gloves to once again touch food, dishes, and utensils. At 12:28 p.m., he took all the food off a standard plate using his contaminated gloves. He placed all the food he had removed on a divided plate and served the meal to a resident. At 12:30 p.m., he left the food service area and went to the stove. With his contaminated gloved hands, he removed roasted potatoes from the oven. He then used his soiled gloved hands and a steam table lid to pour and scrape roasted potatoes off a cooking sheet into a steam table pan. During the lunch meal service from 12:00 p.m. to 12:40 p.m., every chicken nugget and roll served was placed on a meal plate was done using contaminated gloves. During an interview on 1/9/25 at 12:36 p.m., the Acting Dietary Manager (ADM) indicated he should have used tongs to serve the chicken and rolls, but if he had done so it would take too long to serve them. He did not believe he had contaminated his gloves at any time during meal service.			

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	During an interview on 1/9/25 at 1:45 p.m., the Director of the contracted dietary food services company indicated the ADM should have used utensils to served food. The use of gloves instead of utensil increased the risk for cross contamination. A current, undated policy titled, "Food Handling," provided by the Administrator on 1/9/25, at 3:15 p.m., indicated prepared food items will be served with serving utensils so as to avoid hand contamination. A current, undated facility policy titled "Glove Use", provided by the Administrator on 1/9/25 at 3:15 p.m., indicated 2. Staff will use clean barriers such as single-use gloves, tongs, deli paper, and spatulas when handling food. 3. Gloved hands are considered a food contact surface that can get contamination 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 operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning work with food) and after removing single use gloves. ...6. Gloves are just like hands. They get soiled/anytime a contaminated surface is touched, the gloves must be changed, and the hands must be washed. A current, undated facility policy, titled, "Handwashing", provided by the Administrator in 1/9/25 at 3:15 p.m., indicated the following: "...When to wash hands: a. When entering the kitchen at the start of a shift. b. After touching bare human body parts...			

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	...e After...eating or drinking. f. After handling soiled equipment or utensils. g. During food preparation...." 3.1-21(i)(1)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (5) Needs of specialized populations served. (6) Care of cognitively impaired residents (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure required annual dementia education was completed for 4 of 5 employees reviewed for required annual training (CNA 8, LPN 9, Transportation Driver, and RN 11). Findings include: Employee records, provided on 1/8/25, were reviewed on 1/9/25 at 12:45 p.m. and indicated the	F 9999	***It is the policy of this facility to ensure the required annual dementia education for employees is completed.*** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ***Annual Dementia training for CNA 8, LPN 9, RN 11 and Transport Driver will have completed 3 hours of dementia training, by 2.14.2025*** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ***All employees have been scheduled for 3 hours of dementia training, per the 2025 education/inservice training calendar.*** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ***The IDT has developed and implemented an education/inservice calendar to***	02/14/2025

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	following: a. CNA 8, start date 5/18/23, lacked documentation of the three hours annual dementia training for 2024. b. LPN 9, start date 5/1/18, lacked documentation of the three hours annual dementia training for 2024. c. Transportation Driver, start date 3/29/19, lacked documentation of the three hours annual dementia training for 2024. d. RN 11, start date 9/7/23, lacked documentation of the three hours annual dementia training for 2024. During an interview, on 1/9/25 at 12:45 p.m., the Administrator indicated the facility was not able to provide documentation to show the 3 hours of annual dementia training. The facility did cover dementia training in multiple in-services but this was just one of many topics covered during the training. A facility policy, dated 6/30/23, titled, "Guidelines for Dementia Training", provided by the Administrator on 1/13/25 at 10:43 a.m., indicated the following: "... It is the intent of this facility to ensure that staff who render care and services to residents who have a diagnosis of Dementia- have adequate training to meet the needs of these residents who have been affected by the process of Dementia...2) After the initial 6-hour Dementia Training, there will be a 3-hour required Dementia Training Annually, thereafter for all staff...Dementia Training for all staff will be tracked and documented by a designated person in Nursing Management or Human Resources...."		***ensure a minimum of three hours of dementia training each calendar year. Employees who fail to comply with education and inservice training will be further educated per facility policy.*** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ***The IDT will monitor attendance and completion of the required dementia education/inservice. Employees who have not timely completed the training may be removed from the schedule until completion of education/inservice.*** ***The Administrator or designee will randomly review 10 employee files for four weeks, then 5 employee files for four weeks, then 3 employee files per month for four months. Results of the monitoring will be reviewed monthly at the QAPI meeting. Following the audit period if the QAPI Committee determines that substantial compliance has been met the audits may be discontinued.***	

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