STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. BUILDING 00 B. WING	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKE KNOLL VILLAGE	1108 KINGWOOD DRIVE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 29 and 30, October 3, 4, 5 and 6, 2022. Facility number: 012901 Provider number: 155814 AIM number: 201215100 Census Bed Type: SNF/NF: 66 SNF: 15 Total: 81 Census Payor Type: Medicare: 13 Medicaid: 55 Other: 13 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 17, 2022.	F 0000	*Submission of this plan of correction does not constitute an admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted in accordance with requirements under state and federal law.* *Please accept this plan of correction as our credible allegation of compliance as of October 7th, 2022.*	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Megan Miller 10/31/2022

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	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the			

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	resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 55) who was his own representative, received appropriate and timely notice that his Medicare covered services were coming to an end for 1 of 3 residents reviewed for Notice of Medicare Noncoverage (NOMNC) beneficiary notice review. Findings include: On 9/29/22 at 10:48 a.m., Resident 55 was observed in his room watching television (TV). At this time, he indicated he thought he should be going home soon, or at least his goal was to get back home as soon as possible. Resident 55 indicated he still received therapy but did not know how much longer he had, what services were covered, or for how long. On 10/4/22 at 11:15 a.m., the Administrator provided a copy of Resident 55's Notice of Medicare Noncoverage (NOMNC) beneficiary notice. The NOMNC indicated Resident 55's Medicare Part A services would end on 3/8/22. There was a handwritten note for additional information which indicated, " ...On 3/4/33 spoke with [wife] due to cognition, and she is aware of last covered day and is fine...." Resident 55 was listed on his contacts page as his own resident representative, responsible party, primary financial contact, and received his own statements.	F 0582	Past noncompliance: No POC required.	10/21/2022

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	There were two admission agreement packets scanned into Resident 55's medical record. The first was dated 2/8/22, the second was dated 7/27/22. Both packets were reviewed with and signed by the resident as he remained his own responsible party. On 10/4/22 at 12:00 p.m., Resident 55's Medicare charting and nursing progress notes were reviewed in the days leading up to the end of his covered services, from 3/1/22-3/8/22, throughout the notes it was indicated Resident 55 was alert and oriented times (x) 3 and x 4 (person, place, time, situation), and that he was able to make his needs and wants known. During an interview on 10/4/22 at 11:30 a.m., the Business Office Manager (BOM) indicated Resident 55 received his NOMNC before she started in the position. However, she was familiar with Resident 55 and double checked his record on the computer which indicated he was his own responsible party, therefore he should have received a copy of his NOMNC. All residents who were of "sound of mind" should receive a copy of their notice. During a follow up interview on 10/5/22 at 10:31 a.m., Resident 55 indicated his wife was highly involved in his care and decision making, but it remained his wish to be asked and to receive statements directly. Copies could be provided to his wife. This deficiency was corrected by 3/8/22 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included a new BOM being hired and individually educated on the process for providing notifications to residents and/or			

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	representatives as individually applicable. Further, the facility added a quality assurance measure for monthly review for NOMNC and was last reviewed on 9/21/22. 3.1-4(f)(1) 3.1-4(f)(2)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure a resident's Minimum Data Set (MDS) assessment was coded accurately to reflect her mental health diagnoses in regard to her Pre-Admission Screen and Record Review (PASRR) (Resident 16). Findings include: On 10/3/22 at 9:08 a.m., Resident 16 was observed as she was assisted into her wheelchair by an unidentified therapist. Resident 16 indicated to the staff member that she was in a better mood and felt less like crying. She wanted to participate in therapy to get better and go home. Resident 16 indicated, "I cry a lot, but not today." On 10/5/22 at 11:14 a.m., Resident 16's medical record was reviewed. She admitted to the facility on 7/11/22 with active diagnoses which included, but were not limited to bipolar disorder, catatonic schizophrenia, and post-traumatic stress disorder (PTSD). A Pre-Admission Screen and Record Review (PASRR) Level II assessment was completed on 7/15/22 with an effective date of 7/8/22. The Level	F 0641	*All residents who suffer from mental illness have the potential to be affected by this alleged deficient practice.* *Upon immediate notification of this alleged deficiency, the facility initiated education to both the MDS coordinator and Social Services Director related to the accurate coding of the MDS and mental health diagnosis. Additionally, the facility conducted a house-wide audit to ensure no similar inaccuracies were identified. No further concerns were noted.* *To ensure ongoing compliance, the Director of Nursing/Designee is responsible for conducting audits of the coding to ensure the MDS accurately reflects each resident's mental health diagnoses. Twice weekly and for a period of one month, the Director of Nursing shall these*	10/07/2022

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	II determined Resident 16 did have a PASRR condition and gave the following instructions, " ...the facility should mark yes for question A1500 on the MDS, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition ... you fall into the category of having a diagnosis that the PASRR program was designed to assess. Your condition is likely to require expert treatment in the future, that diagnosis is: A mental health condition ...." Resident 16's admission MDS, dated 7/18/22, did not reflect the finding of the PASRR outcome. Section A1500 was selected "no." During an interview on 10/5/22 at 9:10 a.m., the Social Service Director (SSD) indicated Resident 16 did have some behaviors which were related to her mental health diagnoses. She was overly tearful at times and had a recent psychiatric stay for making suicidal statements. The SSD indicated her MDS should code that Resident 16 was a level II.		*conduct random audits of four residents' MDS coding. The Director of Nursing/Designee shall continue these audits once weekly for a period of three months. Then, the Director of Nursing/Designee shall continue these audits for a period of one a month for a week of two months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised, as warranted, based on compliance.*	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare			

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	information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to ensure a complete baseline care plan was implemented for a newly admitted resident for 1 of 3 residents reviewed for baseline care plans (Resident 76). Findings include:	F 0655	*All residents who have recently admitted to the facility and for whom the facility has not yet completed comprehensive care planning have the potential to be affected by this alleged deficient practice.* *Upon immediate notification of*	10/07/2022

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	On 10/6/22 at 9:11 a.m., Resident 76's medical record was reviewed. She admitted to the facility on 7/20/22 after an acute hospital stay where she received treatment for a fractured fibula after a fall at home and required surgery for a new pacemaker to be placed after a 3-degree heart block was found. A hospital discharge summary dated 7/14/22 indicated, " ...doing well post pacemaker ... diagnosed with a fibular fracture ... third-degree heart block diagnosed in after transfer here with pacemaker placed 7/9/22 ... patient somewhat distraught as someone mentioned that she might need a "kidney machine ..." no plans for emergent dialysis and patient's [family member] questions if she should be on a renal diet...." Resident 76 had a baseline care plan, dated 7/20/22, which gave instructions to circle applicable options and place interventions/goals. a. Diet/Nutrition options were not circled. b. Fall Risk options were not circled c. Special Medical Needs/Considerations were not specified. Resident 76's comprehensive care plans were reviewed and lacked documentation of a fall risk care plan, diet/nutrition care plans, and a plan of care to address her newly placed pacemaker. During an interview on 10/6/22 at 12:00 p.m., the Clinical Consultant indicated baseline care plans were completed within 48 hours a resident's admission in order to capture the most important care aspects which would include fall risk, nutrition/diet orders, and other special considerations such as a pacemaker. On 10/6/22 at 1:50 p.m., the Clinical Consultant		*this alleged deficiency, the facility reviewed baseline care plans for all residents for whom it had yet to complete comprehensive care planning. No other concerns similar in nature were identified. Using the facility's policy, the facility initiated on-going, shift-to-shift education to all licensed nursing staff received ongoing, shift-to-shift education related to the appropriate completion of baseline care plans within 48 hours of admission to the facility.* *To ensure ongoing compliance, the DON/Designee shall be responsible for conducting random review of baseline care plans to verify the accuracy of their completion. Within 48 hours of admission, the DON/Designee will review 100% of baseline care plans for a period of one month, no less than 50% of baseline care plans for a period of two months, and no less than 25% of baseline for a period of three months. The Quality Assurance Committee shall review the results of these assessments and any corrective action taken during its monthly meetings for period of no less than six months. Monitoring shall be reviewed/revised, as warranted, based on compliance.*	

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	provided a copy of current facility policy titled, "Care Plan Development and Review," revised 9/2017. The policy indicated, " ...the facility shall develop and implement a baseline care plan within 48 hours of a resident's admission that includes the instructions needed to provide effective and person-centered care of the resident that meet profession standards of quality care ... A baseline care plan shall be developed to include the minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services...."			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure medications were not left in residents' rooms for 5 of 5 residents observed with medications at bedside (Resident 32, 23, 43, 35, and 27), and unauthorized staff were not in the resident's room with unsecured medications for 1 of 5 residents observed with medications at bedside (Resident 32). Findings include: 1. On 10/4/22 at 4:12 p.m., Licensed Practical Nurse	F 0689	*All residents have the potential to be affected by this alleged deficient practice.* *Upon immediate notification of this alleged deficiency, the facility conducted house-wide audits of all resident rooms to ensure that all other medications were secure and inaccessible to unauthorized staff. No other concerns similar in nature were identified. Additionally, the facility immediately initiated on-going, shift-to-shift education*	10/07/2022

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	(LPN) 19 left medications for Resident 32 in her room. The resident was lying in bed, and LPN 19 indicated she would check with her in 2 seconds to see if Resident 32 had taken them. The following medications were left: a. Vascepa (for high triglycerides) 1 gm (grams) 2 capsules ordered for twice a day. b. Glipizide (anti-diabetic) 5 mg ordered for twice a day. c. Xarelto (anti-coagulation) 20 mg ordered for once a day. d. Simethicone (treats bloating) 80 mg ordered for three times a day. On 10/4/22 at 4:37 p.m., LPN 19 was observed to walk past Resident 32's room, with the medication cart, as she continued to pass medications down the hall. She did not check to see if Resident 32 had taken the medications. On 10/4/22 at 4:39 p.m., Certified Nursing Assistant (CNA) 20 and CNA 21 entered Resident 32's room to reposition her roommate. Resident 32's medications had not been taken and were not secure. Resident 32 was lying in bed with her eyes closed. On 10/4/22 at 4:47 p.m., the Clinical Consultant asked LPN 19 to observe Resident 32 take the medications that were provided. On 10/4/22 at 4:50 p.m., LPN 19 observed the resident take the Vascepa, glipizide, and Xarelto. When LPN 19 was observed leaving the resident's room, the simethicone was still in the medication cup in the resident's room. LPN 19 came back and asked Resident 32 if she wanted her to put the medications back into the medication cart until she received her dinner. The resident was agreeable.		*related to the appropriate securement/storage and administration of medications per its policies and procedures to all personnel licensed to administer medications. Lastly, the facility initiated on-going, shift-to-shift education to all personnel related to the immediate reporting of unsecure medication to a licensed nurse. No other concerns similar in nature were identified.* *To ensure ongoing compliance, the Administrator/Designee is responsible for conducting random observations throughout the facility to ensure all medications are secure and inaccessible to unauthorized individuals. On days of work and for a period of one month, the Administrator/Designee shall conduct four random observations of resident rooms each day. Thereafter, the Administrator/Designee shall conduct four random observations of resident rooms on two days of work per week for a period of two months and one day of work per week for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for period of no less than six months. Monitoring shall be reviewed/revised, as warranted, based on compliance.*	

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	2. On 10/3/22 at 1:44 p.m., Resident 23 diagnoses included, but were not limited to, legal blindness and glaucoma. On 9/29/22 at 11:57 a.m., Resident 23 was observed with Refresh Tears 0.5%. lubricant eye drops on her bed side table. The pharmacy instruction indicated to instill one drop in each eye daily. The resident indicated the staff put her eye drops in for her. On her dresser was a bottle of Multi Collagen capsules. The bottle instructions indicated the suggested dose was 3 capsules per day with 8 ounces (oz) of water, juice, or tea. There was no open or expiration date on bottle. Orajel toothache cream (oral antiseptic/pain reliever/astringent) 0.33 oz. and Orajel 3X medication (20% benzocaine) unopened. A small, plastic container of an unidentified liquid with no label, open, or expiration date. The resident indicated she put it in her ears. A plastic baggie of large cotton swabs was next to it. On 10/3/22 at 10:11 a.m., Resident 23 was observed with Refresh Tears 0.5%. lubricant eye drops on her bed side table. The pharmacy instruction indicated to instill one drop in each eye daily. The resident indicated the staff put her eye drops in for her. On her dresser was a bottle of Multi Collagen capsules. The bottle instructions indicated the suggested dose was 3 capsules per day with 8 ounces (oz) of water, juice, or tea. There was no open or expiration date on bottle. Orajel toothache cream (oral antiseptic/pain reliever/astringent) 0.33 oz. and Orajel 3X medication (20% benzocaine) unopened. A small plastic container of an			

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	unidentified liquid with no label, open, or expiration date. The resident indicated she put it in her ears. A plastic baggie of large cotton swabs was next to it. On 10/3/22 11:44 a.m., the Clinical Consultant indicated Resident 23 only had a self-administration assessment for Latanoprost (treats glaucoma) eye drops. On 10/3/22 at 12:08 p.m., the Executive Director (ED) indicated Resident 23 did not have a medication self-administration assessment for the medications in her room. She indicated they would call the family to let them know not to bring medications into the facility without informing the nurse. On 10/3/22 at 12:19 p.m., the Clinical Consultant indicated the unknown, unlabeled liquid in her room was olive oil. Her niece brought it in for her dry ears. He indicated she saw an ear doctor here and had an order for Debrox (earwax removal drops). 3. On 9/29/22 at 1:14 p.m., Resident 43 was in her room, on her over the bed table a container of Miconazole Nitrate was observed. The pharmacy instructions indicated to apply to bilateral (both) feet. On 10/3/22 at 9:50 a.m., Resident 43 was in her room, on her over the bed table a container of Miconazole Nitrate was observed. It appeared to be empty or very close to empty. When asked about it, she indicated the staff would provide another one to keep in her room. On 10/3/22 at 12:08 p.m., the ED indicated Resident 43 did not have a medication			

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	self-administration assessment for the medication in her room. 4. On 9/29/22 at 11:28 a.m., Resident 35 was in bed with her eyes closed. On a shelf by her bed, Ammonia lactate lotion 12% (treats dry skin) was observed. The pharmacy instructions indicated to apply to lower legs every day. It had arrived from pharmacy on 6/18/21. There was no expiration date on the bottle. It was unknown how long it was good for once opened. On 10/3/22 at 10:15 a.m., Resident 35 was in bed with her eyes closed. On a shelf by her bed, Ammonia lactate lotion 12% was observed. The pharmacy instructions indicated to apply to lower legs every day. It had arrived from pharmacy on 6/18/21. There was no expiration date on the bottle. It was unknown how long it was good for once opened. On 10/3/22 at 12:08 p.m., the ED indicated Resident 35 did not have a self-administration assessment for the medication in her room. On 10/5/22 at 2:03 p.m., Resident 35's diagnoses included, but were not limited to, cerebral infarction (stroke), hemiplegia and hemiparesis affecting the right dominant side, and chronic obstructive pulmonary disease (COPD). 5. On 9/30/22 at 10:35 a.m., Resident 27 was in her room. She had Diclofenac sodium 1% (treats inflammation and pain) in her room. The pharmacy instructions indicated to use to bilateral knees 4 times a day. On 10/3/22 at 10:09 a.m., Resident 27 was in her room. The Diclofenac sodium was no longer in her room. On her dresser, there was 2 containers of			

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	Iodoform (medicated cotton gauze strips for wounds) and three bottles of spray wound cleanser. On 10/3/22 at 12:08 p.m., the ED indicated Resident 27 did not have a medication self-administration assessment for the medications in her room. A current policy, titled, "Medication Administration," dated 4/2017, was provided by the Clinical Consultant on 10/5/22 at 10:15 a.m. A review of the policy indicated, " ...Medications are administered to residents only as prescribed and only by person licensed or qualified to do so...Always observe the resident taking their medication(s). Never permit medication to remain in the resident's room. Resident may not self-administer medications unless specifically authorized in writing by the attending physician, and then only in accordance with facility procedures for self-administration...." A current policy, titled, "Medication, Self-Administration," dated 9/17, was provided by the Clinical Consultant (CC), on 10/5/22 at 10:15 a.m. A review of the policy indicated, " ...the interdisciplinary team shall evaluation the resident for the cognitive, physical and visual ability to accomplish this task. The interdisciplinary team shall determine self-administration to be clinically appropriate ...Medications shall be stored in a manner to prevent potential access to confused residents in the facility...." 3.1-25(j) 3.1-25(l) 3.1-25(m) 3.1-45(a)			

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure one freezer and one four-door refrigerator had a thermometer inside, the temperature logs were completed, all foods were labeled and had open dating with expiration dates, the sanitizer buckets had the correct amount of sanitizer, and staff wore beard covers while in the kitchen. These issues had the potential to effect 80 of 81 residents who received food from the kitchen. Findings include: On 9/29/22 at 9:27 a.m., a tour was completed with the Dietary Manager (DM).	F 0812	*All residents who receive nutrition from the facility's kitchen have the potential to be affected by this alleged deficient practice.* *Upon immediate notification of this alleged deficiency, the facility disposed of all unlabeled food items and replaced the necessary thermometers. Additionally, the sanitizer buckets were immediately emptied and refilled with the correct amount of sanitizer, and per instruction, the staff member immediately donned a beard cover. The facility*	10/07/2022

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	Freezer 1 and the four-door refrigerator had no internal thermometers and the temperature logs were incomplete for 9/27/22 and 9/28/22. Nine lidded juice cups had no label or date. The walk-in refrigerator had two 2-liter containers of Coke. Neither had a resident name on them, one was open, and one was still sealed. Several plastic wrapped containers of cheese had no label, open, or expiration dates: one plastic wrapped bag of shredded cheese, 2 plastic wrapped packages of American cheese, and one plastic wrapped package of Swiss cheese. One plastic bag of salad lettuce had no open or expiration date. Tomato soup in a large plastic bin and 2 covered stainless steel containers of hamburgers in beef broth, had no label, open or expiration dates. In the dry storage area, a plastic bag of cake mix had no label, open or expiration date. On 9/29/22 at 10:02 a.m., the DM indicated she would get internal thermometers for Freezer 1 and the four-door refrigerator. On 9/29/22 at 9:47 a.m., the DM tested the amount of sanitizer for the cleaning bucket in the cook area. The first litmus strip she tried showed the sanitizer was at 100, but the litmus strips were expired on 6/2021. She got an unexpired litmus strip and the sanitizer amount was zero. On 9/29/22 at 9:50 a.m., Cook 7 indicated he came in at 5:00 a.m. and clean the kitchen prep counters using the bucket with zero sanitizer before breakfast service.		*initiated ongoing, shift-to-shift education to all kitchen personnel related to the above alleged deficiencies and to the completion of refrigerator temperature logs per its policies and procedures. Lastly, the facility initiated shift-to-shift education related to the need to appropriately don hair/beard coverings upon entering the kitchen.* ***To ensure ongoing compliance, the Administrator/Designee is responsible for conducting random observations of the kitchen to ensure all food is appropriately labeled, sanitization buckets contain the appropriate amount of sanitizer, thermometers are present in necessary refrigerators, and refrigerator temperatures are logged correctly. On days of work and for a period of one month, the Administrator/Designee shall conduct a random observation of the kitchen each day. Thereafter, the Administrator/Designee shall conduct a random observation of the kitchen on two days of work per week for a period of two months and one day of work per week for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly***	

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	On 10/3/22 at 10:47 a.m., the District Manager of Dietary Services (DMDS) indicated the sanitizer bucket in the kitchen prep area was 200-400 parts per million (ppm). The litmus strip did not turn green indicating it was below 400 ppm of sanitizer. On 10/3/22 at 10:52 a.m., the DM emptied the sanitizer bucket and replaced the 200-400 ppm solution with fresh fresh sanitizer solution. It tested at 400 ppm. On 10/3/22 at 10:34 a.m., Laundry aide 15 who was assisting in the kitchen was observed putting clean trays away. He had a full beard and was not wearing a beard net. He indicated he was not aware he needed one, and no one told him to wear one. On 10/3/22 at 10:36 a.m., Dietary aide 10 was observed in the kitchen. He had a surgical mask below his chin, his mustache and goatee were not covered. A current policy, titled, "Storage of Foods under Sanitary Conditions," dated 5/2018, was provided by the ED, on 10/7/22 at 11:45 a.m. A review of the policy indicated, " ...All food items stored in the refrigerator must be labeled and dated if not scheduled to be served at the next meal ...." A current policy, titled, "Food Storage: Cold Foods," dated 4/2018, was provided by the ED, on 10/4/22 at 8:45 a.m. A review of the policy indicated, " ...An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination ...."		***meetings for period of no less than six months. Monitoring shall be reviewed/revised, as warranted, based on compliance.***	

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	A current policy, titled, "Environment," dated 9/2017, was provided by the ED, on 10/4/22 at 8:45 a.m. A review of the policy indicated, " ...All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition ...All food contact surfaces will be cleaned and sanitized after each use ...." A current policy, titled, "Sanitation Buckets," dated 5/2018, was provided by the ED, on 10/4/22 at 8:45 a.m. A review of the policy indicated, " ...The desired concentration ...200-400 ppm (parts per million) for Quat (sanitizer solution) ...Test solution strength as needed ...." A current policy, titled, "Staff Attire," dated 9/2017, was provided by the ED, on 10/4/22 at 8:45 a.m. A review of the policy indicated, " ...All staff members will have their ...facial hair properly restrained ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure proper sanitation procedures for cleaning a reusable blood glucose meter for 2 of 2 residents reviewed for blood glucose monitoring (Resident 29 and 60), and failed to ensure soiled and clean linens were appropriately handled for 4 of 4 residents reviewed for linen handling (Resident 34. 39, 59, and one unidentified resident). Findings include: 1. On 10/4/22 at 3:56 p.m., Licensed Practical Nurse (LPN) 19 was observed to remove the glucometer (blood sugar measuring device) from the medication cart, wipe it for less than 10 seconds with an alcohol wipe, and used it to measure the blood sugar of Resident 29. She did not clean it before returning it to the medication cart. When asked about it, she removed it from the medication cart and cleaned it with an alcohol swab for less than 10 seconds. On 10/4/22 at 4:18 p.m., LPN 19 was observed to	F 0880	*Regarding the alleged deficient practice related to the use of a glucometer, all residents whose blood glucose levels are checked using the facility-approved glucometer have the potential to be affected by this alleged deficiency. Regarding the alleged deficient practice related to the handling of soiled and clean linens, all residents have the potential to be affected by this alleged deficiency.* *Upon immediate notification of the alleged deficiency related to the use of a glucometer, the Clinical Consultant, who is also the facility's Infection Preventionist (IP), immediately re-educated LPN 19 per the facility's policies and procedures related to the use of a glucometer. The facility's IP and DON immediately initiated on-going, shift-to-shift education*	10/07/2022

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	remove the glucometer from the medication cart, wipe it for less than 10 seconds with an alcohol wipe, lay it on a clean gloves on top of the medication cart. She took the glucometer into Resident 60's room and laid it on the uncleaned surface of his over the bed table, then used it to measure the blood sugar of Resident 60. She was observed to clean the glucometer for least than 10 second and put it back into the medication cart. On 10/4/22 at 4:45 p.m., the Clinical Consultant indicated the glucometer were cleaned with bleach wipe for a 3-5 minute cleaning time, depending on which bleach wipe was used and no residents on that hall had blood borne pathogens. Manufacturer's instructions were provided for the glucometer, titled EvenCareG2, Care for the Meter," not dated, was provided by the Clinical Consultant on 10/5/22 at 1:53 p.m. A review of the instructions indicated, " ...Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter ...To disinfect your meter, clean the meter with one of the validated disinfecting wipes ...Wipe all external areas of the meter ...both front and back surface until visibly clean ...Allow the surface of the meter ...to remain wet at room temperature for the contact time listed on the wipe's directions for use ...." Manufacturer's instructions were provided for, "Micro-Kill Bleach Germicidal Bleach Wipes," dated 8/6/2020, by the Clinical Consultant, on 10/5/22 at 1:53 p.m. A review of the instructions indicated, " ...Apply premoistened towelette and wipe desired surface to be disinfected ...a 3 minutes contact time is required for efficacy ...Allow treated surfaces to remain visibly wet for 3 minutes ...ensure that the surface remains		*for all licensed nursing staff related to the appropriate use/disinfecting of a glucometer per facility policies and procedures. Additionally, the facility's IP and DON initiated on-going, shift-to-shift education for all staff related to the appropriate handling of soiled and clean linens, including during transportation. To identify the root cause of this alleged deficiency, the facility conducted a root cause analysis with its IP, Medical Director, Administrator, and Director of Nursing. Lastly, the facility reviewed/updated its LTC infection control self-assessment to ensure it accurately reflected the facility and its policies and procedures.* **To ensure ongoing compliance, the DON/Designee is responsible for conducting random observations of staff to ensure the appropriate use of glucometers and that soiled/clean linens are appropriately handled and transported. On days of a work and for a period of six weeks, the Director of Nursing shall conduct four random observations. Thereafter, the DON/Designee shall conduct four random observations of staff on two days of work per week for a period of six weeks, and one day of work per week**	

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	visibly wet for the entire contact time. Allow surface to air dry ...." A current policy, titled, " ...Blood Glucose Measurement, EvenCare G2," dated 10/2014, was provided by the Clinical Consultant, on 10/5/22 at 10:15 a.m. A review of the policy indicated, " ...If a "facility" meter was used, follow instruction for sanitization listed on the facility designated wipe in an effort to prepare for next use ...." A current policy, titled, " ...Medication Administration," dated 4/2017, was provided by the Clinical Consultant, on 10/5/22 at 10:15 a.m. A review of the policy indicated, " ...Use clean paper towel to set any item down while in the resident's room if it is to be returned to the medication cart ...." 2. On 9/29/22 at 12:38 p.m., Certified Nursing Assistant (CNA) 23 was observed to carry unbagged soiled linens from an unidentified resident's room, down the 200 Hall. She opened the lidded soiled linen bin in the hall and deposited the soiled linen inside. On 10/4/22 at 3:00 p.m., CNA 24 was observed having a conversation with Unit Manager (UM) 25. She was carrying a stack of clean linens up against her body. She entered Resident 34's room and set the stack of linens on his bed. She indicated she should not have held the clean linens against her body. She indicated she had been carrying 2 chucks, several towels, and 2 resident gowns. She picked up all the linens except for one chuck that remained on Resident 34's bed. She distributed the remaining linens to Resident 39 and 59's rooms. A current policy, titled, " ...Linen, Handling,"		**for a period of three months. The Quality Assurance Committee shall review the results of these observations and any corrective action taken during its monthly meetings for a period of no less than six months. Monitoring shall be reviewed/revised, as warranted, based on compliance.**	

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	dated 12/2015, was provided by the Clinical Consultant, on 10/5/22 at 10:15 a.m. A review of the policy indicated, " ...Linen will not be carried against the body ...Soiled linen will be placed in a container (i.e. linen barrel, plastic bag, etc) prior to taking it into the hallway ...." 3.1-18(b)(1)			